



Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Chris Walmsley
Acute Governance Co-ordinator
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

26 September 2022

Dear Sir,

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

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

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

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

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

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

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

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

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

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

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

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to [REDACTED].

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

Yours faithfully

[REDACTED]

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: [REDACTED]
Mobile: [REDACTED]

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

Chair's Notice

[No 94 of 2022]

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

WARNING

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

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

TO:

**Chris Walmsley
Acute Governance Co-ordinator
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ**

IMPORTANT INFORMATION FOR THE RECIPIENT

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

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 24th October 2022**.

APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 17th October 2022**.

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

Dated this day 26th September 2022

Signed:

Personal Information redacted by the USI

Christine Smith QC

Chair of Urology Services Inquiry



SCHEDULE
[No 94 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.
2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.
3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.



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

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.
5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.
6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.
7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?
8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.
9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?



10. What performance indicators, if any, are used to measure performance for your role?
11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?
12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.
13. What systems of governance do you use in fulfilling your role?
14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.
15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?
16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?
17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?
18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.
20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.
21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?
22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?
23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?
24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:
- (i) Waiting times
 - (ii) Triage/GP referral letters
 - (iii) Letter and note dictation
 - (iv) Patient care scheduling/Booking
 - (v) Prescription of drugs



- (vi) Administration of drugs
- (vii) Private patient booking
- (viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
- (ix) Following up on results/sign off of results
- (x) Onward referral of patients for further care and treatment
- (xi) Storage and management of health records
- (xii) Operation of the Patient Administrative System (PAS)
- (xiii) Staffing
- (xiv) Clinical Nurse Specialists
- (xv) Cancer Nurse Specialists
- (xvi) Palliative Care Nurses
- (xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.
26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.
27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.



28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?
29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?
30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?
31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.
32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?
33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?
34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.
35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

**Staff**

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?
37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.
39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?
40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?
41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.



If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

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

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

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

NOTE:

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

**UROLOGY SERVICES INQUIRY**

USI Ref: Notice 94 of 2022

Date of Notice: 26 September 2022

Witness Statement of: Chris Wamsley

I, Chris Wamsley, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 All my full-time employment prior to October 2019 was within the Belfast Health and Social Care Trust. Within the context of my initial role within the Southern Trust, Lead Nurse for Medicine, there was no roles or responsibilities relevant to the Terms of Reference.

1.2 I undertook the role of Acute Clinical and Social Care Governance Coordinator (ACGC) in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction



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process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

1.3 I have suggested throughout the completion of this section 21 that the ACGC who held this position prior to July 2021 would be better to informed to answer certain questions. The ACGCs who held this position prior to my appointment since 2016 was Patricia Kingsnorth within an Interim capacity and Trudy Reid as the permanent capacity.

1.4 From a chronological perspective I have not been in a position under the influence of the Terms of Reference for an extended period of time, only 15 months, therefore I will address each aspect of the Terms of Reference and refer to the appropriate location within the section 21 response.

1.5 As the Terms of Reference refers to the management of clinical and social care governance functions there has been an overview of my roles and responsibility within the delivery of these governance functions within the responses to questions 6, 7, 9, 10, 11 and 13.

1.6 As ACGC I have a role within the lookback review processes which is a central process surrounding assessing cases of potential harm within Urology Services. This process is detailed from paragraph 6.47 to 6.55.

1.7 The Terms of reference make specific reference to the Southern Trust's handling of concerns and complaints. Since undertaken the role of ACGC I have reviewed the reporting, monitoring, escalation and dissemination of learning from complaints and incidents. This information is referenced in the answer to question 6, 7, 9, 16, 20, 24.17 and 35.

1.8 Within this section 21 I have identified the processes of how the ACGC has oversight of complaints and incidents and also the changes in processes which I have implemented since undertaking this role.



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1.9 Since undertaking the role I have amended the structure of monitoring so it has improved Divisional oversight making information more transferable for Assistant Directors to monitor their Divisional performance. This has also been reflected in the data, themes and learning shared at Directorate, Divisional and Service levels.

1.10 Since January 2022 within the Acute Complaints Department all staff members highlighted within complaints are reflected with the datix to provide greater oversight of potential concerns to aid early identification and escalation to operational teams.

1.11 Although I have only held the position for 15 months I have undertaken quality improvement across the governance processes within the Acute Directorate. I have responded to the questions which relate to the application and assessment if clinical governance was “fit for purpose” within the section 21 albeit from a position of hindsight and not having worked within the systems in place at that time. This information is reference within the answers to questions 39, 40, 41 and 43.

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

2.1 All documents which have been referenced in this statement can be located in S21 94 of 2022 – Attachments.



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3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

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

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

4.1. All my full-time employment prior to October 2019 was within the Belfast Health and Social Care Trust. As an overview of the roles held, I was a Band 5 Staff Nurse (Sept 2009 – June 2015), Clinical Charge Nurse (June 2015 – Feb 2017) and Charge Nurse (Feb 2017 – Oct 2019).

4.2. I have held roles within the Southern Health and Social Care Trust as a member of the Nurse Bank in both a Health Care Assistant (Band 2/3) and Staff Nurse (Band 5) capacity. I undertook these roles as a second employment to supplement my income alongside my permanent fulltime employment within the Belfast Trust.

4.3. I commenced full time employment within the Southern Health and Social Care Trust in October 2019 as the Lead Nurse for Medicine, band 8a. The job summary for this role is highlighted below and a complete job description has been included as evidence.



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4.4. The Lead Nurse is responsible to the Head of Service for the operational and professional nursing management and leadership within the Division. The lead Nurse functions at a senior level providing visible, professional nursing leadership, support and direction to ensure safe patient centered care and proactively manage, lead and provide solutions to resolve complex operational issues working with Ward Managers, Patient Flow Team and Head of Service including the leads for Nursing Workforce, Education, Training and Development and Governance.

4.5. The Medical Lead Nurse is responsible for ensuring standards of nursing practice throughout their designated medical specialties are at the required professional standard ensuring safe, high quality clinical services are delivered and lead on programmes of improvement related to implementing and sustaining Regional Nursing Quality Indicators (NQIs).

4.6. The Lead Nurse works with the multidisciplinary team to optimize patient experience and outcomes of care through service and workforce efficiency, productivity and effectiveness. There is an expectation the Lead Nurse contributes to the strategic direction and policy setting for the nursing within their medical Divisions.

4.7. I was successful at interview for the role of Acute Clinical and Social Care Governance Coordinator (ACGC), band 8b, and commenced this post July 2021. The job summary for this role is highlighted below and a complete job description has been included as evidence.

4.8. The ACGC has responsibility for driving forward and coordinating all aspects of the Trusts Clinical and Social Care Governance agenda within the Acute Directorate with and on behalf of the Service Director and the Assistant Director with responsibility for Governance. The ACGC provides an internal and external Directorate focus for the prioritization, linking, implementation,



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review and monitoring of both the operational and professional governance agenda for the Directorate.

4.9. On behalf of the Director the ACGC provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to Clinical and Social Care Governance is required are identified and addressed. The ACGC will contribute to the development of corporate and operational strategy, policy and decision making within the Trust with respect to the Clinical and Social Care Governance agenda within the Directorate and as an integral part of the Trust Clinical and Social Care Governance Working Body and through close collaboration with the Trust's Corporate Assistant Director for Clinical and Social Care Governance.

4.10. The ACGC will be responsible for advising and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate Clinical and Social Care Governance plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director of Clinical and Social Care Governance in respect of any issues relating to the development, implementation, performance management and assurance of Clinical and Social Care Governance plans, systems and procedures and their associated improvement plans.

4.11. The ACGC provides enhanced Clinical and Social Care Governance support and performance improvement expertise and intervention in this area to their Directorate and to the corporate Clinical and Social Care Governance projects where required. They provide the Directorate and the organization with a suite of intelligence information analysis which demonstrates real time performance in relation to all areas of Clinical and Social Care Governance, including incidents, complaints, risk, litigation, audit, clinical indicators and patient safety.



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4.12. The ACGC will, in collaboration with the Trusts Senior Management Team and the Trusts Clinical and Social Care Governance Senior Management, develop the organisation's capacity for continuous improvement in the area of clinical and social care governance and to facilitate a culture of openness and learning from the experience using dynamic leadership and facilitation skills. *Please see:*

1. Evidence 1 – Job Description for Lead Nurse

2. Evidence 2 – Job Description for Acute Clinical and Social Governance Coordinator.

- 5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

5.1. I will provide a description of line management within each position separately

5.2. Initially in my role as Lead Nurse within Medicine. This Lead Nurse role was split across two service areas within Medicine and therefore I was directly line managed by two Head of Services; Head of Service for "Gastroenterology, Rheumatology, Neurology, Diabetes and Endocrine" and Head of Service for "Acute Elderly, Stroke and Patient Flow".

5.3. The Head of Service for "Gastroenterology, Rheumatology, Neurology, Diabetes and Endocrine" was Louise Devlin throughout my time employed as the Lead Nurse. The Head of Service for "Acute Elderly, Stroke and Patient Flow" was Kathleen McGoldrick until her retirement in October 2020. Following Kathleen McGoldrick's retirement there was a restructure within the services allocated to this Head of Service position however there was no change to the areas of responsibility associated to the Lead Nurse



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position. The Head of Service for “Acute Elderly, Stroke, Dermatology, Haematology and Covid Wards” took over line management responsibility for this Lead Nurse position, Patricia Loughran. The Assistant Director with managerial responsibility for these service areas was Anne McVeigh and responsible Director was Melanie McClements (Director of Acute Services).

5.4. Under the Head of Service for “Gastroenterology, Rheumatology, Neurology, Diabetes and Endocrine” the services areas I had line management responsibility for the Diabetic Nurse Specialists, Multiple Sclerosis Nurse Specialists, Gastroenterologist Nurse Specialists, Headache Nurse Specialist, Research Nurses, 1 South, the Day Clinical Centre (Initially based within Craigavon Area Hospital prior to its transfer to South Tyrone Hospital) and the Craigavon Area Hospital Discharge Lounge. An overview of the line management responsibility is highlighted in the table below.

Service Area	Line Management Responsibilities
Diabetic Nurse Specialists	3 x Band 7 Staff Members Shirley Brannigan, Laura Espie, Aine Kelly 2 x Band 6 Rachel Madden, Claire Metcalf-Foster Sinead Sutton (replaced Rachel Madden)
Multiple Sclerosis Nurse Specialists	2 x Band 7 Staff Members Heidi Thompson, Jill Patton
Gastroenterologist Nurse Specialists	3 x Band 7 Ruth Hall, Lynsey Breen, Niamh McCabrey Sorchá Henderson (Secondment), Margaret O'Hara (Secondment)
Headache Nurse Specialist	1 x Band 7 Geraldine Henderson
Research Nurses	2 x Band 6 Fiona Thompson Amanda Adamson



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1 South	36 bedded Acute Medical Ward with specialist interest in Gastroenterology and Diabetes. Band 7 – Karen Kelly
Day Clinical Centre and Discharge Lounge	Day Clinical Centre provides day case interventions including Biological therapies. Band 7 – Sarah Hislop.

5.5 Under the Head of Service for “Acute Elderly and Stroke” I had line management responsibility for the Stroke Specialist Nurses (until recruitment of 8a Stroke Improvement Lead [James Gilpin]), 2 South Stroke, 2 South Medicine, TIA (Transient Ischemic Attack) clinic, the Respiratory and Stroke Research Nurse and the Frailty Unit. An overview of the line management responsibility is highlighted in the table below.

Service Area	Line Management Responsibilities
Research Nurse	1 x Band 6 Denise Cosgrove
Frailty Ward	Unit opened and closed secondary to Covid 19. Ward was based within Ramone 4 Band 7 – Laura Richardson (Resigned) Hannah Jameson (Secondment)
2 South Stroke, 2 South Medicine and TIA Clinic (moved to 3 North)	Ward was a split ward of Stroke and Elderly Medicine Band 7 – Ruth Heatrick (stepped down to Band 6) Tracey Scullion (Secondment) Stacey Leonard (Permanent recruitment)
Stroke Specialist Nurses	2 x Band 7s Margaret O’Hagan Noelleen Lambe

5.6. My current role is the Acute Clinical and Social Care Governance Coordinator. This position has dual lines of responsibility. This position was line managed by the Director of Acute Services, with lines of responsibility to the position of Assistant Director for Clinical and Social Care



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Governance. On appointment Melanie McClements was the Director of Acute Services (Line Manager) and Caroline Doyle was the Interim Assistant Director of Clinical and Social Care Governance.

5.7. Following the retirement of the Acute Services Director in August the Directorate was divided into two separate Directorates; “Medicine and Unscheduled Care” Directorate and “Surgical, Clinical and Cancer Services and Integrated Maternity and Women’s Health” Directorate. The Interim Director for the “Medicine and Unscheduled Care” is Cathrine Reid and the Interim Director for “Surgical, Clinical and Cancer Services and Integrated Maternity and Women’s Health” is Trudy Reid.

5.8. Within this role I am responsible for the Acute Governance Staff Team members. An overview of the staff I am responsible for are included within the below table.

Service Area	Line Management Responsibilities
Datix and SAI Management	Acute Governance Manager – Band 7 David Cardwell, Carly Connelly, Joanne Bell, Sandra Burns Acute Governance Officer – Band 5 Roisin Farrell
Complaints	Acute Complaints Manager - Band 6 Collette McCaul Acute Complaints Officers - Band 5 x 2 Chrissy Toman, Sarah McStay (Temporarily Seconded to Mental Health and Learning Disability Directorate) Natalie Creaney (Secondment) Acute Governance Assistance - Band 3 Emma Young (Maternity Leave) Danielle Canning (Secondment for Maternity Leave)



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Standards and Guidelines	<i>Standards and Guidelines Manager</i> Band 7 – Chris Warr Standards and Guidelines Officer Band 5 – Natalie Creaney (Secondment – moved to complaints team)
Point of Care Testing and Medical Equipment.	<i>Patient Safety and Quality Manager for POCT and Medical Devices - Band 7</i> Craig Cromie (Secondment)
Urology Lookback Team	<i>USI Governance Manager</i> Band 7 – Dawn King <i>USI Governance Assistance</i> Band 3 Jordan Young (Resigned) Natasha Irvine (Resigned) Laura McStay
Family Liaison	<i>Family Liaison Officer.</i> Band 6 Fiona Sloan (Resigned)

5.9. The position of Family Liaison Officer was under the line management of the ACGC however due to a change in corporate service delivery it was agreed this provision would be better provided as a central corporate governance function rather than held internally by each individual Directorate. As such the line management responsibility was transferred from the ACGC to under the Medical Director's Office. On appointment of the Corporate Clinical and Social Care Governance Coordinator (Stacey Hetherington) undertook direct line management for this role.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**



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6.1 I have staff management responsibilities within my current role of ACGC to the staff highlighted within the third table of question 5.

6.2 There are two processes in which I manage staff under my direct responsibility.

6.3 Initially there are the core requirements of the Southern Trust where appraisals are required annually. I am responsible for providing appraisals to the staff under my direct responsibility. These staff members will undertake the appraisals for those under their responsibility lines. The table below highlights who undertakes appraisals for each staff member within the Acute Governance Team.

Manager	Staff Members
Chris Wamsley (ACGC – Band 8B)	Acute Governance Managers – Band 7 Acute Governance Officers – Band 5 Acute Complaints Manager - Band 6 Standards and Guidelines Manager - Band 7 Patient Safety and Quality Manager for POCT and Medical Devices - Band 7 USI Governance Manager - Band 7 USI Governance Assistance - Band 3
Collette McCaul Complaints Manager	Acute Complaints Officers - Band 5 Acute Governance Assistance - Band 3
Chris Warr Standards and Guidelines Manager	Standards and Guidelines Officer

6.4 During July and August there were high levels of staff absences due to annual leave entitlements, term time provision, staff employment changes and sickness. As such it was agreed that all annual appraisals would be completed during October 2022. This was to allow a focus within September to progress governance actions which had been reduced due



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to reduction in staffing resource. As I commenced this post in July 2021 these will be the first appraisals undertaken by me with this staffing compliment. The previous annual appraisals were completed by the previous ACGC prior to their retirement.

6.5 A number of staff under my line management are registered nurses with an active NMC pin. As advocated by the NMC, and the Southern Trust, there is a requirement that NMC registrants undertake a minimum of two sessions of clinical supervision annually. These staff members are Chris Warr (Standards and Guidelines Manager), Sandra Burns (Acute Governance Manager) and Dawn King (USI Governance Manager).

6.6 As line manager I speak and meet with all staff members across my governance teams at a minimum on a weekly basis but I regularly have a daily presence within their offices/workspaces. I emphasise and encourage an open door policy so all staff are able to raise any concerns with myself to try to ensure that all are appropriately discussed and addressed.

6.7 As the Acute Governance Team provides oversight and assurance functions to the Acute Services Directorate (now two directorates of "Medicine and Unscheduled Care" and "Surgery, Clinical and Cancer Services and Integrated Maternity and Women's Health") measures of performance are monitored closely by the Directors, the Division's Assistant Directors and myself as ACGC. This allows each Division/Directorate to know their current position with regard to core functions of governance. This function allows the ACGC to monitor performance from each separate governance functions and therefore afford the opportunity to address concerns identified directly with core team members to identify delays or deficits within delivery of governance functions. To provide an overview of this each subset of the Governance team will be highlighted.



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Acute Complaints Team

6.8 As line manager I liaise daily with the Complaints Manager and the complaint's team members. I make daily enquiries with regard to current complaints and offer assistance and maintain oversight of complaints progression.

6.9 I monitor the number of complaints returning with errors from the Directors. When increases in errors occur I collectively review the situation with the Complaints Manager to identify performance concerns. When performance concerns exist I support the Complaints Manager to follow the process highlighted within the Capability Policy and Procedures. I have had experience of this in the ACGC role with a Band 5 Complaint Officer not performing to the necessary standard and I collectively engaged with the Complaints Manager to ensure that the individual was supported alongside addressing their performance issues. This was completed through action planning and improved monitoring which led to an improvement in performance. A copy of this individual's action plan has been included as evidence.

6.10 Complaints are monitored daily by the Complaints Manager, with concerns being escalated to the ACGC by email or telephone communication. Complaints Officers will also escalate particular concerns with current complaints and I maintain oversight.

6.11 The ACGC provides weekly complaints data to the Directors during their weekly Governance meeting. This weekly meeting provides an overview of the number of complaints broken down by Division. A RAG rating system (red - greater than 20 working days, amber - 10 to 20 working days and green – less than 10 working days) is used to monitor response times for current complaints. This is supported by an overview document, "Acute Complaints Overview", which provides additional detail including the complainant's name, current position of response and length of time within the complaints system.



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6.12 Reopened complaints are also included within this weekly meeting agenda and highlight the number by Division and if they are outstanding a meeting.

6.13 Complaints are a standing agenda item within the monthly Acute Clinical Governance Meeting and Acute Clinical Governance Forum. For this meeting there is information highlighted in 6.11 and 6.12 alongside a complaints report. This complaints report initially provided high level information regarding themes and numbers by Directorate. Following collective engagement with the Acute Complaints Team I helped develop a new report structure which provides Directorate level oversight but also Divisional oversight improving oversight of complaints performance and lessons learned.

6.14 When these monitoring processes identify delays in completing complaints responses I will review this with the Complaints Officer and Complaints Manager to identify where the process became delayed. Where this relates to an internal process within complaints I work collectively with the team to address these concerns. If the delay is identified within the operation team then I liaise with the appropriate Head of Service and Assistant Director to highlight the issue so that they may be addressed operationally. To assist Assistant Directors and Head of Service to have oversight of their complaints an updated position is provided by their assigned Complaint's Officer on a weekly basis. The Complaints Manager will also provide escalation by email to highlight those complaints which are outside the regionally agreed response time to the operational Head of Service, Assistant Director and myself as ACGC when necessary.

6.15. Every quarter a Clinical and Social Care Governance Report is created for the Senior Management Team of the Southern Trust and the Trust Board Members. This report includes numerous aspects of clinical and social care governance with one such area being complaints.



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6.16 The Trust holds a weekly Governance Debrief attended by all directorates which has “complaints” as a standing agenda item. This process highlights the new complaints into the organization by their risk grading with those of moderate grading and above discussed in greater detail. Complaints outside the regional response time are escalated in this meeting to identify and assist address barriers to responding.

6.17 The Trust’s complaints are also monitored by external organization through the completion of the “CH8 Report” and a “Closed Complaints Report”. The “CH8 report” provides data to the informatics team within the Department of Health. This is to allow high level data analysis and identify trends. The “Closed Complaints” report is completed on a monthly basis and shared with the Strategic Planning and Performance Group (SPPG). This report also allows for data and trend analysis alongside the identification of potential regional learning which could be shared.

6.18 Complaints which have exhausted the complaints process progress to the Northern Ireland Public Services Ombudsman (NIPSO). The Complaints Manager coordinates the response for the ombudsman cases. On arrival the Complaints Manager and I review the requests and share with the relevant operational team. The Complaints Manager escalates difficulties or delays in accessing information to the appropriate Head of Service and Assistant Director to ensure collaboration in completion. Throughout drafting the ombudsman response the Complaints Manager maintains ongoing communication through face to face, telephone or email communication to ensure timely completion of requests.

3. Evidence 3 – Capability Plan

4. Evidence 4 – 20221010 - Acute Complaints Overview

5. Evidence 5 – 20210705 Acute SMT Report (Previous Complaints Report format)



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6. Evidence 6 – 202205 Acute Directorate Complaints Report (New Complaint Report Format)
7. Evidence 7 – 202209 CH8 report
8. Evidence 8 – 202208 Acute Draft Closed Complaints Report
9. Evidence 9 – 20220901 – CSCG Governance Committee Report
10. Evidence 10 – 20220606 Directors Governance Update Meeting Report.

Acute Standards and Guidelines

6.19 Chris Warr has been employed as the Standards and Guidelines Manager throughout my time as ACGC and I maintain regular email and telephone contact as Chris predominantly completes his role from home. I am added into email communication surrounding progression of different aspects of his role to monitor progression while also providing an “open door policy” where Chris can ring and highlight areas of concern at any time.

6.20 The Acute Services have a twice monthly Standards and Guidelines meeting allowing monitoring of progression of current Standards and Guidelines within the Directorate. This affords the opportunity to identify the “Clinical Change Leads” from each Division and to liaise and progress work, identify and highlight barriers and develop action plans.

6.21 The provision of Standards and Guidelines is also monitored at the weekly Governance Debrief which provides corporate oversight of the current Standards and Guidelines under review, afford the opportunity to monitor areas of concern and liaise with the Standards and Guidelines Manager to ensure appropriate actions are developed to mitigate or complete.

6.22 On a monthly basis a “Professional Leads Meeting” is facilitated by myself as ACGC. The membership of this group includes representations from numerous multidisciplinary team members who assist with the



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implementation of Standards and Guidelines. The topics for discussion within the agenda are based on the outcomes from the fortnightly Standards and Guidelines meeting and is a vehicle to aid the dissemination and implementation of recommendations.

6.23 The Standards and Guidelines Manager and I are aware that a backlog of Standards and Guidelines exists and this is recognised within the Acute Directorate risk register (Risk Number 3529). The Standards and Guidelines team has recently been without their band 5 Governance Officer position. This position is currently in the process of external recruitment and on appointment, following initial induction, an action plan will be developed to progress and monitor the backlog effectively.

6.24 There is a corporately held database of Standards and Guidelines which provides an oversight position of all Standards and Guidelines issued to the Southern Trust and their level of compliance. This is held by Caroline Beattie, the SHSCT Senior Manager for Standards, Risk and Learning. The Acute Standards and Guidelines Manager has access to this database and provides updates routinely as work is progressed.

6.25 Weekly update emails of new Standards and Guidelines is shared on a weekly basis by the SHSCT Senior Manager for Standards, Risk and Learning to Senior Managers across the Southern Trust including those within the Acute Directorate. The Standards and Guidelines Managers monitors distribution of these guidelines and highlights when these have been distributed through numerous forums.

Evidence 11 – 20221018 - Agenda for Standards and Guidelines Meeting

Evidence 12 – 20220414 Agenda for Professional Leads Meeting

Evidence 13 – 20221014 Email for Standards and Guidelines providing weekly update.



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Acute Governance Managers Incidents and SAls

6.26 As line manager I liaise daily with the Governance Managers. I enquire daily surrounding their current position, work plans for the week, any barriers to progress and offer assistance and maintain oversight of incidents and SAI progression.

6.27 To simply explain oversight I have divided this into two subcategories incidents and SAls.

Incidents

6.28 Incidents throughout the Acute Directorate are logged through the Datix system. Every Datix is emailed through to the Governance Managers and myself, as the ACGC, to review. These incidents are reviewed daily and incidents which are graded as high risk, major or catastrophic, or describe an incident which needs further senior review, are escalated to the Divisional Screening Meetings. When necessary these are escalated to the Director and Assistant Directors via email to ensure additional oversight of the risk.

6.28 Incidents escalated to the Divisional Screening Meetings arrive from numerous channels including Datix incident reporting, complaints, litigation and patient case reviews which identify learning following their presentation and peer review at the morbidity and mortality (M+M) meeting.

6.29 Each division within Acute Services has its own screening meeting where incidents are discussed with group members to collectively decide if a further investigation is necessary to identify system and process learning for the organization using the HSCB 2016 "Procedure for the Reporting and Follow up of Serious Adverse Incidents SAI". This forum monitors the discussion and progression of these incidents until action is collectively agreed by the Divisional Screening Group members.



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6.30 The membership of the screening meetings have a universal core membership of the Assistant Director of the Division, the Divisional Medical Directors of the Division, Clinical Governance Coordinator and Governance Manager. Some divisions have increased their core membership to include the Clinical Directors and Heads of Service for the Division as detailed in the table below. When necessary, specialist teams are requested to attend to provide additional specialist input to the decision making process, e.g. a Microbiologist. These meetings are facilitated by the Governance Managers. The table below identifies the staff member who attend these forums.

Division	Membership
Medicine	Divisional Medical Director for Medicine – Governance Dr Philip Murphy Divisional Medical Director for Medicine – Workforce Dr Seamus Murphy Divisional Medical Director for Elderly Medicine Dr Patricia McCaffrey CAH Clinical Director for Medicine – Dr Una Bradley DHH Clinical Director for Medicine – Dr Donna Muckian Clinical Director for Elderly Medicine – Dr Bronagh McGleenon Assistant Director for Acute Services – Charlotte Anne Wells Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns Governance Officer – Roisin Farrell
Acute Medical Ambulatory Patient Flow	Divisional Medical Director for Medicine – Governance Dr Philip Murphy Divisional Medical Director for ED – Dr Gareth Hampton CAH Clinical Director for Medicine – Dr Erskine Holmes DHH Clinical Director for Medicine – Dr David Mawhinney Assistant Director for Unscheduled Care – Mary Burke Head of Service Patient Flow/ Ambulatory and Acute Medicine



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	Unit - Sharron Holmes Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns Governance Officer – Roisin Farrell
Emergency Department	Divisional Medical Director for ED – Dr Gareth Hampton CAH Clinical Director for Medicine – Dr Erskine Holmes DHH Clinical Director for Medicine – Dr David Mawhinney Assistant Director for Unscheduled Care – Mary Burke Head of Service for ED – Paul Smyth Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns Governance Officer – Roisin Farrell
Surgery and Elective Care	Divisional Medical Director for Anaesthetics, Theatres and Intensive Care – Dr Raymond McKee Divisional Medical Director for Surgery and Elective Care Mr Ted McNaboe Division Medical Director for Urology Services Improvement Mr Mark Haynes Clinical Director for ENT and Urology – post vacant Clinical Director for General Surgery – Mr Adrian Neill Clinical Director for Anaesthetics, Theatres and Intensive Care Dr Aiden Cullen Assistant Director for Surgical and Elective Care, Anaesthetics, Theatres, Intensive Care and Outpatients – Ronan Carroll Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns Governance Officer – Roisin Farrell
Radiology	Divisional Medical Director Cancer and Clinical Services Dr Tariq Shadid Clinical Director for Radiology – Imran Yousuf



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	Assistant Director for Clinical and Cancer Services – Barry Conway Head of Service for Diagnostics – Denise Newell DHH Site Lead Radiographer - Louise Fawcett-Marsh Operational Support Lead - Sharon Glenny CAH/STH Site Lead Radiographer – Ann Tate Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns Governance Officer – Roisin Farrell
Integrated Maternity and Women's Health	Divisional Medical Director for Obstetrics and Gynaecology Dr Beverley Adams Assistant Director for Obstetrics and Gynaecology Caroline Keown CAH Clinical Director for Obstetrics and Gynaecology Dr Andrew Know DHH Clinical Director for Obstetrics and Gynaecology Dr Katherine Loane and Dr Janet Acheson (Job Share) Consultant Anaesthetist Dr Alison Blair and Dr Rachel Mathers Head of Service for Obstetrics and Gynaecology – Wendy Clarke Risk Midwives – Joanne Gluck/ Patricia McStay/ Patricia Kingsnorth Lead Midwife – Mary Dawson, Oonagh Kelly-Campbell, Michelle Portis, Josie Rushe, Consultant Midwife – Jennifer McKenna Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – David Cardwell/ Carly Connolly/ Joanne Bell/ Sandra Burns
Cancer Services	Assistant Director for Clinical and Cancer Services – Barry Conway Head of Service for Cancer Services - Clair Quin Operational Support Lead - Sharon Glenny



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	Lead Nurse for Medicine - Nicola Shannon Cancer Services Coordinator - Sinead Lee RISOH Implementation Officer/Service Administrator in Cancer Servicers - Andrea Muldrew Clinical and Social Governance Coordinator – Chris Wamsley
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6.31 Datix numbers are monitored by the Acute Governance Team, and these are shared monthly at the Acute Clinical Governance Meeting and Acute Clinical Governance Forums. The responsibility for completion of datix investigations rests with the operational teams however oversight to ensure completion is monitored and there is feedback through the governance teams.

6.32 The Trust's weekly Governance Debrief attended by all Directorates includes incident review position as a standing agenda item. The process highlights the number of incidents "awaiting review" and "in review" for each Trust Directorate. Each Governance Team is responsible for liaising with their operational teams to create and implement an action plan to address their backlog of incident investigations. The Acute Governance Team changed their format for communicating outstanding datix. This changed January 2022 with the improved reporting structure. Since implementation of this process the Datix backlog within Acute Services Directorate has reduced from 1819 to 594.

6.33 'Incidents' are a standing agenda item within the monthly Acute Clinical Governance Meeting and Acute Clinical Governance Forum. Initially this incident report included a high level detail surrounding the number and trends of incidents within Acute Services. I felt this detail was necessary at both Directorate and Divisional oversight and therefore a new report was developed which showed trends over time. This was completed for each Division to provide Directorate level oversight but also to improve oversight of incident trends and lessons learned within each Division.



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6.34 A secondary report surrounding incidents arising from these two governance meetings is the “Major and Catastrophic Incident report”. This report selected a week period within the month and then reviewed all incidents at major or catastrophic level, discussing them with the Senior Managers within Acute Services. This report then changed to cover the full month period in December 2021 to provide greater insight into all high risk incidents within the major and catastrophic categories.

6.35 Every quarter a Clinical and Social Care Governance Report is created for the Senior Management Team of the Trust and the Trust Board Members. This report includes numerous aspects of clinical and social care governance with one such area being incidents. This reviews the number of incidents per Directorate and at each level of risk over a time period. This facilitates the monitoring of trends and anomalies which can trigger further investigation and enquiry.

Evidence 14 – HSCB SAI Policy

Evidence 15 – 20211101 – 20211107 Weekly Governance report

Evidence 16 – 20210705 Acute SMT Report (Previous Incident Report format)

Evidence 17 – 202208 Acute Incident Report (New Incident Report Format)

Evidence 18 – 20221004 Section 16 of Agenda (SEC CCS IMWH Directorate Governance Meeting)

Evidence 19 – 20221004 Outstanding Datix Report (SEC CCS IMWH Directorate)

Evidence 20 – 20210607 - Major and Catastrophic Incident Report (Previous Report Format)

Evidence 21 – 20220802 Major and Catastrophic Incident Report (New Report Format)

Serious Adverse Incident (SAI) Investigations.

6.36 The Acute Governance Team is responsible for the coordination and completion of SAI investigations. The Acute Directorate has a large number



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of specialties and therefore holds the largest proportion of SAIs within the Southern Trust. The completion of the SAI investigations is facilitated by the Acute Governance Managers, Risk Midwives (for Integrated Maternity and Women's Health cases only) and the ACGC.

6.37 I liaise with the Governance Managers daily to monitor progress and their weekly work plans, addressing barriers and progressing issues at source to assist with the continuous completion of SAI investigations in a timely manner. I liaise with the Risk Midwives weekly to monitor progression of their SAI investigations.

6.38 To improve monitoring a new meeting was established to facilitate all those engaged in Acute SAIs within one meeting forum to discuss progression and action barriers. This meeting commenced recently, in September 2022, and therefore the agenda documentation is being amended within each meeting to develop a robust and streamline process which provides oversight of all SAIs. To date this has improved communication internally and has assisted with the flow of SAIs.

6.39 The Divisional Screening Meetings, as highlighted previously, are the main method of providing oversight of SAI progression between the Acute Governance and operational teams.

6.40 The monitoring of SAIs is provided within the monthly Acute Clinical Governance Meeting and Acute Clinical Governance Forum. This provides a breakdown of the number of SAIs within each designated timeframe (more than 26 weeks, less than 26 weeks, within timescales and number of level 3 SAIs). On a weekly basis this same information is highlighted at the weekly Directors Governance Update alongside an opportunity to highlight barriers or information needing escalation for oversight.

6.41 The Acute Clinical Governance Forum is the platform where SAIs are approved prior to sharing draft reports with the SPPG and service users/



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service user's family. This meeting allows the Senior Manager Team within Acute Services, Clinical Directors, Divisional Medical Directors and the ACGC to critically challenge the content within SAI reports to ensure appropriate learning is identified, SMART (Specific, Measurable, Achievable, Realistic and Time-bound) recommendations are identified and appropriate people are identified to implement these recommendations.

6.42 The Trust's weekly Governance Debrief attended by all Directorates includes the SAI position within each Directorate as a standing agenda item. This provides a breakdown of the number of SAIs within each designated timeframe. Once approved and shared with the SPPG the overview of the SAI and learning is shared to transfer learning.

6.43 The ACGC attended a monthly meeting with the SPPG and Corporate Governance colleges where the current position of each SAI is discussed and any questions, queries or escalations the SPPG wish to raise are addressed, actioned and barriers delaying progression are discussed. This meeting format has recently changed to a bimonthly meeting and the attendance has increased to contain all Directorates within the Southern Trust. This meeting ensures the same level of oversight is provided from all Directorates but also increases the time between meetings to encourage progression of SAIs.

Evidence 22 – 20220923 SAI Performance Meeting SPPG/SHSCT Meeting Agenda

Evidence 23 – 20210816 – 20210822 Weekly Governance report

Evidence 24 – 20220621 Monthly Acute Clinical Governance Meeting Agenda

Evidence 25 – 20220610 Monthly Acute Governance Forum Agenda

Evidence 26 – 20221018 Acute SAI Oversight Group



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Patient Safety and Quality Manager – Point of Care Testing and Medical Devices.

6.44 As line manager I liaise daily with the Patient Safety and Quality Manager. I enquire daily surrounding their current workload, progression of audits, any barriers and progression to offer assistance and maintain oversight of their workload.

6.45 The Patient Safety and Quality Manager generates reports relating to the audits they undertake and these are shared across the operational team. This includes Point of Care (POC) devices and also user compliance against the set standards within the regional POC testing policy. User non-compliance is escalated using the process set out with in standing operating procedure. When enacting this process the Patients and Safety Quality Manager informs myself by email to monitor levels of non-compliance.

6.46 The Patient Safety and Quality manager is also accountable for medical devices within the Acute Services Directorate. This aspect of their role is currently being developed and they work collectively with the Medical Devices Team within estates. As this aspect of their role continues to develop I actively engage with their progression and development of their input into providing greater assurance into the use of medical devices within Acute Services.

Evidence 27 – 202207 USC Glucometer User Audit

Evidence 28 – POC Device Audit (3 Reports CAH Glucometer, DHH Glucometers and INR Devices)

Evidence 29 – EQA testing of POCT Devices (3 Reports Glucometer, INR and Pregnancy)

Evidence 30 – 202204 Medicine Fridge Audit

Evidence 31 – 202206 Equipment Management Audit for Medical Devices

Evidence 32 – Follow up Audit from National Patient Safety Alert



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USI lookback

6.47 As line manager I liaise daily with the Governance Manager for the USI to enquire about their workload, tasks under completion, estimated timeframes and any barriers in progressing to meet the deadlines of the USI requests. I encourage an open door policy where concerns may be raised directly with myself at any stage to prevent unnecessary delay within the process.

6.48 This role has two main facets, the USI requests and the Urology lookback.

a. USI Requests

6.49 The requests are made by the USI team surrounding information and documentation retrieval needed within a set time period. On receipt of these requests I work in collaboration with the USI Governance Manager to understand the workload associated with each request, the resources required to complete and assess the realistic ability to deliver within their specified time frames. When the request is unachievable within the allocated timeframe I actively liaise with the USI team early within the Southern Trust to highlight the barriers, explain what the Acute Governance Team ability is to deliver and engage in obtaining realistic timeframes.

6.50 I liaise with the USI team through a combination of email, telephone and in-person communication so that both the Acute Governance Team members and the USI members are able to collectively track progress and address barriers.

b. Urology Lookback Review

6.51 The USI Governance Manager works collectively with the Head of Service for Clinical Assurance for the Urology Inquiry in the coordination of



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the Urology Lookback Review. The list of patients highlighted by the Urology External Reviewer generated a list of service users who need discussed within the Urology Screening Meeting. This discussion identifies if the threshold was met for a Structured Clinical Record Review (SCRR).

6.52 The membership of this meeting is highlighted in the below table.

Urology Lookback Review	Divisional Medical Director for Anaesthetics, Theatres and Intensive Care – Dr Raymond McKee (Previously Dr Damian Scullion) Divisional Medical Director for Surgery and Elective Care Mr Ted McNaboe Division Medical Director for Urology Services Improvement Mr Mark Haynes Assistant Director for Surgical and Elective Care, Anaesthetics, Theatres, Intensive Care and Outpatients – Ronan Carroll External Urology Consultant – Dr Krishna Sethia Head of Service for Clinical Assurance for the Urology Inquiry – Sarah Ward. Clinical and Social Governance Coordinator – Chris Wamsley Clinical Governance Manager – Dawn King/ David Cardwell/ Carly Connolly
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6.53 Each case that is progressed through screening has a datix generated, documented within the screening meeting sheets and have a screening outcome sheet completed. Progression of screening meetings is monitored by myself and I liaise with the USI Governance Manager to discuss barriers to progressing these meetings.

6.54 Throughout this process numerous Urology Screening Meetings have been cancelled which has slowed the progression of the screening process for Structured Clinical Records Review (SCRR). The predominant reason has been the unavailability of the Divisional Medical Director for



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Urology Improvement to attend the meetings due to clinical commitments or commitments of others within the USI. The membership of this group includes the DMD for Urology Improvement, Assistant Director for “Surgery and Elective Care, Anaesthetics, Theatres, Intensive Care and Outpatients and Head of Service for Clinical Assurance for the Urology Inquiry therefore when the Urology Screening Meeting is unable to occur the key stakeholders are fully informed of the rational and are aware of the progression of cases through the Urology Lookback Screening process.

6.55 The USI Governance Manager assists in liaising with the external SCRR reviewers to ensure a complete and timely review. I liaise with both the USI Governance Manager and Head of Service for Clinical Assurance for the Urology Inquiry to ensure ongoing progression and action any delays escalated regarding SCRRs.

Evidence 33 - 20220704 Urology Lookback Screening Meeting.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

7.1 Within answer 6 I have highlighted the systems in place that provides assurance to the standards of governance in the Southern Trust with regards to complaints, standards and guidelines, incidents, SAIs, the Urology Services Inquiry lookback, point of care testing and medical devices.

7.2 Within this question I will identify further aspects of governance within the ACGC role and the systems in place to assure the standards in place within the Acute Services Directorate.

Internal Audit

7.3 As ACGC I am responsible for monitoring and liaising with the operational teams to implementation the agreed recommendations from the



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internal audits for the Acute Services Directorate. The Director of Finance, Procurement and Estates is responsible for the collation of Internal Audit recommendations for the Southern Trust however the responsibility for implementation of each recommendations is the responsibility of the operational team.

7.4 The Internal Audit report is completed every quarter for the Southern Trust Senior Management Team and Trust Board. As ACGC I liaise with the Assistant Head of Internal Audit, Jennifer McCaw, routinely to discuss the criteria for implementation of all internal audit recommendations assigned to Acute Services and to evidence progression to date.

7.5 Prior to completion of the Internal Audit report for the Senior Management Team all Directorates meet to discuss progress quarterly so there is oversight of current progress and outstanding actions.

Sign Off Reports

7.6 As ACGC we are responsible for sharing the Acute Directorates current compliance with diagnostic tests sign off, both from laboratories and Radiology. The report is shared within the monthly Acute Clinical Governance Meeting and Acute Clinical Governance Forum.

7.7 The information within this report is provided from Business Service Organisation (BSO) and is presented from a Southern Trust and Regional perspective. The information is not presented at a Directorate, Divisional or service level which would specifically identify a singular areas compliance.

7.8 A further report has been developed to demonstrate the data within this report in a run chart and control chart format. This is to facilitate the changes in sign off over time. Although this provides greater oversight for trend analysis with the available data it has limited assurance from a Directorate or Divisional level as this data portrays an overall Southern Trust or regional perspective.



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7.9 Sign off information from this report is included once a month at the weekly Governance Debrief. This provides corporate oversight of the Southern Trust position within sign off.

Evidence 34 – 20220901 – 20220930 - BSO Sign Off report

Evidence 35 – 202210 Monthly Sign off Trends Report

Risk Registers

7.10 The ACGC works collectively with the operational teams to ensure time review of Divisional and Directorate Risk Registers.

7.11 It is the responsibility of operational teams to reflect all risks within the appropriate risk register. The ACGC, collectively with the Complaints Manager, facilitate updates to the risk registers with the information provided by the operational team so they reflect the current risks within each Division.

7.12 The Risk Registers, Divisional, Directorate and Corporate, are shared on a monthly basis within the Acute Clinical Governance Meetings and Acute Clinical Governance Forum. They are standing agenda items at both meetings. The ACGC also offers support to Divisional Teams through attending their Divisional Governance Meetings at their request to ensure timely updates.

Policy Scrutiny

7.13 As ACGC I am the Acute Services representative on the Policy Scrutiny committee. This committee provides the oversight, assurance and approval function for all new policies and policies updates.

7.14 As the Acute representative I am responsible for liaising with the operational team to ensure timely completion of policies within their areas of responsibility and also presenting their policy within the meeting to gain approval.



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7.15 Alongside the policy presentation an implementation plan must be designed and presented for each policy.

- 8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

8.1. The role of ACGC is similar to all positions within the Southern Trust and is subject to an annual appraisal from the direct line manager, Director of Acute Services.

8.2. The most recent appraisal was completed by Melanie McClements on the 29 November 2021. This was four months after I commenced the ACGC role. A copy of this documentation is provided as evidence. The objectives agreed within this most recent appraisal were:

- a) Restructure governance reports for both monthly governance meetings. Embrace greater statistical assurance methods and learning feedback loops.
- b) Increase involvement within Urology to ensure timely and accurate completion of all components
- c) Completion of SAI training, essential for my current roles and responsibilities.
- d) Increase engagement with operational teams to improve accuracy and completion of Internal Audit and risk registers.
- e) Update on all mandatory training which has currently expired.



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8.3. The Southern Trust “Performance and Personal Development Review Policy” includes the standards for undertaking an appraisal and is included as evidence.

8.4. As a registered Nurse I also have commitments to the Nursing and Midwifery Council (NMC) which include clinical supervision and revalidation. My most recent date for revalidation was 31 August 2021 and this was completed by Melanie McClements. This was completed in line with the NMC’s Revalidation guidance and the Southern Trust Nursing and Midwifery Accountability and Assurance Framework and Performance and Personal Development Review Policy. Copies of my revalidation documentation, the NMC guidance and the South Trust documents are included as evidence.

8.5. The ACGC role has accountability to the Assistant Director for Clinical Governance, a role held within the Medical Directorate, alongside the Director of Acute Services. My performance is also monitored through the processes metrics used to monitor governance processes over which I have management responsibility. These processes are monitored through numerous forums which allow stakeholders within the Acute Directorate, Southern Trust or external agencies, such as the SPPG, to question and request additional information regarding my performance on any governance process. These forums and metrics affords the Assistant Director of Clinical Governance the ability to monitor and challenge my performance. These performance measures have been identified above within the answers to question 6 and question 7.

8.6. I endeavour to share all external reports surrounding governance processes performance with the Director of Acute Services and the Assistant Directors of the relevant Divisions so they too are aware of the results of these metrics, and therefore my level of performance.

8.7. Examples of these process metrics are number of SAls within each timeframe, number of complaints outside regional response timeframe,



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number of internal audit recommendations requiring implementation. These and other metrics are shared openly throughout the organisation within numerous forums including within the weekly governance updates drafted by myself for the Directors within Acute services.

Evidence 36 – 20211129 Appraisal Document

Evidence 37 – Performance and Personal Development Review Policy

Evidence 38 – 20220831 Revalidation Document

Evidence 39 – NMC Revalidation Guidance

Evidence 40 – Nursing and Midwifery Accountability and Assurance Framework

Evidence 41 – Standards for competence for Registered Nurses.

Evidence 42 – 20211129 Clinical Supervision Document

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1. Within the management of Clinical and Social Care Governance there are numerous external and internal policies and procedures essential to the role of the ACGC. To identify each of these policies and guidelines I will address each through the governance function they serve.

9.2. Within the identification and completion of SAls the Southern Trust follow the Health and Social Care Board (HSCB) (2016) "Procedure for the Reporting and Follow up of Serious Adverse Incidents". The RQIA have undertaken a review of this procedure and generated a review document in 2022 "RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland".

9.3. Complaints management has several internal and external policies which directly influence the management of complaints. The internal policy



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of “Policy for the Management of HSC Complaints 2019” influences the Trust management of complaints. There is also the supplementary external guidance from the Department of Health “Guidance in relation to the Health and Social Care Complaints Procedure” which has been issued in April 2018 and updated this year in April 2022.

9.4. NIPSO also have guidance documents which influence the management of complaints within the Southern Trust. These documents include the 2009 “Principles of Good Administration”, 2009 “Principles of Good Complaint Handling”, 2009 “Principles for Remedy” 2019 “Guidance on issuing an apology”, 2020 “Records Matter” and the “Signposting to the Ombudsman – a guide for public authorities”.

9.5. Incident management has internal and external policies which influence practice. The internal policy for “Reporting and Management of Adverse Incident” is currently in design with the Assistant Directorate for Clinical and Social Care Governance. The current active policy for incidents is the 2014 “Southern Health and Social Care Trust Incident Management Procedure”.

9.6. Depending on the nature of the incident under review they may be a need to escalate to other pathways, and therefore, would potentially be influenced by their policies and procedures.

9.7. For potential incidents which involve adult safeguarding then the safeguarding process must be enacted. This would be following the guidance within the highlighted within the “Adult Safeguarding Policy, Prevention and Protection in Partnership”. This policy reflects the Regional 2015 policy “Adult Safeguarding: Prevention and Protection in Partnership Policy”.

9.8. Health and Safety incidents automatically are referred to the Health and Safety Teams within the Southern Trust. The Health and safety Department will undertake the reporting of incidents to the Health & Safety Executive,



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Northern Ireland (HSENI) which fall under the 1995 “Reporting of Injuries, Diseases and Dangerous Occurrences Regulations” (RIDDOR). The 2018 Southern Trust “Health & Safety at Work Policy” identifies the process for these referrals. The Health and Safety Executive in 2013 provided guidance for Health and Safety Executive (2013) “Reporting injuries, diseases and dangerous occurrences in health and social care. Guidance for employers”. The five RIDDOR reportable criteria are:

- a) The injury sustained is major;
- b) If a member of the public on Trust premises is killed or taken to hospital;
- c) If the injury sustained is an “Over 3 day injury”;
- d) If there has been a dangerous occurrence;
- e) If a notification of a reportable work-related disease has been involved.

9.9. Certain incidents reach the threshold for a potential lookback. The Southern Trust follow the guidance for lookback issued by the Department of Health in 2021. This included the Department of Health’s HSC (SQSD) issued on 16 July 2021, the 2021 “Policy for Implementing a Lookback Review Process” and the 2021 “Regional Guidance for Implementing a Lookback Review Process”.

9.10. Incidents which involve a medical device and estates, plant, equipment or buildings should be reported to the Northern Ireland Adverse Incident Centre (NIAIC). The supporting external policy was issued by the Department of Health in 2021 “Reporting Adverse Incidents and disseminating Safety Information”. This would also be advised by the Southern Trust 2012 policy for “Management of Medical Devices and Equipment” and the 2010 “Management of Equipment and Medical devices Operational Procedures Manual”. On occasion there is also the pathway for



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Medical Device Alerts which would be submitted to the Southern Trust which highlights potential risks or concerns with particular medical devices, an example is included as evidence.

9.11. Medical Devices are governed by the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA's 2021 document for "Managing Medical Devices. Guidance for health and social care organisations" provides the basis for medical device management within the Southern Trust and their medical device policy is currently being updated.

9.12. The MHRA are also a governing body for severe and adverse blood reactions. The internal 2018 Southern Trust "Blood Transfusion Policy" highlights the escalation to the external bodies if transfusion reaction reaches the set thresholds. These incidents are referred to the Southern Trust Haemovigilance Team to monitor and ensure the correct escalations and referrals are made. The external policies and guidance documents which guide this practice include the 2021 MHRA/ Serious Hazards of Transfusion (SHOT), the 2010 MRHA SABRE user guide and the reporting in the SHOT (2022) "Definitions of current SHOT reporting categories and what to report".

9.13. On occasions incidents that occur within the Acute Services Directorate reach the threshold for an "Early Alert". The "Early Alert" system is the system through which the Southern Trust can notify the Department of Health in a prompt and timely way of incidents which have occurred which may require urgent attention by the Health Minister, Chief Professionals or policy leads, and/or require urgent regional action by the Department. The Southern Trust follows the regional guidance for submitting an "Early Alert" and this is the basis of the internal 2022 "Policy for Reporting of Early Alerts to the Department of Health". The regional guidance for "Early Alerts" was updated by the Department of Health in 2020 and shared within the HSC (SQSD) 5/19. This document also made reference to the original Policy Circular (2010) and a reminder to follow this policy in 2014. The criteria for escalating an "Early Alert" for incidents are:



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- a) Require urgent regional action;
- b) Involves contacting patients/clients about possible harm;
- c) Involves a press release about harm;
- d) Where there is potential regional media interest;
- e) Police are involvement in investigation;
- f) The incident involving children;
- g) Involves a suspension of staff or breach of statutory duty.

9.14. Within the normal service delivery within Acute Services Directorate the majority of clinical areas have access and use of a Point of Care Testing (POCT) device. The management of POCT devices and compliance with usage is managed by the Acute Clinical Governance Team, under the direct guidance of the Patient Quality and Safety Manager for POCT and Medical Devices. The policy used for the management of the POCT devices is a regional policy which has been adopted by the Southern Trust in 2022 “Northern Ireland Regional Point of Care Testing Policy”.

9.15. The role of ACGC assists the operational teams within the management of their risk registers. This is aligned to the Southern Trust’s “Interim Risk Management Strategy 2019 – 2022”. The risk registers enable the Divisions/ Directorate Trust to identify the totality of its risk and quantify those that are deemed as acceptable or present significant risks that may affect the objectives of the Trust.

9.16. Within the governance role we align with the values of Health and Social Care and Southern Trust of “openness and honesty” and therefore



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within the daily provision of governance functions we are compliant by embracing the professional duty of candour. The Southern Trust is within the process of developing its “Being Open Policy” however there is external guidance provided by the General Medical Council and Nursing and Midwifery Council on the professional duty of candour. As a registered professional I follow these practices to maintain compliance with the NMC code of conduct and preserve safety.

9.17. As a central aspect of governance there is a need to access large volumes of confidential or personal information to review safety and assess quality of care. There is therefore a large component of the governance role governed by information governance practices. The Southern Trust 2021 “Information Governance Policy” identifies the arrangements for the management of information which all health and social care staff must be compliant with.

9.18. The finalisation of the Neurology Inquiry identified key learning, especially pertaining to governance structures and systems which need adopted by all Health and Social Care providers. Principles such as “You cannot unknow what you know” were highlighted as was reviewing how we manage complaints with greater emphasis being placed on detecting misconduct or poor practice and learning and improving services.

9.19. I am made aware of new policy or guideline changes through three main communication streams. As a panel member on the Policy Scrutiny Committee I assist with the review and approval of new policy and procedures within the Trust. Alongside any new policy there must be an implementation plan which advises the suggested strategy for sharing with all stakeholders. The second channel is through the Acute Standards and Guidelines meeting where external agencies would highlight changes to regional policies and this is disseminated throughout the organisation via the management structures. The third communication stream is through the



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monthly Governance Coordinator Meetings were relevant governance concerns are raised and discussed.

Evidence 43 – RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland

Evidence 44 – Policy for the Management of HSC Complaints 2019

Evidence 45 – Guidance in relation to the Health and Social Care Complaints Procedure 2019

Evidence 46 – Guidance in relation to the Health and Social Care Complaints Procedure 2022

Evidence 47 – Parliamentary and Health Service Ombudsman 2009 Principles of Good Administration

Evidence 48 - Parliamentary and Health Service Ombudsman 2009 “Principles of Good Complaint Handling”

Evidence 49 - Parliamentary and Health Service Ombudsman 2009 “Principles of Remedy”

Evidence 50 – Northern Ireland Public Services Ombudsman (N14) 2019 “Guidance on issuing an apology”.

Evidence 51 - Northern Ireland Public Services Ombudsman 2020 “Records Matter”.

Evidence 52 - Northern Ireland Public Services Ombudsman “Signposting to the Ombudsman – a guide for public authorities”.

Evidence 53 – Southern Health and Social Care Trust (2014) “Southern Health and Social Care Trust Incident Management Procedure”

Evidence 54 – Southern Health and Social Care Trust (2021) “Adult Safeguarding Policy, Prevention and Protection in Partnership”

Evidence 55 – DGSS&PS (2015) “Adult Safeguarding: Prevention and Protection in Partnership Policy”

Evidence 56 – Southern Trust (2018) “Health & Safety at Work Policy”

Evidence 57 – Health and Safety Executive (2013) “Reporting injuries, diseases and dangerous occurrences in health and social care. Guidance for employers”.



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Evidence 58 – Department of Health (2021) “Northern Ireland Adverse Incident Centre (NIAIC). Reporting Adverse Incidents and disseminating Safety Information”

Evidence 59 – Southern Trust (2012) “Management of Medical Devices and Equipment”

Evidence 60 – Southern Trust (2010) “Management of Equipment and Medical Devices Operational Procedures Manual”

Evidence 61 – MHRA (2021) “Managing Medical Devices Guidance for health and social care organisations”

Evidence 62 - Medical Device Alert example (2021) Philips_Foam_NaPSA_update

Evidence 63 – Southern Trust (2018) “Blood Transfusion Policy”

Evidence 64 – MHRA/SHOT (2021) “UK Haemovigilance user guide”

Evidence 65 – MHRA/SABRE User Guide (2010) “Investigating and Reporting Transfusion Related Serious Adverse Reactions and Event”

Evidence 66 – SHOT (2022) “Definitions of current SHOT reporting categories and what to report”.

Evidence 67 – Southern Trust (2022) “Policy for Reporting of Early Alerts to the Department of Health (DoH)”

Evidence 68 – Department of Health (2020) “Early Alert System”

Evidence 69 - Department of Health (2014) “Early Alert System”

Evidence 70 - Department of Health (2010) “Early Alert System”

Evidence 71 – Southern Trust (2022) “Northern Ireland Regional Point of Care Testing Policy”

Evidence 72 – Southern Trust (2019) “Interim Risk Management Strategy 2019 – 2022”

Evidence 73 – NMC and GMC (2022) “Openness and honesty when things go wrong: the professional duty of candour”.

Evidence 74 – Southern Trust (2021) “Information Governance Policy”

10. What performance indicators, if any, are used to measure performance for your role?



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10.1. Within the role of ACGC the completion of clinical and social care governance functions are collaborative and completed with operational teams. Therefore, there are no performance metrics which isolate and measure the ACGC performance.

10.2. There are numerous metrics used to monitor governance functions and on occasion these are used to challenge performance within a singular process of governance.

10.3. These areas of monitoring have been identified within the answer to question 6 and question 7 with some examples including outstanding complaints, incidents, SAIs, SAI recommendations, Internal Audit recommendations and Standard and Guidelines.

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

11.1. As ACGC there are numerous standards which much be upheld, both internally and externally. The methods of monitoring the governance processes have been highlighted within the answers to questions 6, 7 and 10.

11.2. The Acute Services Directorate has a large number of Divisions and sub-specialities. As ACGC I monitor the measures of governance processes performance and escalate to all Directors and Assistant Directors so everyone is aware of the current position of Acute Services governance processes benchmarked against the regional targets.

11.3. Within a weekly meeting with Directors I discuss progression, improvements and deficits within the provision of governance processes. With regard to areas over which have I have limited oversight I plan and develop actions to gain greater oversight.



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11.4. I work collectively with Directors and Assistant Directors to redesign governance information which is relevant and assist their oversight of their service areas. I request feedback on both their opinions of the governance provisions for their areas, their priorities to address concerns and on the performance of myself as ACGC to improve assurance structures for their Division or Directorate.

11.5. The systems in place to monitor performance of the ACGC were limited to outcome measures held corporately. This would be items such as number of complaints (open and closed), number of SAIs, number of Datix not finalised, number of reported incidents per month, number of incident at each risk grading and identifying common themes within complaints/datix. Since appointment as ACGC I have focused on increased use of data and developing process measures. This is to highlight data over time rather than singular data points to aid trend analysis, identify deficits and improve assurances.

11.6. The ACGC is a role that requires effective collaborative working to successfully implement governance arrangements. Singular systems measures do not capture the isolated individual performance of the ACGC. This reinforces the need for effective engagement, communication and feedback loops with all senior management so the data can be used in collaboration to highlight areas of good governance provision and areas where increased focus, and resource, is necessary.

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

12.1 Since undertaking the role of ACGC I have made an active change to increase statistical information surrounding governance processes. As such there are improved metrics to provide oversight of the governance role. As these have been developed since commencing this role in July 2021 the



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metrics were not previously measured. This may have identified governance processes that had not progressed or had been implemented however as the system of assessment/measurement was not previously completed it was “unknown”. Since commencing this role I do not have experience of systems being bypassed.

12.2. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

12.3. As I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

12.4 I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

13. What systems of governance do you use in fulfilling your role?

13.1. As ACGC systems of governance are central to delivering all daily functions within my role. The systems of governance have been highlighted with the answers to questions 6, 7 and 10.

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.



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14.1 Within previous roles within the Belfast Health and Social Care Trust I completed a large volume of quality improvement work. One of these quality improvement initiatives was implemented regionally, as a result of my leadership, innovation and drive for improving safety and quality of care I was awarded the prestigious Royal College of Nursing Nurse of the Year award for 2018.

14.2. I have also recently completed a MSc in Business Improvement within the University of Ulster in 2021. A large volume of this curriculum involves quality improvement principles and theories.

14.3. Within my time as ACGC I have implemented quality improvement initiatives within governance processes however I have not engaged with the Trust Quality improvement Team.

14.4. I have also been involved in several quality improvement projects which are clinical facing but relate to governance items which have included the Quality Improvement Team. The Acute Directorate Quality Lead, Elaine Campbell has currently three projects which I am a member within.

14.5. The Quality Improvement Team's Head of Service attends the weekly Governance Debrief Meeting and they are approachable and willing to discuss any improvement projects. I would have no concern in engaging with this team to improve quality governance services if and when required.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

15.1. It is my understanding the Head of Service for "ENT, Urology, Outpatients and Ophthalmology" Services collectively with the Clinical



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Director for “Urology and ENT” Services are responsible for overseeing the quality of services in Urology.

15.2. Their point of escalation is the Assistant Director for “Surgery and Elective Care, Anaesthetics, Theatres and Intensive Care and Outpatient Services” and the Divisional Medical Director for Surgery. This now would include the Divisional Medical Director for Urology Service Improvement.

15.3. Within the provision of services the individual practitioners are also responsible for the quality of service they provide. The majority of clinical staff are registered to a professional body such as Urology Consultants with the General Medical Council or Senior Nurses with the Nursing and Midwifery council and therefore a level of responsibility for the quality of service rests with those who physically deliver the service.

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

16.1. It is my experience that the clinical governance arrangements of Urology Services are overseen by the Head of Service for “ENT, Urology, Outpatients and Ophthalmology” Services and the Clinical Director for “Urology and ENT Services”. This is supported by the Assistant Director for “Surgery and Elective Care, Anaesthetics, Theatres and Intensive Care and Outpatient Services” and the Divisional Medical Directors for Surgery and Urology Service Improvement.

16.2. The chair of the Urology Morbidity and Mortality meeting works collectively with the Head of Service and Clinical Director to deliver on clinical governance arrangements.

16.3. Each division within the Acute Services Directorate holds its own Divisional Governance Meeting. This provides a platform for the operational



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team to discuss the concerns within their Division openly across the Senior Management Team. The Acute Governance Team do not attend this meeting routinely but would by request to address key agenda items.

16.4. The ACGC supports clinical governance arrangements for all services within the Acute Service Directorate. The operational teams liaise collectively with the ACGC and the appropriate team members when required to address bespoke clinical governance pieces of work.

16.5. The Acute Complaints Team would liaise with the operational teams surrounding complaints relating to Urology Services. The information would be obtained by the investigator who would be a member of the operational team. This information would be shared with the Complaints Officers who would assist with drafting a response using this information. Following completion this draft response is then shared with the Head of Service for approval. This would be approved at Assistant Director and then Director level prior to being shared with the service user/ complainant.

16.6. For informal complaints and enquires the Complaints Manager would liaise directly with the Head of Service to obtain the necessary information. This would then be drafted and sent to the enquiring party.

16.7. Incidents relating to Urology Services which reach the threshold for SAI would progress through the processes described with the answer to question 6 (paragraphs 6.26 – 6.43)

16.8. Recommendations which are formulated from SAIs, or other review processes such as incident reviews, debriefs, M+M meetings and complaints, are the responsibility of the assigned “responsible person”. There is a role for the Acute Governance Team within this process with regard to monitoring of implementation of recommendations. This is to provide assurances that recommendations are implemented or that progress has been made sharing this with the responsible Divisional Teams.



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16.9. Any Standards or Guidelines which refer to Urology Service are identified within the fortnightly Standards and Guidelines meeting. At this meeting the Standard and Guidelines Manager liaises directly with the Assistant Director for Surgical and Elective Care, Anaesthetics, Theatres and Intensive Care to identify a Consultant as a Clinical Change Lead. The Clinical Change Lead is whom the Standard and Guidelines Manager works collectively with to complete the baseline position audit and identify barriers which prevent full compliance. Following completion of this process the outcome of the process is presented at the Standards and Guidelines Meeting to obtain the consent of the Assistant Director for approval.

16.10. The Head of Service responsible for Urology Services, alongside the Clinical Director are responsible for highlighting the risks within their service area. Once identified the risk must be placed on the appropriate risk register: Divisional; Directorate; or Corporate. The operational team will complete a form to add their risk to the risk register and send to the Acute Governance Team to process and update. The Complaints Manager adds the risk to the appropriated register within the Datix systems. Updates are provided to the Acute Governance Team who will translate the updates onto the datix system and routinely run the reports. The risk register for the each Division and Directorate is included within the monthly Acute Clinical Governance meetings and Acute Clinical Governance Forum.

16.11. Internal Audit recommendations are monitored by the ACGC and are shared within the monthly Acute Clinical Governance meetings and Acute Clinical Governance Forum. The ACGC will liaise with the operational teams for any recommendations under their responsibility. For recommendations identified within Urology Services the ACGC would liaise directly with the Head of Service to obtain up to date and accurate information to provide an update.



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16.12. Urology Services have a Morbidity and Mortality meeting which follows the regional agenda template. This meeting provides a forum for Urology staff to discuss safety and quality issues within their service area and develop actions to provide greater governance within their service provision. As ACGC I do not attend this meeting however items discussed in other governance forums, such incidents escalated to Screening Meetings, may be referred to the Morbidity and Mortality Meeting for collective discussion or dissemination of learning.

16.13. Each clinical service may engage in clinical audits, both internal and external clinical audit. For external audit processes the Audit Lead would link with the Clinical Audit Team and facilitate the collection of data aligned with the set timeframes from the external organisation facilitating the national audit. For internal clinical audits the service establish what they wish to audit and complete a Clinical and Social Care Audit Registration Form to ensure there is a register of the clinical audits being completed for each Directorate.

Evidence 75 – Email to Acute Governance Team from Service Level for bespoke Complaints and Incidents Data.

Evidence 76 – Risk Assessment Form

Evidence 77 – Guidance for the Regional Morbidity and Mortality (M&M) Process

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

17.1 Within the context of my initial role as Lead Nurse for Medicine there were no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.



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17.2 I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

17.3. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

18. Did you feel supported by staff within urology in carrying out your role?

Please explain your answer in full.

18.1 Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

18.2 I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

18.3. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.



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Urology services

- 19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.**

19.1. As ACGC I have responsibilities within the provision of clinical and social care governance processes across all areas within the Acute Services Directorate collectively with the operational teams. Urology Services is one sub-speciality within the large number of services under within the Acute Services Directorate.

19.2. The answer to Question 16 identifies the aspect of ACGC role within the provision of governance services in Urology Services.

- 20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.**

20.1 As ACGC I would work collectively with all members of the operational teams to address clinical and social care governance related matters.

20.2. With issues directly related to Urology Services I would liaise with the Head of Service for "ENT, Urology, Outpatients and Ophthalmology" or the Assistant Director for "Surgery and Elective Care, Anaesthetics, Theatres and Intensive Care and Outpatient Services".

20.3. For incidents within Urology Services which reach the threshold for escalation to the Surgical Screening Meeting then the Urology incident



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would be reviewed and discussed by the members of the group to collectively decide on the next steps to progress.

20.4. There are no formal meetings which relate specifically to Urology Services clinical and social care governance which are attended by myself as ACGC.

20.5. Following the completion of the Urology SAI there has been a meeting group established to progress the recommendations of the collective SAIs. The “Task and Finish Group SAI Recommendations” meeting is held monthly to discuss progress of the actions however includes all cancer sites rather than Urology Services isolation.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

21.1. As ACGC I have responsibilities within the provision of clinical and social care governance processes across all areas within the Acute Services Directorate collectively with the operational teams. Urology Services is one sub-speciality within the large number of services under within the Acute Services Directorate.

21.2. The answer to Question 16 identifies the aspect of ACGC role within the provision of governance services in Urology Services.

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?



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22.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

22.2. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

22.3. My answer to this question can only be provided through the lens of hindsight and therefore I am unable to comment on if the governance systems were perceived as effective and efficient at the time.

22.4. Since undertaking this post in July 2021 I have amended processes and systems within governance to improve statistical oversight, monitoring of trends at Divisional alongside Directorate Level, and improve systems of oversight and improve assurances internally within the Acute Services Directorate and also Corporately for the organisation as a whole.

22.5. The improvement in governance systems have been implemented in collaboration with other Southern Trust Clinical and Social Care Governance Coordinators and therefore was looking at improving governance in totality, as a Directorate and Corporate function, rather than within singular improvement in a sub-speciality. Improvement in the overall structures of governance will consequently strength governance structures throughout all divisions and specialities which would include Urology Services.

22.6. I have also requested an increase in staffing resource within the Acute Governance Team to ensure there is sufficient operational resource to monitor and preserve governance functions. A band 5 Acute Clinical and



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Social Care Officer role has been developed and are currently in the process of recruitment. One band 5 governance staff will be allocated to each clinical Division within Acute Services to address the identified lack of resource to progress some core governance functions and support the Divisions, and therefore specialities such as Urology Servicers, ability to deliver high quality systems of governance ought to improve.

22.7. As improvement work has been implemented and continues across all governance processes within the Acute Services Directorate since I have undertaken the role of ACGC I would be of the opinion the efficiency and effectiveness of governance processes and procedures across the Acute Directorate service areas was not effective. This opinion however as stated comes from a position of hindsight and I cannot comment if these processes and systems were felt to be effective at the time of provision.

Evidence 78 - Clinical and Social Care Governance Officer band 5 Job Description

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

23.1. Within the context of my initial role as Lead Nurse for Medicine there were no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

23.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to



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this position. Therefore, I am not in a position to provide an answer to this question.

23.3. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

(i) **Waiting times**

24.1 I have no specific responsibility or input into this area of Urology.

(ii) **Triage/GP referral letters**

24.2 I have no specific responsibility or input into this area of Urology.

(iii) **Letter and note dictation**

24.3 I have no specific responsibility or input into this area of Urology.

(iv) **Patient care scheduling/Booking**

24.4 I have no specific responsibility or input into this area of Urology.



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(v) Prescription of drugs

24.5 I have no specific responsibility or input into this area of Urology.

(vi) Administration of drugs

24.6 I have no specific responsibility or input into this area of Urology.

(vii) Private patient booking

24.7 I have no specific responsibility or input into this area of Urology.

(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs

24.8 I have no specific responsibility or input into this area of Urology.

(ix) Following up on results/sign off of results

24.9 I have no specific responsibility or input into this area of Urology.

24.10 As ACGC I would share a report on sign off within the monthly governance meetings (Acute Clinical Governance Meeting and Acute Clinical Governance Forum) which includes sign off of information at a Southern Trust and Regional perspective. The information for this report is provided from Business Service Organisation and is not presented at a service level.

Evidence 34 – 20220901 – 20220930 - BSO Sign Off report

Evidence 35 – 202210 Monthly Sign off Trends Report



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(x) **Onward referral of patients for further care and treatment**

24.11 I have no specific responsibility or input into this area of Urology.

(xi) **Storage and management of health records**

24.12 I have no specific responsibility or input into this area of Urology.

(xii) **Operation of the Patient Administrative System (PAS)**

24.13 I have no specific responsibility or input into this area of Urology.

(xiii) **Staffing**

24.14 I have no specific responsibility or input into this area of Urology.

(xiv) **Clinical Nurse Specialists (xv) Cancer Nurse Specialists**

24.15 I have no specific responsibility or input into this area of Urology.

(xvi) **Palliative Care Nurses**

24.16 I have no specific responsibility or input into this area of Urology.

(xvii) **Patient complaints/queries**



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24.17 As ACGC I would be responsible for the management of the Acute Complaints Team who would liaise with the operational teams surrounding complaints relating to Urology Services.

24.18 The Complaints Team would share the complaint with the relevant stakeholders within Urology Services who would undertake the investigation of the complaints content.

24.19 Information would be obtained by the investigator and shared with the Complaints Officers who would assist with drafting a response using this information. Following completion, a draft response is then shared with the Head of Service for approval. If approved this would be escalated through the Assistant Director and then Director for their approval prior to being shared with the service user/ complainant.

24.20 For informal complaints and enquires the Complaints Manager would liaise directly with the Head of Service to obtain the necessary information. This would then be drafted and sent to the enquiring party.

24.21 The Acute Complaints Team would log the complaints information within the datix system throughout the complaints process. Following the generation of updated complaints report learning from closed complaints has been shared which provides an opportunity for this information to be distributed and shared for learning. This report provides learning at a Divisional level rather than a service level however all complaints completed will be included which would include urology complaints. Prior to this report themes of complaints were shared at a Directorate level within the complaints report as identified within Evidence 5 which was shared as part of the Acute Clinical Governance Meeting and Acute Clinical Governance Forum agendas.



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Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

25.1. As an employee of the Southern Trust if I had a concern I would follow the procedure set out within the Southern Trust 2018 policy "Your Right to Raise a Concern (Whistleblowing)".

25.2. As a registered professional I am also duty bound as highlighted within the NMC "The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates" to report and raise concerns. There is also support in how to raise these issues through the NMC "Raising Concerns: Guidance for nurses, midwives and nursing associates".

Evidence 79 - Southern Trust (2018) "Your Right to Raise a Concern Policy and Procedure (Whistleblowing)."

Evidence 80 – Southern Trust "How staff can raise concerns."

Evidence 81 – NMC Raising concerns

Evidence 82 – NMC "The Code"

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, or any other matter regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.



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26.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

26.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

26.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

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

27.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

27.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.



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27.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

28.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

28.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

28.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

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

29.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

29.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the



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process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

29.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

30.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

30.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

30.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

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

31.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.



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31.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

31.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

32.1. From my time within the Southern Trust I have raised concerns surrounding practice which has resulted in escalation through procedures and implementation of outcomes and learning for sharing and implementation.

32.2. Within the context of my initial role as Lead Nurse for Medicine I have had to escalate some staff members practice due to safeguarding concerns. Following the identification of these concerns a safeguarding processes was commenced following the safeguarding policy and procedures. The staff member was removed from practice, advised of the allegation and suspended pending investigation. The Senior Managers within Medicine were informed alongside the Nurse bank Manager and Acute Head for Social Work.

33.3. There was a delay in escalating the concerns to myself as the Lead Nurse and the staff members within the ward were advised of the correct process to increase their knowledge of raising concerns. The incident was shared at the Senior Nurses Forum so all Ward Managers would have greater awareness of raising concerns.



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Evidence 83 – Safeguarding Concern Email

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

33.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

33.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

33.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

34.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

34.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as



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part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

34.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

35.1. Within Health and Social care and the Southern Trust we align with the values of “openness and honesty” and therefore within the daily provision of service delivery and governance functions we must be compliant by embracing the professional duty of candour.

35.2. The Southern Trust is within the process of developing its “Being Open Policy” which will work collectively with the whistleblowing policy and procedures. Once developed and imbedded within the organisation this will improve and support the structures for raising concerns. There are also external guidance currently provided by the General Medical Council and Nursing and Midwifery Council on the professional duty of candour and this should support the escalation of concerns.

35.3. Improving collaborative systems of governance which are corporately run and information is accessible and readily available will improve early identification of potential negative trends and promote early intervention to address.



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35.4. The increase in appropriate and effective governance and performance information will assist the operational teams to also identify areas of concerns and develop action plans to address. Governance information needs to be available at all levels in a format that is transferable, i.e. there must be Directorate level data for Directorate oversight, Divisional level for Assistant Directors and Service level for Head of Services.

35.5. The use of a corporate mandatory training system for core governance processes to have oversight and control of the minimal standards of education all members within the organisation will contain. This allows a balanced assessment of the baseline knowledge and ability of the Southern Trust workforce to engage, escalate, investigation, identify and action concerns.

35.6. Systems of governance need to improve the level of essential information and how this is assigned to appropriate escalation streams to identify concerns from governance processes. An example would be the inclusion of all people involved within incidents and complaints so if there is a trend of individual practitioners this is identified easily and escalated to the appropriate service area and professional manager.

36.6. Within the function of ACGC and the Acute Governance Teams it is essential that we provide the information and have effective processes and systems which can identify concerns early and be escalated. The addressing of concerns is undertaken through the affected operational team therefore effective communication and collective working is essential. Governance further has a role to monitoring the concerns, providing information and feedback regarding the concern, monitor implementation of recommendations/action plans and share identified learning throughout the organisation if appropriate to increase safety and quality of services.



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36.7. Individual practitioners must have awareness of self-governance and follow their professional registered bodies' policies, procedures and advice relating to duty of candour, providing safe and high quality care. The delivery of care is the responsibility of all staff and therefore equally it is responsibility of all staff to support governance functions.

36.8. The Acute Service Directorate covers a large number of specialities. To complete governance processes effectively and provide effective governance information to all service areas the governance and operational teams must be effectively resourced. The Acute Governance Team is requesting additional resources to improve the governance process we deliver and increase our ability to provide accurate and effective information to inform service areas of any potential concerns early.

36.9. When concerns arise there must be timely action by operational teams to address but this also must coincide with provision of support for the individual through escalation through our HR processes. There are structures developed within the Southern Trust such as the "Dentists and Doctors in Difficulty" and "Nurses in Difficulty" group provide a collective forum to discuss, provide oversight and assist in action planning concerns.

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?



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36.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

36.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.

36.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

37.1. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services.

37.2. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position. I therefore am not in a position to provide the answer to this question.



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37.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

38.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

38.2. Within the context of my initial role as Lead Nurse for Medicine there was no roles or responsibilities relevant to the operation, governance or clinical aspects of Urology Services and therefore I should not have been made aware of these concerns.

38.3. I would suggest that the ACGC who held this position prior to July 2021 would be better informed to answer this question.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

39.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in



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the process of being identified and established when I was appointed to this position.

39.2. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

39.3. My answer to this question can only be provided through the lens of hindsight and also from the perspective of an individual who did not work with the governance systems in which there has been concerns identified. I believe the concerns were multifactorial rather than from a single source and some key points are highlighted below.

39.4. The Acute Directorate is large in size and providing a wide variety of clinical services. Urology Services is a singular speciality within this large Directorate and therefore the level of resource external to the operational team within Urology Services addressing governance issues was small. Similarly the allocated services to each Head of Service alongside the daily acute pressures such as bed capacity would limit the time available to develop and progress strong governance systems and processes. This is one issue which the Acute Governance Team collectively with operational teams has developed a new band 5 role to increase the resource; a dedicated band 5 per clinical Division to focus on core governance processes to support the creation and delivery of safe and high quality governance process.

39.5. The methods used to monitor aspects of governance processes did not effectively identify individuals who concerns were raised on multiple occasions. One such example would be the Acute Complaints Department did not monitor the names of staff highlighted within complaints, this created a missed opportunity to identify individual were numerous concerns may have been raised to address concerns. Since January 2022 this has



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been amended and all those identified within a complaint are identified within the datix system to facilitate identification and support the revalidation processes of staff members. This concern is similar to that which has recently been identified through the Neurology Inquiry.

39.6. Governance systems themselves were managed in silos with each clinical Directorate having a Clinical and Social Care Governance Coordinator and allocated Governance Team. Although there were systems for monitoring core functions, such as complaint returns, incident numbers, SAI progression, monitoring and implementation functions were not monitored centrally. An example of this is within the implementation of SAI recommendations. SAI recommendations are developed following the completion of an SAI report and the operational team are responsible for implementing these agreed actions. The assurance of implementation through monitoring should be held by the Directorate and Corporate Governance systems however no such monitoring was available. The Directorate Governance Teams provided updated status when requested however no continual oversight was maintained. As a consequence SAI recommendations implementation was not monitored effectively. The Acute Governance Team did not monitor actions which had been implemented or escalate to the operational teams their outstanding actions. Equally operational teams did not provide updated positions on their outstanding recommendations for their services. This is being addressed currently from a collaborative approach using the Datix system to collate actual positions in real time and maintain a communication position between operational, directorate governance and corporate governance teams.

39.7. Within the management of clinical and social care governance processes there was no central corporate training on key principles and functions. As a fundamental component of common governance processes, complaints and incident management, there is no singular corporate mandatory training. Any training provide was completed on request of staff



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members and was bespoke to each Directorate and team facilitating this training. With the lack of oversight in governance processes training it is difficult to have assurances on individual practitioner's knowledge and skills within these core processes. This is equally true for those undertaking investigation for completion of these governance processes which leads to variation in the quality and level of response. This ultimately leads to potential limitations in identifying concerns, providing awareness, implementing mitigations and sharing the learning.

39.8. Within healthcare environments the majority of clinical facing practitioners are registered to a professional body. There is a responsibility that there is self-governance for all practitioners to follow initially the values, policies and procedures of the organisation in which they work, the core values, policies and procedures of Health and Social Care but ultimately the code of conduct and guiding documents from their registered professional body. Within Urology Services it is evident that there was also a failure for practitioners to govern their practice by their registered bodies' guiding documents and principles.

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

40.1. I consider there to be learning for the governance systems following Urology Services review.

40.2. Initially there has been a move from "silos" to developing governance systems which have oversight across numerous teams. This is to allow Service Level, Divisional, Directorate and Corporate oversight of the progression of governance functions. Only through the universal use of



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Trust-wide procedures and standing operating procedures and the use of Trust wide systems for monitoring and assurance can improved governance oversight be obtained. This will prevent information becoming isolated in areas or teams being prevented or restricted in implementation or learning.

40.3. There needs to be a development within governance data so information can be provided at Directorate, Divisional and Service Level to assist with trend analysis, identify concerns and promote early action to improve quality and safety. Isolated numbers provide insufficient information to understand current position or progress within services and therefore there must be a combination approach to show data over time for analysis. Only through generation and analysis of this information can service level detail be added to account for current status of governance positions.

40.4. Governance processes need to include outcome and process measures. As highlighted governance is a collaborate process between the Acute Governance Team and Acute Services operational teams. Increased measurement of processes will allow for monitoring of delays in the system but also allow for accurate assurance of implementation of each governance function. This facilitates the production of information highlighting current position. An example would be within the implementation of SAI recommendations. Although the implementation of recommendations is the responsibility of the operational team the Acute Governance Team is responsible for providing assurance that all actions have been implemented or to escalate outstanding actions to the operational team for action. This feedback loop ensures potential learning is not lost and is translated into tangible outcomes to improve safety and quality of service.



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40.5. The provision of universal corporate mandatory training on core governance functions such as complaints management, incident reporting and investigating incidents. This provides assurance over the knowledge shared to all employees and also that individuals are aware of their roles and responsibility within each process.

40.6. There needs to be an increase of audit capability, which would include the auditing of Multidisciplinary Team Meetings to ensure the collectively agreed actions have been followed appropriately within the set timeframe agreed.

40.7. The governance systems and processes need to be appropriately resourced so they can deliver assurance from service to corporate level accurately and appropriately. Governance is the responsibility of all staff members within the service, however, to ensure high quality governance systems work appropriate time and resources must be provided so that the quality of information entered and returned from these processes delivers effective and efficient systems of safety, quality and assurance.

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in



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the process of being identified and established when I was appointed to this position.

41.2. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

41.3. My answer to this question can only be provided through the lens of hindsight and also from the perspective of an individual who did not work with the governance systems in which there has been concerns identified.

41.4. As identified in the answer to Questions 39 and 40, the governance systems within Urology Services were not effective. The majority of governance information was shared at a Directorate level which lacked sufficient detail to pull out themes within Divisions and was not easily translated universally to all services areas within Acute Services.

41.5. The concerns identified within Urology Services, such as complaints and outstanding SAI actions, details were not readily available in the context of “service area level”. As this information and data were not available those accountable for Urology Services were not fully informed of the current position of these governance functions relating to these concerns.

41.7. Once concerns were identified they were escalated for review, which has ultimately lead to this Urology Service Inquiry and the lookback exercise associated with potential deficiencies in Mr O’Brien’s clinical practice.

42. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance



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arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

42.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

42.2. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.

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

43.1. I undertook the role of ACGC in July 2021. At this stage the concerns within Urology services had been identified and were shared with me as part of the induction process into this role. The public inquiry team was in the process of being identified and established when I was appointed to this position.

43.2. I would suggest that the ACGCs who held this position prior to July 2021 would be better informed to answer this question.



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43.3. My answer to this question can only be provided through the lens of hindsight and also from the perspective of an individual who did not work with the governance systems in which there has been concerns identified.

43.4. The answers I have provided to Question 39, 40 and 41 identify that from my perspective, which is through a lens of hindsight, that the governance systems in place were not fit for purpose. I am unable to comment if it was felt during the time they were in place that they were believed to be fit for purpose.

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

NOTE:

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



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Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Chris Wamsley

Date: 24th October 2022

Section 21 Notice Number 94 of 2022**Witness Statement: Chris Wamsley****Index**

Document
Evidence 1 - 8A Lead Nurse Medicine
Evidence 2 - 8B Acute Clinical and Social Care Governance Coordinator
Evidence 3 - Capability Plan
Evidence 4 - 20221010 - Acute Complaints overview
Evidence 5 - 20210705 - May 2021 Acute SMT Governance Report
Evidence 6 - Acute Directorate Complaints Report May 2022
Evidence 7 - CH8 -Sept 2022
Evidence 8 - Acute Draft Closed Complaints Report August 2022
Evidence 9 - 20220901_CSCG Governance Committee Report Sept 2022
Evidence 10 - 20220606 Directorate Meeting
Evidence 11 - 20221018 Updated Acute SG Agenda
Evidence 12 - 20220414 Agenda Professional Leads
Evidence 13 - 20221014 standards and guidelines
Evidence 14 - Procedure-for-the-reporting-and-follow-up-of-SAIs-2016
Evidence 15 - 20211101 20211107 Weekly Governance Report
Evidence 16 - 20210705 - May 2021 Acute SMT Governance Report - incidents
Evidence 17 - Incident report August 2022
Evidence 18 - Section 16 of 20221004 SEC CCS IMWH Directorate Governance Agenda October
Evidence 19 - 20221004 Outstanding Datix report SEC CCS IMWH
Evidence 20 - 20210607 - Major and Catastrophic Incidents report within Acute Clinical Governance Meeting
Evidence 21 - 20220802 - New version of Major and Catastrophic Incidents report within Acute Clinical Governance Meeting
Evidence 22 - SAI Performance Meeting SPPG SHSCT
Evidence 23 - 20210816 20210822 Weekly Governance Report
Evidence 24 - 20220621 Acute Directorate Governance Agenda June
Evidence 25 - 20220610 Acute Clinical Governance Forum Meeting Agenda
Evidence 26 - ASOG - 20221018
Evidence 27 - USC GLucometer User Audit July 2022
Evidence 28 - POCT Device Audits (3 reports CAH Glucometers, DHH Glucometers and INR Devices)
Evidence 29 - EQA testing of POCT Devices (3 Reports - Glucometers, INR and Pregnancy)
Evidence 30 - Medicine Fridge Audit
Evidence 31 - Equipment Management Audit May June 2022 FULL
Evidence 32 – Follow up audit from National Patient Safety Alert
Evidence 33 - 20220704 Urology Screening
Evidence 34 – BSO Sign Off report
Evidence 35 – Monthly Sign off Trends Report
Evidence 36 – Appraisal Document
Evidence 37 - Performance and Personal Development Review Policy
Evidence 38 – Revalidation Document
Evidence 39 - NMC Revalidation
Evidence 40 - Nursing and Midwifery Accountability and Assurance Framework
Evidence 41 - nmc-standards-for-competence-for-registered-nurses

Evidence 42 – Clinical Supervision Document
Evidence 43 – RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland
Evidence 44 - Policy for the Management of HSC Complaints 2019
Evidence 45 - Guidance in Relation to the HSC Complaints Procedure - April 2019
Evidence 46 – Guidance in relation to the Health and Social Care Complaints Procedure 2022
Evidence 47 – Parliamentary and Health Service Ombudsman 2009 Principles of Good Administration
Evidence 48 - Parliamentary and Health Service Ombudsman 2009 “Principles of Good Complaint Handling”
Evidence 49 - Parliamentary and Health Service Ombudsman 2009 “Principles of Remedy”
Evidence 50 – NIPSO 2019 “Guidance on issuing an apology”
Evidence 51 - NIPSO 2020 Records Matter
Evidence 52 - Northern Ireland Public Services Ombudsman “Signposting to the Ombudsman – a guide for public authorities”
Evidence 53 – SHSCT 2014 SHSCT Incident Management Procedure
Evidence 54 – SHSCT 2021 Adult Safeguarding Policy Prevention and Protection in Partnership
Evidence 55 – DGSS and PS 2015 Adult Safeguarding Prevention and Protection in Partnership Policy
Evidence 56 – Southern Trust 2018 Health and Safety at Work Policy
Evidence 57 – HSE 2013 Reporting injuries diseases and dangerous occurrences in health and social care
Evidence 58 – Department of Health 2021 Northern Ireland Adverse Incident Centre (NIAIC) Reporting Adverse Incidents
Evidence 59 – Southern Trust (2012) “Management of Medical Devices and Equipment”
Evidence 60 – Southern Trust (2010) “Management of Equipment and Medical Devices Operational Procedures Manual”
Evidence 61 – MHRA (2021) “Managing Medical Devices Guidance for health and social care organisations”
Evidence 62 - Medical Device Alert example (2021) Philips_Foam_NaPSA_update
Evidence 63 – Southern Trust (2018) “Blood Transfusion Policy”
Evidence 64 – MHRA SHOT (2021) “UK Haemovigilance user guide”
Evidence 65 – MHRA SABRE User Guide (2010) “Investigating and Reporting TR SAR and Event”
Evidence 66 – SHOT (2022) “Definitions of current SHOT reporting categories and what to report”
Evidence 67 – Southern Trust (2022) “Policy for Reporting of Early Alerts to the Department of Health (DoH)”
Evidence 68 – Department of Health (2020) “Early Alert System”
Evidence 69 - Department of Health (2014) “Early Alert System”
Evidence 70 - Department of Health (2010) “Early Alert System”
Evidence 71 – Southern Trust (2022) “Northern Ireland Regional Point of Care Testing Policy”
Evidence 72 – Southern Trust (2019) “Interim Risk Management Strategy 2019 – 2022”
Evidence 73 – NMC and GMC (2022) “Openness and honesty when things go wrong the professional duty of candour”
Evidence 74 – Southern Trust (2021) “Information Governance Policy”
Evidence 75 – Email to Acute Governance from Services Area for bespoke complaints and Incidents data
Evidence 76 - Risk Assessment Form
Evidence 77 - Guidance for the Regional Mortality and Morbidity (MM) Process
Evidence 78 - Clinical and Social Care Governance Officer band 5 Job Description

Evidence 79 - Southern Trust (2018) Your Right to Raise a Concern Policy and Procedure (Whistleblowing)
Evidence 80 – Southern Trust “How staff can raise concerns.”
Evidence 81 – NMC Raising concerns
Evidence 82 - NMC The Code
Evidence 83 - Safeguarding Concern Email



JOB DESCRIPTION

JOB TITLE	Lead Nurse Medicine
BAND	8A
DIRECTORATE	Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Head of Service
ACCOUNTABLE TO	Assistant Director

JOB SUMMARY

The Lead Nurse will be responsible to the Head of Service for the operational and professional nursing management and leadership within the Division. The Post holder is expected to function at a senior level providing visible, professional nursing leadership, support and direction to ensure safe patient centered care and will proactively manage, lead and provide solutions to resolve complex operational issues working with Ward Sisters/Charge Nurses, Patient Flow team & Heads of Service including the lead for nursing workforce, education, training and development and governance.

He / She will be responsible for ensuring the standards of nursing practice throughout all relevant specialities are at the required professional standard ensuring that safe, high quality clinical services are delivered and will lead on programmes of improvement related to implementing and sustaining Regional Nursing Quality Indicators (NQIs).

As the Lead Nurse you will work with the entire Multi- disciplinary team (MDT) to optimize patient experience and outcomes of care through service and workforce efficiency, productivity and effectiveness. The Post holder will be expected to contribute to strategic direction and policy setting for the nursing within their Division.

KEY DUTIES/RESPONSIBILITIES

Service Delivery

1. Assure the highest standards of clinical care by the provision of management & leadership for nursing staff, patients, relatives, carers and visitors.
2. Lead and develop excellent patient care through continuous review of evidence based clinical standards, policies & standard operating procedures.
3. Create a strong patient focused team, embedding the regional patient/client experience standards (Respect, Attitude, Behaviour Communication, Privacy and Dignity), that challenges organisational and professional barriers and boundaries.
4. Develop a culture that is flexible and positive to change, where staff feel valued and where opportunities are actively created for individuals to maximise their potential and excel.
5. Promote a learning environment for staff, ensuring that the education, training and developmental needs of staff are reflected in the annual Education Commissioning, appraisal and PDP processes.
6. Promote a culture, which is underpinned by honest, open communication and team working across disciplines
7. Participate in clinical and professional networks across acute hospital sites within the Trust.
8. Contribute to the development and implementation of the nursing strategy as agreed by the Executive Director of Nursing.
9. Lead the effective implementation and ongoing monitoring of regional quality and operational initiatives
10. Provide advice, guidance, support and professional leadership to Ward/Department Sisters/Charge Nurses, Nurses, Specialist Nurses, the Patient Flow Team and Support Workers, demonstrating a responsible attitude in order to promote confidence in the service.
11. Ensure close collaborative working with the patient flow team to deliver on the regional performance standards for unscheduled and elective care

12. Responsible for the monitoring of clinical standards including observations of care provision e.g. all NQI's thus providing an assurance to senior management.
13. Support the effective implementation of environmental cleanliness standards. Ensure staff have a clear understanding of the care and environmental standards they are expected to be maintained, taking prompt action to rectify any non-compliance.
14. Support the process for monitoring patient experience and assist to implement actions in the light of patient feedback, thus achieving a high level of patient satisfaction.
15. Act as mentor/coach to enhance the performance and capability of staff through formal and informal interactions, provide constructive feedback to staff, supporting them to develop enhanced skills and ability.
16. Ensure that all decontamination requirements are met and adhered to in all Trust services under your span of control.
17. Develop appropriate mechanisms for accessing the views and facilitating the involvement of service users and carers in the development and delivery of services

Quality/Governance

1. Take personal responsibility for individual professional growth, development & revalidation. Maintaining clinical competence and credibility within nursing practice
2. Support the Head of Service in the effective and efficient management of clinical services.
3. Work to foster and develop an environment where nurses are valued and in adherence with the NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics. Ensure effective record keeping and documentation in line with NMC Guidelines.
4. Ensure systems are in place that ensures that staff keep up to date with current developments regarding patient care.
5. Ensure staff maintain confidentiality at all times, including the storage of

records and the transfer of verbal and written information.

6. Ensure effective communication systems are in place to support programmes of care and, or care pathways.
7. Assist the Head of Service in the effective implementation of ;
 - (I) robust induction and development review/ appraisal programmes
 - (II) clinical supervision framework
 - (III) preceptorship programmes for newly appointed nursing staff.
8. Establish and maintain clear systems and processes for accountability for staff.
9. Monitor and support the use of appropriate clinical governance policies, guidelines, and protocols for staff, reviewing and monitoring compliance, specifically to support the Trust's policy and procedures for dealing with complaints, clinical incidents and serious adverse incidents
10. Assist the Head of Service with co-ordinating the response to complaints prior to submission through line management structures.
11. Review nursing issues arising from complaints about services provided ensuring that appropriate action is taken; lessons are learnt and reflected in practice.
12. Work with the infection control team and clinical colleagues, monitor infection control rates and take forward those actions and changes necessary to prevent and minimise hospital acquired infections
13. Ensure systems are in place for the procurement, safe use. Storage, maintenance, decontamination and disposal of medical devices and other equipment.
14. Support the Head of Service to ensure that the service complies with the requisite controls assurance standards with particular reference to decontamination, medicines management, environmental cleanliness, infection control and management of medical devices.
15. Ensure control robust systems are in place to assure the Executive Director of Nursing that all nurses have current registration with NMC
16. Ensure that all recommendations arising from RQIA inspections are acted upon and implemented in a timely manner.

Leadership & Setting Direction

Provide highly accessible, approachable and visible professional nursing leadership and operational management support to Ward Sisters/Charge Nurses, ensuring clinical services develop in line with evidence based practice.

1. Act as a role model inspiring and empowering nurses to implement new ways of working
2. Ensure efficient and appropriate professional development and succession planning are in place for nursing staff.
3. Support the Head of Service in the development of the directorate policies and to contribute to the development of Trust policies where appropriate.
4. Support the Head of Service in the review, development, implementation and delivery of services, ensuring integration with corporate and service group strategies and service delivery priorities.
5. Support the Head of Service in the development of strategic and operational plans for the delivery of services, in line with regional strategies, Ministerial and HSSA priorities.
6. Assist the Head of Service with service development proposals and business cases as related to nursing.
7. Deputise for the Head of Service

Development and Innovation

1. Promote and facilitate the implementation of the Trusts Personal Performance and Development Review.
2. Support the management structures and practices to ensure a culture of effective team working, continuous improvement and innovation
3. Lead the annual training needs analysis for nurses in all relevant Specialities.
4. Participate in the recruitment and appointment of staff in accordance with Trust policy.
5. Actively promote new ways of working and models of service delivery to

improve services for patients.

In conjunction with the Head of Service, promote innovation and change to underpin the modernisation of services with a view to re-profiling across the Trust where necessary

Strategic Planning and Development

1. Support the Service with the development of the strategic plan for the delivery of facilities within the Acute Services Directorate on behalf of Director of Acute Services, in line with regional strategies, Ministerial and HSCA priorities.
2. Contribute to the strategic direction of the Trust and to the achievement of corporate objectives as appropriate.
3. Work with members of relevant teams on the innovative development of new and existing services.
4. Challenge the status quo in the planning and delivery of all relevant clinical services.

Financial and Resource Management

1. Deliver all services within remit of responsibility within financial balance and identify to the Head of Service where conflicts arise
2. In conjunction with the Head of Service critically assess workforce, skill mix and explore options to create new roles within financial constraints.
3. In conjunction with the Head of Service monitor the use of bank and agency staff and ensure that the Trust policies for bank and agency use are implemented
4. Assist the Head of Service to ensure systems are in place for procurement, maintenance and replacement of all medical devices
5. Assist in the management of services and budget and ensure financial targets are met.
6. Assist with identification of cash releasing schemes and meet financial savings as outlined by Director of Acute Services.

People Management

1. Provide clear and strategic leadership to staff and ensure a highly skilled, flexible and motivated workforce to provide high quality patient care.
2. Support the Head of Service in the development and implementation of workforce modernisation initiatives within clinical services.
3. Ensure compliance with employment legislation, HSS directives and Trust standing orders, policies, procedures and regulations by introducing appropriate systems when required.
4. Encourage a culture that allows staff to maximise their potential, ensuring that they are able to contribute to the Trust Corporate strategy.
5. Ensure full engagement of all professional staff working in areas of responsibility.
6. Ensure staff are led and managed within agreed Policies and procedures.
7. Manage staff performance and action accordingly.
8. Ensure the Trust's sickness absence policy is implemented within the services and establish an effective mechanism for regularly monitoring levels of sickness and absence, taking corrective action where necessary.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
2. Maintain staff relationships and morale amongst the staff reporting to him/her.
3. Review the organizational plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.
4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

Corporate Management

1. Contribute to the Trust's corporate planning, policy and decision making processes and ensure the Acute Services Directorate objectives and decisions are effectively communicated.
2. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Directorate effectively discharges its functions.
3. Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, codes of conduct, operations and accountability.
4. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

GENERAL REQUIREMENTS

The post holder will be required to:

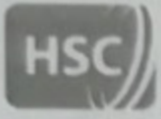
1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of

Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximize his/her potential and continue to meet the demands of the post.
6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

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



Southern Health
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Quality Care - for you, with you

Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator



Working together



Excellence



Openness & Honesty



Compassion

**BE PROUD.
BE PART OF IT.**



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JOB DESCRIPTION

JOB TITLE	Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator
BAND	8B
DIRECTORATE	ACUTE
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of, the Service Director and the Assistant Director with responsibility for Governance. They will provide an internal and external Directorate focus for the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust with respect to the CSCG agenda within the Directorate and as an integral part of the Trust CSCG Working Body and through close collaboration with the Trust's Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate CSCG plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director for CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.



The post holder will provide enhanced CSCG support and performance improvement expertise and intervention in this area to their Directorate and to corporate CSCG projects where required. He/She will provide their Directorate and the organisation with a suite of intelligent information analyses which demonstrate real time performance in relation to all areas of CSCG, including Incidents, Complaints, Risk, Litigation, Audit, Clinical Indicators and Patient Safety. The post holder will also be required in collaboration with the Trust Senior Management Team and the Trust CSCG Senior Manager, to develop the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic leadership and facilitation skills.

KEY DUTIES / RESPONSIBILITIES

Directorate Responsibilities

1. On behalf of the Director of Acute Services, to take the lead within the Directorate in providing assurance to the organisation that all aspects of CSCG are of a sufficiently high standard of compliance and to ensure that the Trust CSCG systems and processes are embedded within the Directorate and are providing timely assurance and alerts to both the Service Director and the organisation.
2. Lead on ensuring that at each level of the Directorate, staff have access to timely, high quality and appropriate information in relation to incidents, complaints, audit, clinical indicators, litigation and risk and that within each service team this information is being acted on appropriately in order to mitigate risk, improve quality of care and patient and client safety.
3. In particular to coordinate via the Directorate governance team the timely and appropriate responses to both incidents and complaints on behalf of the Directorate and to ensure standards of response times and patient / client satisfaction in the complaints process is maintained.
4. To ensure that strong links are maintained between Directorates and corporate functions such as complaints, the management of SAI's and litigation.
5. Lead on the investigation of serious adverse incidents in the Acute Directorate, ensuring that a consistently high standard of investigation and report writing is maintained at all times.
6. Lead on patient/family engagement in relation to serious adverse incidents within the Acute Directorate.



7. Lead on the interpretation and implementation planning of all standards and guidelines in relation to patient and client care and service provision within the Directorate and facilitate service teams to ensure that these are implemented, monitored and reviewed in a timely manner.
8. Provide project management leadership when required in relation to implementation of standards and guidelines and / or the implementation of new Trust wide systems and processes related to CSCG. Identify any constraints, including resources, to implementation in a timely way and immediately report this to the Director and/or Assistant Director with responsibility for CSCG.
9. Use expert analytical skills to interpret the broad range of performance information and other data, including internal and external benchmarking, to identify service and Directorate trends, exceptions, risks and alerts in relation to CSCG issues and to present these in an appropriate format to service teams and the Director.
10. Lead on provision of specialist clinical governance and risk management knowledge and expertise to sensitively and constructively challenge and assist directorate teams in diagnosing and addressing the complex issues and factors which are preventing them maximizing their CSCG performance in relation to patient and client quality care and safety.
11. Lead on provision of specialist expertise to the Director and their senior managerial and clinical staff in relation to the management of incidents and complaints requiring detailed analysis and significant learning.
12. Provide expert advice and knowledge to the Directorate in relation to the concepts of risk management and mitigation and ensure that the Directorate proactively manages risk at all levels of service on a continuous basis.
13. Develop and foster excellent working relationships with service teams at all levels of the Directorate based on confidentiality and trust to enable and foster a Directorate and organizational culture of openness in relation to patient and client care.
14. Hold the other members of the governance team to account in relation to the successful delivery of all aspects of CSCG across the Divisions within the Directorate.



15. On behalf of the Director take the lead on ensuring good communication and clear lines of accountability relating to operational and professional CSCG. Coordinate the various Directorate Governance fora, assist the Director in prioritising new CSCG plans and projects, and be a focal reporting point for professional support and governance functions within the Directorate.
16. Lead on the provision of appropriate training in all aspects of CSCG for Directorate staff.
17. Develop and maintain strong networks with organisational, regional and national CSCG colleagues, keeping up to date with latest thinking and developments and bring this intelligence back to the organisation to inform and drive improvement.

Organisational Responsibilities

1. On behalf of the Service Director lead on the provision of key Directorate information and data in a timely and appropriate format to the organisation which provides corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard within the Directorate.
2. Lead the Directorate representation on the Trust CSCG working body and contribute to, and lead on as appropriate, the development, implementation and audit of organisational wide CSCG policies and procedures.
3. Be the lead within the Directorate in relation to sharing and learning from CSCG trends, exceptions, alerts and risk at an organisational wide level via the Trust CSCG working body. Disseminate this information throughout the Directorate and develop measures to evidence that learning has resulted in changes in practice.
4. Work collaboratively with the Trust's Corporate Assistant Director for CSCG to ensure that there is a clear, two way line of communication from Acute Directorate to SMT Governance and Trust Governance Committees.
5. Act as one of a small number of experts in CSCG who advise the Trust, via the CSCG working body, on organisational, regional and national policies, their organisational implications and potential implementation plans / methodologies.
6. Take the lead in planning and implementation of Trust wide policies and procedures as required via the CSCG working body and actively bring forward to the CSCG working body forum strategic plans for driving forward the CSCG



3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern

agenda within the Southern Trust and influencing and shaping this agenda regionally.

7. Ensure through providing robust monitoring arrangements, that at all times the Directorate is complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation this must first be brought to the attention of the Director of Acute Services. Where the issue remains unresolved the post holder must identify the deviation or exception to the SMT Governance via the appropriate Executive Director.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.
2. Ensure access to skills and personal development through appropriate training and support.
3. Promote a culture of openness and honesty to enable shared learning.
4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.
5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.
2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.



3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

- To work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- To ensure effective communication with service users and families and to embed the role of Family Liaison as a key mechanism to involve and support families
- Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.



5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

<April 2021>





Southern Health
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PERSONNEL SPECIFICATION

JOB TITLE AND BAND

Acute Clinical & Social Care Governance
(CSCG) Co-ordinator Band 8B

DEPARTMENT / DIRECTORATE

Acute Services

HOURS

37.5

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Experience	1. Have delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. 2. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years. 3. Have successfully demonstrated high	Shortlisting by Application Form



4. A good level of computer literacy
5. Demonstrate the ability to write clear reports related to complex

	level strategic and people management, and organisational skills for a minimum of 2 years.	
Qualifications/Registration	1. Have a relevant professional qualification at degree level of above, and worked for at least 2 years in a senior management role (band 7 or above) in a major complex organisation with responsibilities for aspects of risk management and governance.* - Or 2. Have worked for at least 4 years in a senior management role in a major complex organisation with responsibilities for aspects of risk management and governance.*	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. <i>This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.</i>	Shortlisting by Application Form
SECTION 2: The following are ESSENTIAL criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	<i>The following are essential criteria which will be measured during the interview stage.</i> 1. Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff. 2. Evidence of highly effective planning and organisational skills. 3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills.	Interview



	4. A good level of computer literacy 5. Demonstrate the ability to write clear and concise reports related to complex subject matter.	
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DESIRABLE CRITERIA

SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted

Factor	Criteria	Method of Assessment
Experience	Have 2 years' experience in Clinical and Social Care Governance setting.	Shortlisting by Application Form

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at

<http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model>.

Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

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

Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER



Successful applicants:

- may be required to attend for a Health Assessment
- can expect to be placed at the minimum point of the pay scale, although a higher starting salary, within the range of the pay band may be available if the person appointed has experience relevant & equivalent to the post. If the successful candidate is an existing HSC employee moving to a higher band, AfC Pay on Promotion will apply.



**Working Together**

We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

- I work with others and value everyone's contribution
- I treat people with respect and dignity
- I work as part of a team looking for opportunities to support and help people in both my own and other teams
- I actively engage people on issues that affect them
- I look for feedback and examples of good practice, aiming to improve where possible

**Compassion**

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

- I am sensitive to the different needs and feelings of others and treat people with kindness
- I learn from others by listening carefully to them
- I look after my own health and well-being so that I can care for and support others

**Excellence**

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.

- I put the people I care for and support at the centre of all I do to make a difference
- I take responsibility for my decisions and actions
- I commit to best practice and sharing learning, while continually learning and developing
- I try to improve by asking 'could we do this better?'

**Openness & Honesty**

We are open and honest with each other and act with integrity and candour.

- I am open and honest in order to develop trusting relationships
- I ask someone for help when needed
- I speak up if I have concerns
- I challenge inappropriate or unacceptable behaviour and practice

Action plan devised 19th July 2021-

Personal Information redacted by the USI

Issue of concern	Standard Required	Affect it has	Support Mechanisms to be put in place	Learning Development provided	Review Date Weekly	Timescale for improvement	Contact Mentor
Personal Information redacted by the USI has an unacceptable levels of errors when drafting complaints	No errors identified within draft on completion. Good presentation and correct use of tone and language.	Affects the timeliness of responses being approved, reduces compliance with complaints targets. Reflects on the standard of quality produced by the office. Negatively portrays quality of investigation completed to Service user.	Work to be reviewed for a 3 months by manager for proofing who will identify areas requiring improvement. Weekly/fortnightly review and feedback on progression towards achieving desired level of competence.		(1 st review date) 6th August 2021	3 months	Collette McCaul
Concern surrounding Personal Information liaison with clinical staff, patients and stakeholders in a sensitive, confidential and appropriate manner	Professional and courteous manner to be displayed to everyone.	Impacts the successful working relationships necessary to timely address service user concerns. Potentially disengages service users leading to	Customer service training. To provide the fundamentals of civility leaflet as guidelines.		As above	3 months	Collette McCaul

Action plan devised 19th July 2021-Personal Information redacted by the
USI

		further detriment to both service users and their families.					
Personal Information redacted by the USI is unable to identify all relevant stakeholders whose involvement is essential for a robust complaints investigation to be completed.	To be able to identify all relevant persons who need to be input to complaint response based on department and division	Affects the target time to receive responses causing delays to the process.	Crit sheet is already supplied for all the relevant areas, team leads, lead nurses and AD. Read SOPs To consistently use this sheet to identify relevant areas and to communicate with team members for further assurance		As above	3 months	Collette McCaul
Personal Information redacted by the USI is unable to recognise her responsibility and accountability for results	To be accountable for results and take responsibility for both positive and negative results	No direct affect	Weekly/fortnightly review and feedback on progression towards achieving desired level of competence.		As above	3 months	Collette McCaul

Personal Information redacted by the USI

Signature: (Employee)

10th August 2021

Issue of concern	Progress to date
Personal Information redacted by the USI has an unacceptable levels of errors when drafting complaints	Personal Information redacted by the USI
Concern surrounding Personal Information redacted by the liaison with clinical staff, patients and stakeholders in a sensitive, confidential and appropriate manner	Personal Information redacted by the USI
Personal Information redacted by the USI is unable to identify all relevant stakeholders whose involvement is essential for a robust complaints investigation to be completed.	Personal Information redacted by the USI

Personal Information redacted by the USI

10th August 2021

Personal Information redacted by the USI is unable to recognise her responsibility and accountability for results	Personal Information redacted by the USI

Personal Information redacted by the USI

10/08/2021.

10/08/2021.

13th September 2021

Issue of concern	Progress to date
Personal Information redacted by the USI has an unacceptable levels of errors when drafting complaints	Personal Information redacted by the USI
Concern surrounding Personal Information redacted by the USI liaison with clinical staff, patients and stakeholders in a sensitive, confidential and appropriate manner	
Personal Information redacted by the USI is unable to identify all relevant stakeholders whose involvement is essential for a robust complaints investigation to be completed.	

Personal information redacted by the USI

13th September 2021

Personal information redacted by the USI is unable to recognise her responsibility and accountability for results	Personal information redacted by the USI

PROBATIONARY REPORT (6 MONTHS)

NAME: Personal Information redacted by the USI		POST: <u>Governance Officer</u>	
DEPT: <u>Acute - The Manton</u>		STAFF No: Personal Information redacted by the USI	
DATE OF APPOINTMENT	PERIOD COVERED BY REVIEW	ABSENCES DURING REVIEW PERIOD AND REASONS	
Personal Information redacted by the USI			
TRAINING UNDERTAKEN DURING REVIEW PERIOD			
Personal Information redacted by the USI			
Personal Information redacted by the USI			
PERFORMANCE DURING REVIEW PERIOD			
MAIN TASKS UNDERTAKEN		ACHIEVEMENTS/COMMENTS RE: PERFORMANCE	
Personal Information redacted by the USI			
ARE YOU SATISFIED WITH EMPLOYEE'S PROGRESS TO DATE:		Personal Information redacted by the USI	
ADDITIONAL COMMENTS/ACTION TO BE TAKEN TO IMPROVE PERFORMANCE (3 MONTHS)			
Personal Information redacted by the USI			
Signed: Personal Information redacted by the USI		(Manager)	
Signed: Personal Information redacted by the USI		(Probationer*)	
		Date: <u>19/7/2021</u>	
		Date: <u>19/07/2021</u>	
* Signature confirms that the above review has been discussed with you.			
E-MAIL TO: Personal Information redacted by the USI			

Date: 26 July 2021

PRIVATE AND CONFIDENTIAL

Staff Number

Personal Information redacted by the USI

Personal Information redacted by the USI

Dear

Personal Information redacted by the USI

I refer to your Contract of Employment with the Southern Health & Social Care Trust as and wish to confirm the information given to you that due to your unsatisfactory performance, primarily the errors in complaints responses and understanding of complaints, since you took up this post on 01 December 2020, your confirmation of appointment is to be withheld. Your probationary period is therefore extended for a further 3 months, 01 October 2021. During this period, your performance will continue to be monitored and reviewed in accordance with the action plan we discussed.

If the necessary improvements are made, then you will be confirmed in post. If however, there continue to be issues during your extended probationary period, a decision may be taken not to confirm you in post and your employment with the Trust may be terminated. Please note that termination can occur before the end date of the extended probationary period.

If this is the case, I will arrange to meet with you at which you can be accompanied by a trade union representative or work colleague. It is hoped that this action will not be necessary and that you will be able to make the necessary improvements in order to be confirmed in post. I will continue to provide appropriate support and guidance to you during this time. If you have any queries regarding the content of this letter, please do not hesitate to speak to me.

Yours sincerely

Mrs Collette McCaul
Acute Governance Manager

Copy to: Employee Relations

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
Personal information redacted by the UST		SEC		4 North	30/05/2022	15/06/2022	29/06/2022	113	Anthony Glackin	20/06/2022	01/07/2022, 21/07/2022, 30/09/2022	Chrisy	To Be Drafted
		SEC		Vascular Surgery	06/06/2022	20/06/2022	04/07/2022	108	Alastair Lewis, Amie Nelson		15/07/2022, 30/09/2022	Chrisy	Spoke to [Personal Information] on telephone. Emailed him issues as discussed on call. He is to confirm these and then we will send out for investigation. Apologies for delay given. 04/10/2022
		SEC		Orthopaedic Surgery	09/06/2022	23/06/2022	07/07/2022	105	Jane Scott	18/07/2022 14/09/22	15/07/2022, 30/09/2022	Natalie	23/09/2022 Ronan
		SEC		Gen Surgery Clinic	21/06/2022	05/07/2022	20/07/2022	92	Matthew McAlinden, Jane Scott	11/08/2022	21/07/2022, 30/09/2022	Chrisy	Response to be sent to [Personal Information] - Patient wants to know why he was removed from waiting list last year. Sent to Matthew McAlinden/Jane Scott 21/07/2022
		SEC		3 South	01/07/2022	18/07/2022	01/08/2022	80	Laura White, Wendy Clayton, Dr Vlachgeorhos		01/08/2022	Chrisy	21/09/2022 Ronan
		SEC		T&O	05/07/2022	20/07/2022	03/08/2022	78	Louise Currie, Paula McKay, Brigeen Kelly, Grace Hamilton		15/08/2022	Chrisy	27/09/2022 - Ronan and Grace Hamilton
		SEC		Orthopaedics	15/07/2022	29/07/2022	12/08/2022	69	Amie Nelson, Mr McNaboe, Mr Bunn		01/09/2022	Chrisy	Patient wants to know why she waited in Ward for 5 weeks to be assessed by Orthopaedic Consultant.
		SEC		Endoscopy Suite	21/07/2022	04/08/2022	18/08/2022	63	Mr Hashmi, Mr Thompson, Amie Nelson		01/09/2022	Chrisy	Patient suffered a perforated oesphagus during endoscopy. Mr Hashmi needs notes to respond. Issue with obtaining these. 04/10/2022
		SEC		Female Medical	22/07/2022	05/08/2022	19/08/2022	62	Amie Nelson & Sent to Malcolm Sloan / Tracey Kelly re the equipment issues.		01/09/2022	Chrisy	Various consultants involved in patients care. Wife wants to know why they were told last year in DHH that he did not hav cancer. Dr Gamal Ahmed and Manus not required to input. Sent to both of them as per NIECR.
		SEC		HDU	25/07/2022	08/08/2022	22/08/2022	59	Jill Barton, Josie Matthews, Amie Nelson		01/09/2022	Chrisy	Daughter upset that she was not with father when he died in the HDU.
		SEC		3 South	28/07/2022	11/08/2022	25/08/2022	56	Amie Nelson,		01/09/2022	Chrisy	Wendy has advised that patient was under care of Mr Yousaf 29/07/2022
		SEC		Orthopaedics	28/07/2022	11/08/2022	25/08/2022	56	Mr Murray, Dr Rainey, Amie Nelson, Ronan Carroll, Brigeen Kelly			Chrisy	Received from OPPC 28/07/2022. Sent to Dr Rainey & Mr Murray. No response. Sent to Amie Nelson & Ronan Carroll 10/08/2022 & 23/08/2022. No response. Sent to Brigeen Kelly 02/09/2022
		SEC		ENT	29/07/2022	12/08/2022	26/08/2022	55	Wendy Clayton		07/09/2022	Chrisy	03.10.22 - With Director
		SEC		Ortho	05/08/2022	19/08/2022	05/09/2022	45	Mr Bunn, Wendy Clayton, Brigeen Kelly, Amie Nelson, Orla Poland		01/09/2022	Chrisy	Investigation email sent
		SEC		Urology	08/08/2022	22/08/2022	06/09/2022	44	Wendy Clayton			Chrisy	Complaint sent to Wendy 08/08/2022. Complaint first came in 28/01/2021 however could not be investigated as going through Urology Review. Review outcome now received so complaint can be investigated. Patient informed of same. Wendy responded - needs to discuss.
		SEC		4 North	08/08/2022	22/08/2022	06/09/2022	44	Amie Nelson, Adrian Neill, Mr Yousaf, Flo Fegan		01/09/2022	Chrisy	07/10/2022 Trudy Director
		SEC		Urology	09/08/2022	23/08/2022	07/09/2022	43	Wendy Clayton, Mr Tyson		01/09/2022	Chrisy	Ronan requested amendments to draft response - sent to Wendy / Mr Tyson 05/09/2022
		SEC		Urology/Gen Surgery	14/09/2022	25/08/2022	09/09/2022	41	Mark Haynes Mr Hashmi		07/09/2022	Chrisy	Questions for meeting sent to Mr Haynes & Mr Hashmi 14/09/2022. Awaiting suggested dates for meeting. Requested again 04/10/2022
		SEC		Orthopaedics	15/08/2022	30/08/2022	13/09/2022	37	Wendy Clayton, Amie Nelson	12/09/2022	12/09/2022	Chrisy	Investigation email sent
		SEC		Ortho	15/08/2022	31/08/2022	14/09/2022	36	Mr Ronan McKeown, Paula McKay, Brigeen Kelly		14/09/2022	Chrisy	Drafted - sent to Brigeen for review 14/09/2022
		SEC		Ortho	16/08/2022	31/08/2022	14/09/2022	36	Mr Connolly, Mr Murnaghan, Brigeen Kelly		15/09/2022	Chrisy	12.09.22 - Back to Brigeen
		SEC		Urology	24/08/2022	08/09/2022	21/09/2022	29	Wendy Clayton		20/09/20222	Chrisy	Complainant [Personal Information] contacted 09/09/2022 [Personal Information] to send in questions that need addressed at meeting. Sent further email 04/10/2022 requesting questions.
		SEC		Urology	30/08/2022	13/09/2022	27/09/2022	1	Wendy Clayton, Mr Khan		n/a	Chrisy	Complaint from SE Trust. Patient unhappy with care in SE Trust. Was treated by Mr Khan here in CAH. Mr Khan's input required for response.
		SEC	OPPC	3 South	02/09/2022	16/09/2022	30/09/2022	20	Laura White, Wendy Clayton, Paula McKay, Brenda Byrne, Caroline Breen, Brigeen Kelly		28/09/2022	Chrisy	Manager advised on 14/09/2022 that complaint had to be progressed. Sent to OPPC.
		MED/SEC		3 South / 1 South	13/09/2022	27/09/2022	11/10/2022	9	Caroline Breen, Paula McKay, Wendy Clayton, Karen Kelly, Trudy Kelli, Louise Devlin		10/10/2022	Chrisy	Reply from Ann McCorry - no specific response required from Pharmacy

drafting date days for drafting

Personal information redacted by the USt											
SEC		General Surgery Clinic	13/09/2022	27/09/2022	11/10/2022	9	Amie Nelson			Chrisy	MLA enquiry received also. Sent out to staff involved in response 04/10/2022
SEC		3 South	15/09/2022	29/09/2022	13/10/2022	7	Virginia Murphy, Flo Fegan, Dr Todd, Dr Murphy			Chrisy	Investigation email sent
SEC		Trauma Ward	16/09/2022	03/10/2022	17/10/2022	3	Jonathon Bunn, Paula McKay, Brigeen Kelly			Chrisy	Investigation email sent
SEC		4 South	20/09/2022	04/10/2022	18/10/2022	2	Ashlene Kelly, Tracey McGuigan, Amie Nelson, Ann McCorry			Chrisy	Investigation email sent
SEC		General Surgery Clinic	22/09/2022	06/10/2022	20/10/2022	0	Mr Epanomeritakis, Amie Nelson, Adrian Neill			Chrisy	Investigation email sent
SEC		Trauma Ward	23/09/2022	07/10/2022	21/10/2022	-1	Rachel Jameson, Paula McKay, Brigeen Kelly			Chrisy	Investigation email sent
SEC		Orthodontics	26/09/2022	10/10/2022	24/10/2022	-4	Joy Carleton, Amie Nelson			Chrisy	Investigation email sent
SEC		Urology	26/09/2022	10/10/2022	24/10/2022	-4	Wendy Clayton			Chrisy	28/09/2022 Trudy
SEC		General Surgery	26/09/2022	11/10/2022	25/10/2022	-5	Jane Scott & Matthew McAllinden			Chrisy	Investigation email sent
SEC		Urology	26/09/2022	10/10/2022	24/10/2022	-4	Wendy Clayton & Matthew Tyson			Chrisy	Investigation email sent
SEC		Pre-op	29/09/2022	13/10/2022	27/10/2022	-7	Rachel Donnelly, Emmajane Kearny & Helena Murray			Chrisy	Investigation email sent
SEC		SEC	03/10/2022	17/10/2022	31/10/2022	-11	Jane Scott			Natalie	Investigation email sent

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
Personal information redacted by the USI		IMWH		Delivery Suite	18/05/2022	01/06/2022	17/06/2022	125	Mary Dawson, Wendy Clarke	09/06/2022 30/06/2022 18/07/22	17/06/2022, 21/07/2022	Natalie	Director 10/08/22 Resent 26/08/2022. Resent 22/09/22. Resent 28/09/22 07/10/22 Trudy Reid has requested for "round the table" discussion with response. Caroline/Chris to reword this.
		IMVH		MAU	20/07/2022	03/08/2022	17/08/2022	64	Wendy Clarke, Josie Rushe	10/08/2022 06/09/2022	01/09/2022	Natalie	23.09.22 Caroline to approve
		IMWH		Assesement	02/08/2022	16/08/2022	31/08/2022	50		14/09/2022	01/09/2022	Natalie	05.10.22 - With Director - 10.10.22 Resent
		IMWH	DHH ED	Gynae	24/08/2022	08/09/2022	21/09/2022	29	Gareth Hampton, Paul Smyth	12.09.22 06/10/22	20/09/2022	Natalie	07/10/22 - to be drafted
		IMWH		Maternity	01/09/2022	15/09/2022	29/09/2022	21	Mary Dawson, Wendy Clarke		n/a	Natalie	27.09.22 - Caroline Keown to approve
		IMWH		Obstetrics	12/09/2022	26/09/2022	10/10/2022	10	Mary Dawson, Jenna Magee, Wendy Clarke	22/09/2022 06/10/22	10/10/2022	Natalie	21.09.22 - Response received from Dr Knox - awaiting Nursing input escalated 22.09.22
		IMWH		Delivery Suite/Recovery Suite	27/09/2022	11/10/2022	25/10/2022	-5	Mary Dawson, Wendy Clarke, Caroline Keown			Natalie	Investigation email sent

drafting date days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
Personal Information redacted by the USI		CCS		Physiotherapy/ ED	21/07/2022	04/08/2022	18/08/2022	63	Charlotte Anne Wells, Rachel Greer, Paul Smyth, Gareth Hampton	06/10/2022	01/09/2022	Natalie	Investigation email sent OPPC respinse received
		CCS		Radiology	22/07/2022	05/08/2022	19/08/2022	62	adamb01@hotmail.com			Natalie	05.09.22 - With Director
		CCS		Wigs	15/08/2022	30/08/2022	13/09/2022	37	Clair Quin, Fiona Reddick	12/09/2022	12/09/2022	Natalie	06.10.22 Director
		CCS		Radiology	16/08/2022	31/08/2022	14/09/2022	36	Denise Newell. Dr A McClelland, Kay Carroll		12/09/2022	Natalie	Director 23/08/22, Director left original chart with Charlotte-Anne 05/10/22 - Amended draft response sent to director on duplicate chart
		CCS		AHP	24/08/2022	08/09/2022	21/09/2022	29	Caroline Breen	21/09/2022 06/10/22	20/09/2022	Natalie	Ongoing issue re whether this is OPPC or not. Catherine Sheeran / Celene Kirrane say no, Flo Fegan / Caroline Breen say yes. Currently with Caroline Breen for response 01/09/2022
		CCS		Orhtoptics	07/09/2022	21/09/2022	05/10/2022	15	Declan McClements		10/10/2022	Natalie	22.09.22 - Barry to approve
		CCS		Mortuary	26/09/2022	10/10/2022	24/10/2022	-4	Rachel McCracken, Geoff Kennedy			Natalie	Trudi Kelly emailed 26/09/2022 - this issue lies with the Mortuary not Ward. For screening at next CCS screening meeting per Carly 10/10/2022
		CCS		Haematology	29/09/2022	13/10/2022	27/10/2022	-7	Mark Bridgham, Clair Quin			Natalie	Investigation email sent
		CCS		Radiology	03/10/2022	17/10/2022	31/10/2022	-11	Denise Newell			Natalie	Response from radionolgy received - needs to go to ED for nursing input 10/10/2022

drafting date days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD														
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments	
Personal Information redacted by the USI		MED		Ramone	28/04/2022	12/05/2022	26/05/2022	147	Trudi Kelly, Patricia Loughan			Chrisy	With director for signing 06/10/2022 Sent again 07/10/2022	
		MED	ED/FSS	Stroke/rehab/1 North/ED CAH/ED DHH	16/05/2022	30/05/2022	16/06/2022	126	Audrey Wilson-Reid, Ursula Haughey, Patricia Loughan,	09/06/2022/ 17/06/2022 26.07.22	17/06/2022, 21/07/2022	Natalie	18/08/22 Charlotte - To be redrafted 05/10/2022	
		MED		ED CAH/1 North	09/06/2022	23/06/2022	07/07/2022	105	Sinead Corr, Joanne McEvoy, Trudi Kelly		15/07/2022	Natalie	03/08/22 Charlotte - To be redrafted 05/10/2022	
		MED		2 North	17/06/2022	01/07/2022	19/07/2022	93	Victoria Burnett, Audrey Wilson Reid, Kay Carroll, Kerry Gordon,	02/09/2022	21/07/2022, 30/09/2022	Chrisy	04/10/2022 Charlotte	
		MED		Ward 1 Ramone	24/06/2022	08/07/2022	25/07/2022	87	Audrey Wilson-Reid, Louise Devlin		27/07/2022	Chrisy	Sent to Audrey and Louise 22/07/2022	
		MED		3 South / Medical Doctor	04/07/2022	19/07/2022	02/08/2022	79	Dr P Murphy	04/08/2022 01/09/2022 07/09/2022	01/08/2022	Chrisy	29/09/22 Currently drafting - need response from AMU Dr Ahmad. Complainant updated by phone 29/09/2022	
		MED		1 North	08/07/2022	25/07/2022	08/08/2022	73	Ruth Weir, Audrey Wilson-Reid, Kay Carroll, Daniel Flannery, Artur Mlodzianowski, Philip Murphy		15/08/2022	Chrisy	26/09/22 Response drafted - however issues need clarification from Sister. Dr Flannery also needs to provide a response. Email sent to Kay Carroll 27/09/22	
		MED	ED	Male Medical	11/07/2022	26/07/2022	09/08/2022	72	Gareth Hampton, Philip Murphy	10/08/2022	10/10/2022	Chrisy	To Be Drafted	
		MED		Female Medical	11/07/2022	26/07/2022	09/08/2022	72	Pauline McParland, Abby McConnell, Kay Carroll		01/09/2022	Chrisy	Investigation email sent	
		MED		Ramone ward 1	19/07/2022	02/08/2022	16/08/2022	65	Trudi Kelly,Patricia Loughan		07/09/2022	Chrisy	Investigation email sent	
		MED		3 North	27/07/2022	10/08/2022	24/08/2022	57	Norma Parker, Trudi Kelly, Patricia Loughan, Lorna Cherry		01/09/2022	Chrisy	Investigation email sent	
		MED	ED	Ward 1 Ramone	01/08/2022	15/08/2022	30/08/2022	51	Lisa Frazer, Rachel Greer, Paul Smyth, Audrey Wilson Reid, Louise Devlin	06/09/2022	01/09/2022	Chrisy	Investigation email sent 06.09.22 - Reminder sent	
		MED		Level 4 Stroke	05/08/2022	19/08/2022	05/09/2022	45	Patricia Loughan, Ursula Haughey, Lynn easley, Caroline McQuiggan	14/09/2022	01/09/2022	Chrisy	Investigation email sent	
		MED	HSW	2 South Stroke	05/08/2022	19/08/2022	05/09/2022	45	Elizabeth Henderson, Trudi Kelly. Patricia Loughan, Flo Fegan Dr Gormley		12/09/2022	Chrisy	Response received from Dr McCormick 22/09/2022	
		MED		1 North	08/08/2022	22/08/2022	06/09/2022	44	Ruth Weir , Audrey Wilson-Reid, Kay Carrol		01/09/2022	Chrisy	Kay reviewing response from Maria Fegan 01/09/2022	
		MED		2SS	15/08/2022	30/08/2022	13/09/2022	37	Elizabeth Henderson, Trudi Kelly. Patricia Loughan		12/09/2022	Chrisy	29/09/22 Cathrine	
		MED		3 North	16/08/2022	31/08/2022	14/09/2022	36	Norma Parker, Trudi Kelly, Patricia Loughan		12/09/2022	Chrisy	28/09/2022 Charlotte	
		MED		Diabetic	16/08/2022	31/08/2022	14/09/2022	36	Dr Mae McConnell, Kay Carroll, Louise Devlin		12/09/2022	Chrisy	18/08/2022 Charlotte	
		MED		1 South	17/08/2022	01/09/2022	15/09/2022	35	Mr A Murdock, Trudi Kelly, Louise Devlin		12/09/2022	Chrisy	14/09/2022 Charlotte	
		MED		Gastro	19/08/2022	05/09/2022	16/09/2022	34	Dr Gafer, Dr P Murphy		14/09/2022	Chrisy	23/08/2022 Charlotte	
		MED		Level 4 Stroke	24/08/2022	08/09/2022	21/09/2022	29	Ursula Haughey, Patricia Loughan		20/09/2022	Chrisy	Investigation email sent	
		MED		DCC STH	24/08/2022	12/09/2022	26/09/2022	24	Dr Hillemand, Louise Devlin		23/09/2022	Chrisy	21/09/2022 Charlotte	
		MED		FMW	26/08/2022	13/09/2022	27/09/2022	1	Pauline McParland, Abby McConnell, Kay Carroll		27/09/2022	Chrisy	Lost Property Complaint - Investigation email sent	
		MED		1 South	30/08/2022	13/09/2022	27/09/2022	1	Louise Devlin, Charlotte-Anne Wells		27/09/2022	Chrisy	2 complaints received within days. Patient admitted at time. Consent form sent to Ward. Consent obtained. Complaint on hold - Medical Director seeking legal advise, as per Louise Devlin 31/08/2022. Holding letters to be issued.	
		MED		1 South	30/08/2022	13/09/2022	27/09/2022	1	Karen Kelly, Trudi Kelly, Louise Devlin		27/09/2022	Chrisy	30.09.22 - Charlotte-Anne to approve	

drafting date days for drafting

Personal Information redacted by the USI	MED		Male Medical	31/08/2022	14/09/2022	28/09/2022	22	abby McConnell, patricia McGrath Kay Carroll		27/09/2022	Chrisy	Out for investigation
	MED		ED	05/09/2022	21/09/2022	05/10/2022	15	Dr Hillemand			Chrissy	NIAS advised they will respond directly to patient. ED advised patient under care of medical team during time in ED. Dr Hillemand getting notes to provide response 09/09/2022 ed response from Laura Ohare received await medical response
	MED		Neurology	07/09/2022	22/09/2022	06/10/2022	14	Dr Forbes, Liz Carragher, Trudi Kelly, Louise Devlin		10/10/2022	Chrisy	Dr Forbes provided response 08/09/2022. Requiring information re policy on virtual visitng from Louise Devlin.
	MED/SEC		3 South / 1 South	13/09/2022	27/09/2022	11/10/2022	9	Caroline Breen, Paula McKay, Wendy Clayton, Karen Kelly, Trudy Kelli, Louise Devlin		10/10/2022	Chrisy	Reply from Ann McCorry - no specific response required from Pharmacy
	MED		HSW	21/09/2022	05/10/2022	19/10/2022	1	Flo Fegan & Virginia Murphy			Chrisy	Concern 6 to be approved. Concern 8 to be responded to. Resent 05/10/2022
	MED		Male Surgical	23/09/2022	07/10/2022	21/10/2022	-1	Judith Mitchell, Abby McConnell, Kay Carroll			Chrisy	Investigation email sent
	MED		Cardiology	26/09/2022	10/10/2022	24/10/2022	-4	Diane Lilburn, Jude Tweedie, Kay Carroll			Chrisy	Investigation email sent
	MED	CCS	1 South	26/09/2022	11/10/2022	25/10/2022	-5	Karen Kelly, Trudi Kelly, Louise Devlin & Julia Baltacioglu			Chrisy	Investigation email sent 05.10.22 - Radiology Response received
	MED		Cardiology	28/09/2022	12/10/2022	26/10/2022	-6	Dr Mick Connolly, Kay Carroll			Chrisy	Investigation email sent
	MED		Stroke/Rehab	29/09/2022	13/10/2022	27/10/2022	-7	Ursula Haughey, Patricia Loughan			Chrisy	Investigation email sent
	MED		3 North	29/09/2022	13/10/2022	27/10/2022	-7	Charlotte-Anne Wells/Chris Wamsley			Chrisy	To be drafted
	MED		Male Medical	05/10/2022	19/10/2022	02/11/2022	-13	Patricia McGrath, Abbey McConnell, Grace Hamilton			Chrisy	Investigation email sent
	MED		Neurology	05/10/2022	19/10/2022	02/11/2022	-13	Karen McKnight, Louise Devlin, Philip Murphy			chrisy	Investigation email sent
	MED		Rheumatology OPD	07/10/2022	21/10/2022	04/11/2022	-15	Stephanie Walker, Louise Devlin, Philip Murphy			Chrisy	Investigation email sent

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD

Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrissy	Comments
Personal information redacted by the USI		ED		CAH DHH	21/06/2022	05/07/2022	20/07/2022	92	Dr Beg, Rachel Greer, Sharon Holmes	18/07/2022 18/08/22 06/09/22 06/10/22	21/07/2022, 30/09/2022	Natalie	18.08.22 ED responses received - need input from Dr Beg
		ED		ED	21/06/2022	05/07/2022	20/07/2022	92	Paul Smyth, Julie Rankin, Julie Martin	18/07/2022 14/09/22	21/07/2022, 30/09/2022	Natalie	Investigation email sent - Escalation 18/07/22
		ED		ED DHH	22/06/2022	06/07/2022	21/07/2022	91	Clare Digney, Josie Matthews, Amie Nelson, Gareth Hampton, Pauline Fearon, Paul Smyth	18/07/2022	21/07/2022	Natalie	13.09.22 - With litigation A/W Coroners report and SAI
		ED		ED DHH	06/07/2022	21/07/2022	04/08/2022	77	Paul Smyth, Gareth Hampton, Pauline Fearon	14/09/2022 06/10/22	15/08/2022	Natalie	Investigation email sent
		ED		ED DHH	06/07/2022	21/07/2022	04/08/2022	77	Paul Smyth, Gareth Hampton, Rachel Greer	14/09/2022 06/10/22	15/08/2022	Natalie	Investigation email sent
		ED		ED DHH	19/07/2022	02/08/2022	16/08/2022	65	Gareth Hampton, Paul Smyth, Rachel Greer	06/10/2022	01/09/2022	Natalie	07/10/22 To be drafted
		ED	CCS	ED DHH	25/07/2022	08/08/2022	22/08/2022	59	Ruth Spedding, Gareth Hampton, Paul Smyth,	14/09/2022 21/09/2022	01/09/2022	Natalie	07.10.22 To be drafted
		ED		ED DHH/FMW/Stroke-Rehab	25/07/2022	08/08/2022	22/08/2022	59	Ursula Haughey, Patricia Loughan, OPPC	27/09/2022 05/10/22	07/09/2022	Natalie	07/10/22 - to be drafted

Acute SMT Report on Patient Experience and Adverse Incidents

Introduction

The attached report looks at complaints, compliments and adverse incidents for the month of May 2021 in Acute Services.

Key Messages

Complaints

- There were 36 formal complaints received in May 2021.
- The 2 day acknowledgement target has been met at 100% for May complaints. The Regional target of the 20 day response time has been 48% in April 2021. Some of the complaints are very overdue and would need further escalation for responses. Reminders have been sent from Governance Office and ongoing meetings are happening to try and facilitate a more timely response time. The target the Governance Department would ultimately like to achieve is over 70% as this was where we were pre covid. Work is ongoing to try and get this target but help is required from all departments to achieve this namely with more timely responses so that the final response can be signed off timelier.
- The top subjects of complaint in May 2021 were Quality of Treatment and Care with 27 complaints and 21 complaints were due to lack of communication.
- Year to date the top subject of complaint is Quality of Treatment and Care with 165 formal complaints to date with Staff Attitude sitting at 134.
- Currently we have 4 new reopened complaints for May 2021. There has been an upturn in reopened complaints due to further issues more than incomplete first responses. However out of 362 formal complaints year to date only 47 have required a further response which works out at 12% of the complaints reopened and 88% resolved. The target for going forward would be reducing this to below 10% in the first instance.

Compliments

There were 21 compliments overall recorded for the month May 2021 across the Directorate.

Please make sure that the Ward Managers/ Staff log any compliments they received either passed on via email or letter through the compliments portal on the intranet. It is the responsibility of the Ward/Areas to log their own compliments.

Incidents

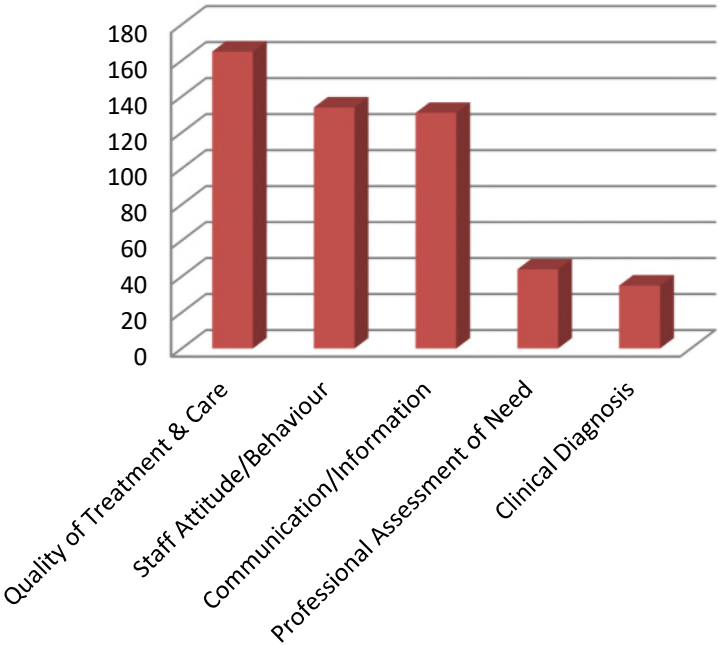
- There were 689 incidents recorded in May 2021 compared to May last year where 514 were recorded.
- Patient Behaviour including violence and aggression has now become the top incident for 2020/2021 year with is the top incident for the period April 2020 to May 2021 contributing to 1737 incidents recorded. Patient falls contributed to 1493 of the incidents for the current year and it has been advised that the Falls form be filled out for each area in relation to major and catastrophic falls which was sent out by the Corporate Team to the ADs to disseminate.

PATIENT EXPERIENCE (Complaints and Compliments)

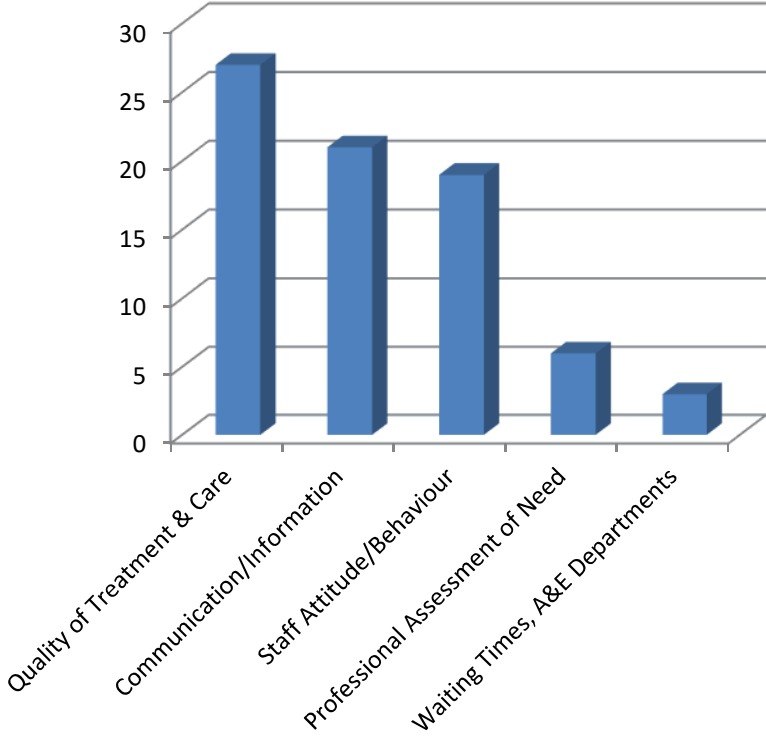
Complaint Statistics

	Formal Complaints	Informal Complaints	MLA Enquiries	Re-Opened Complaints	Awaiting Consent	Ombudsman*
May-20	8	5	12	1	2	3
Jun-20	20	6	9	2	5	0
Jul-20	34	2	29	1	7	0
Aug-20	35	3	27	1	3	1
Sep-20	26	3	34	7	6	0
Oct-20	30	2	15	6	4	2
Nov-20	34	3	30	6	0	0
Dec-20	25	4	25	6	1	0
Jan-21	30	4	32	3	1	1
Feb-21	20	4	22	4	3	1
Mar-21	35	2	15	3	2	0
Apr-21	29	7	18	3	3	1
May-21	36	8	15	4	1	0
Total	362	53	283	47	38	9

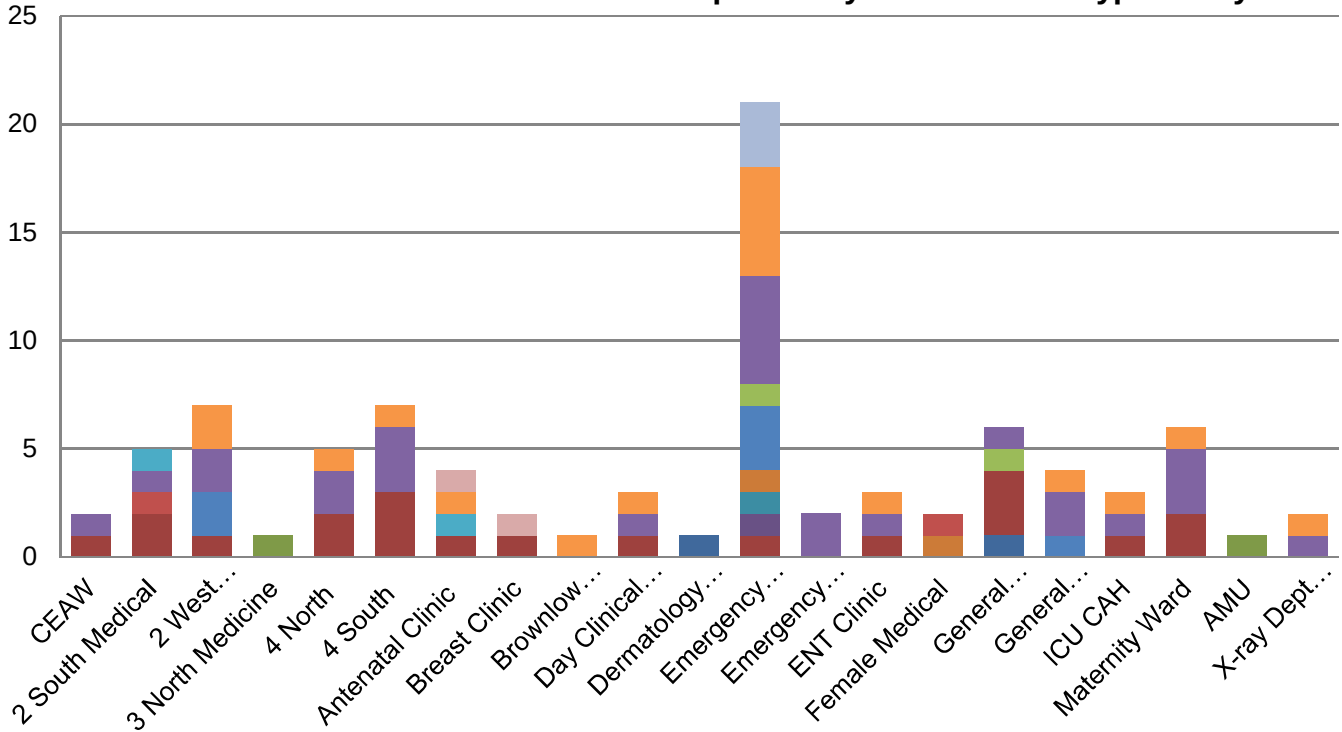
Top 5 Subjects of Complaints Total
Year to Date (April 2020-
May 2021)



Top 5 Complaints from May-2021



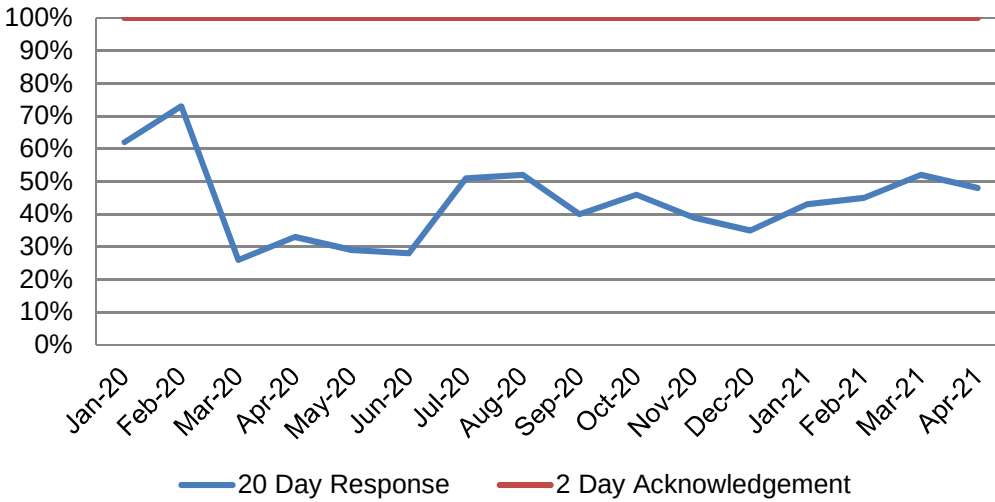
Formal Complaints by Location and Type - May 2021



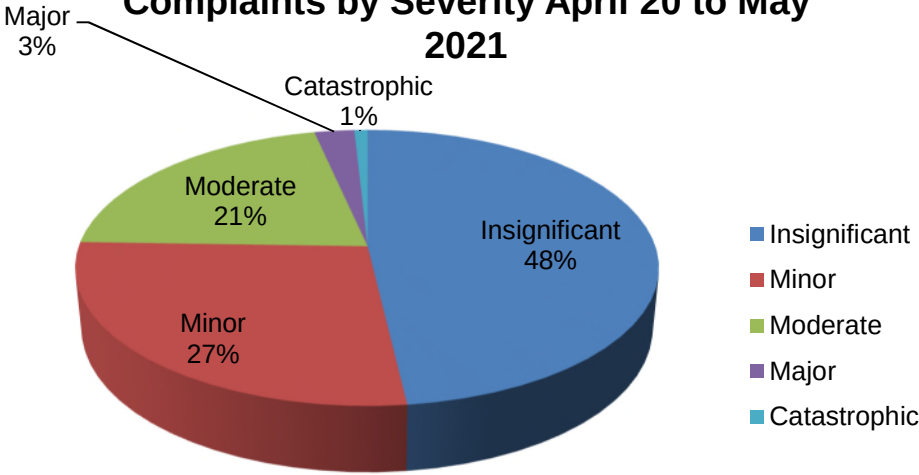
Complaints by Division and Date
Received
May 20 to May 21

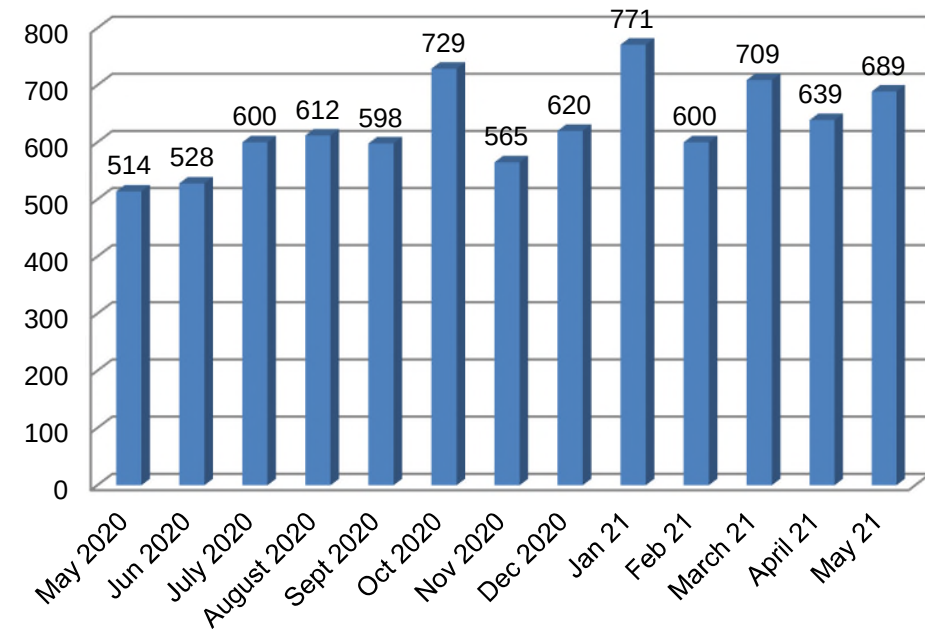
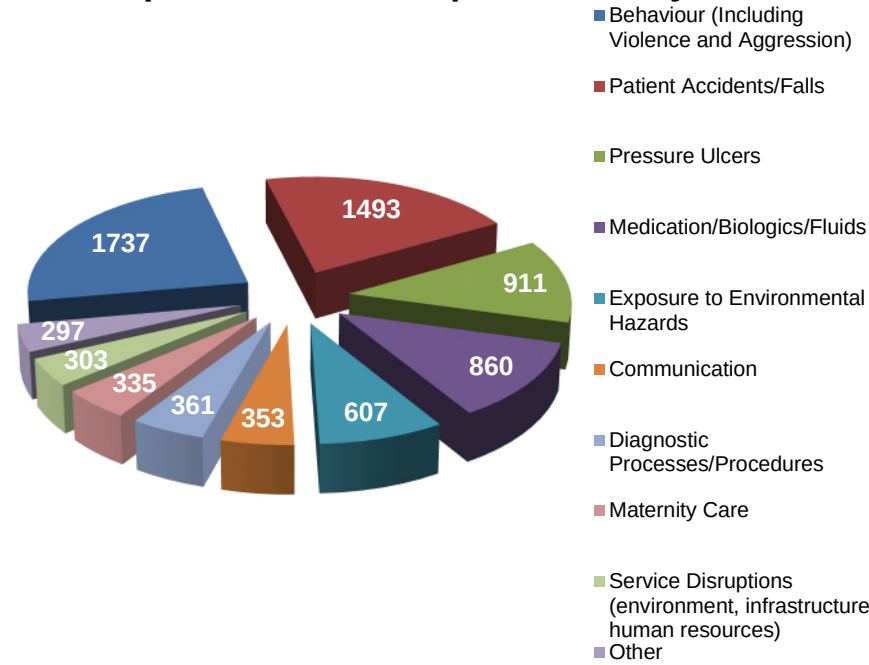
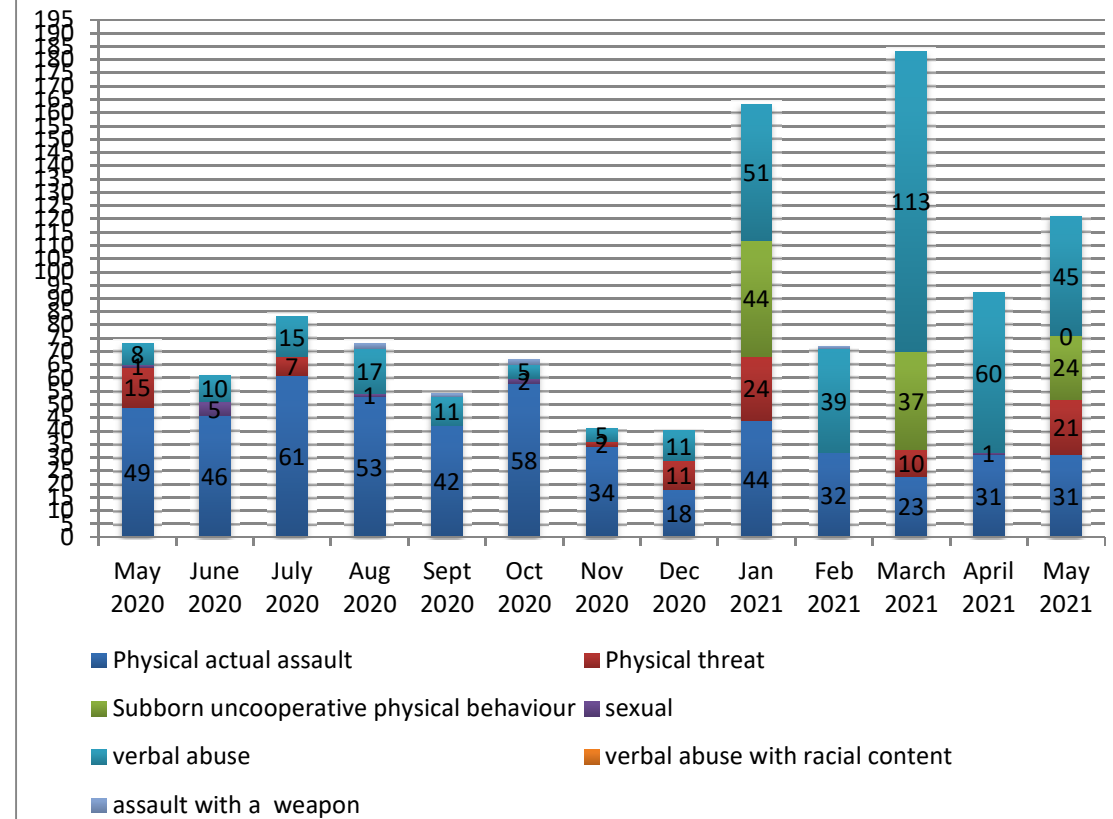
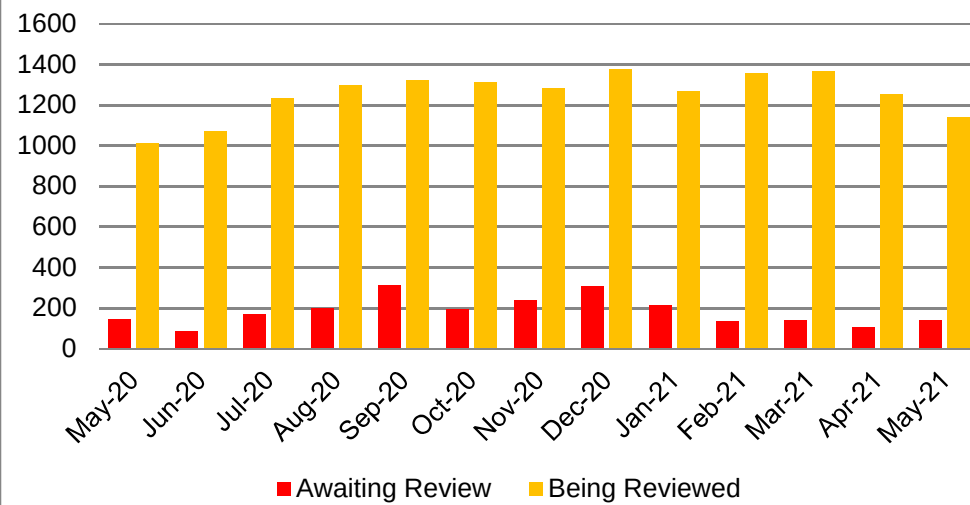
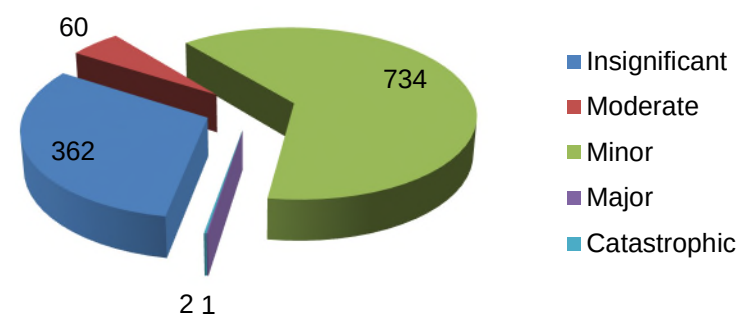
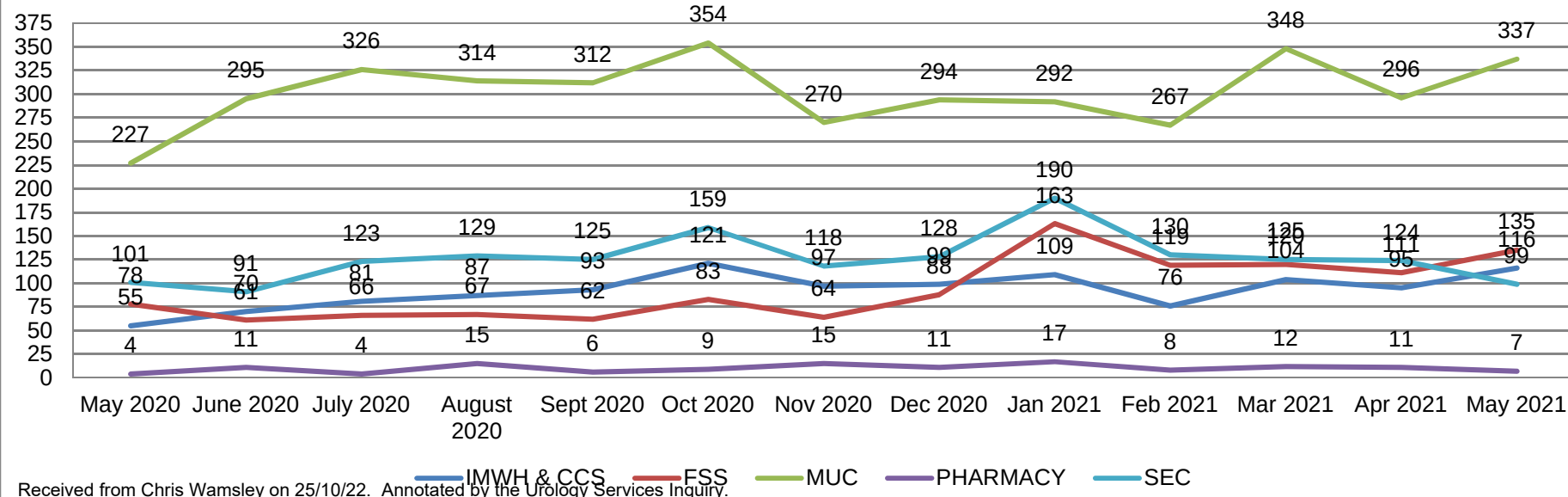
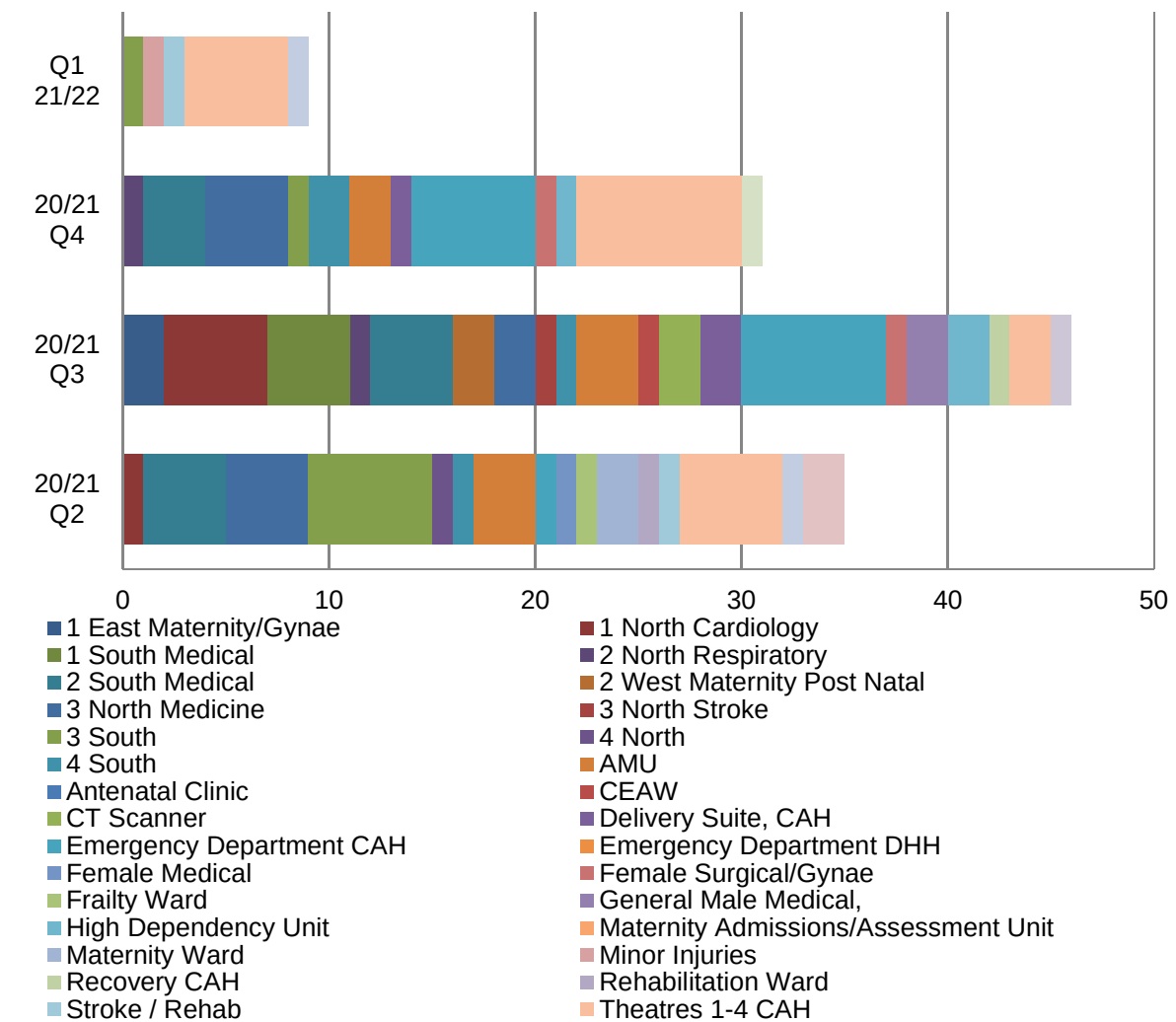
	May 20	Jun 20	July 20	Aug 20	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Total
IMWH / CCS	0	10	7	7	5	8	13	14	6	17	13	15	23	138
FSS	1	0	1	1	6	0	2	1	1	0	5	2	0	20
MUC	3	11	10	19	23	34	22	44	37	15	56	31	50	355
PHARMACY	0	0	0	0	0	0	0	0	1	0	0	0	0	1
SEC	2	1	5	6	8	8	11	0	14	5	9	18	21	108

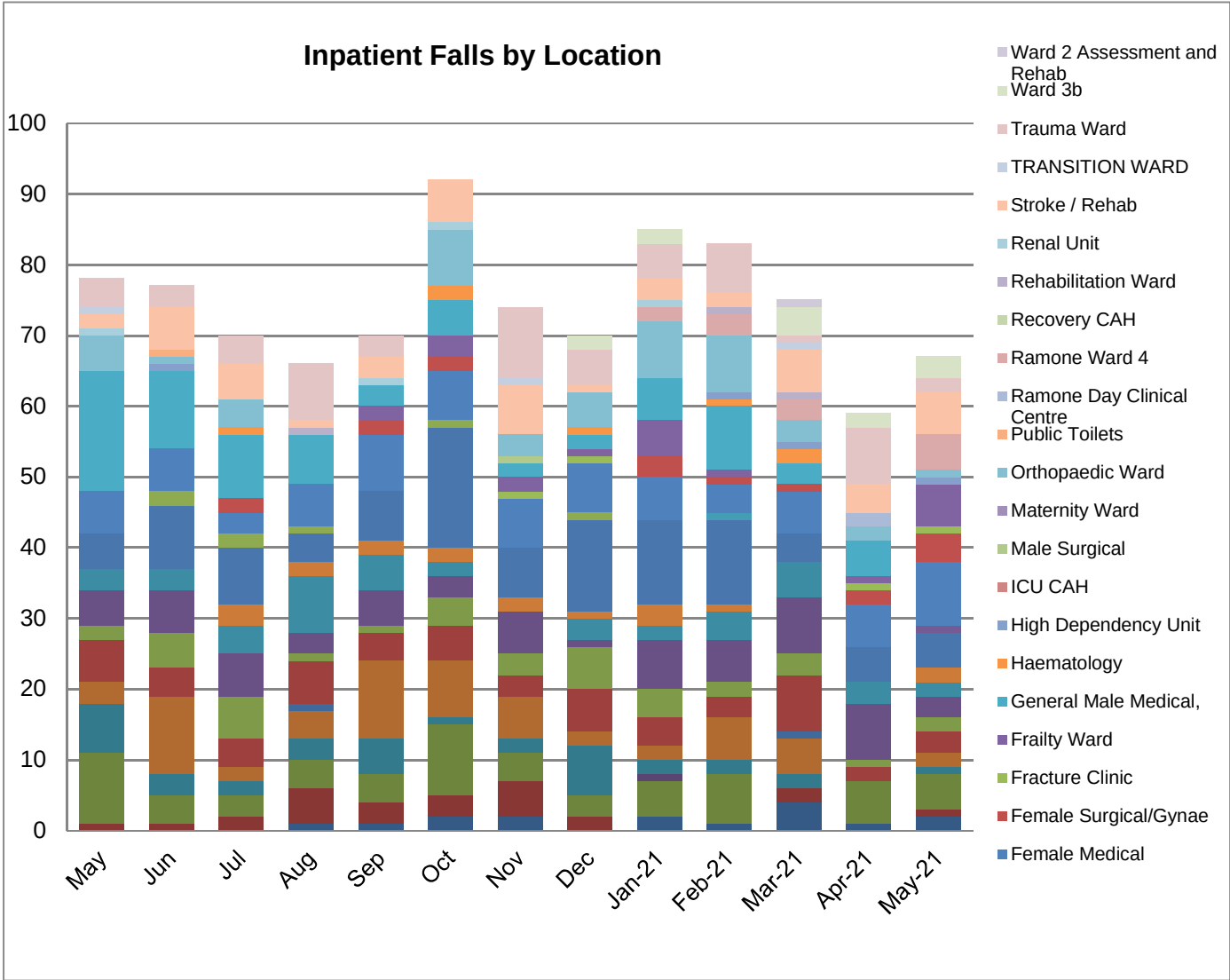
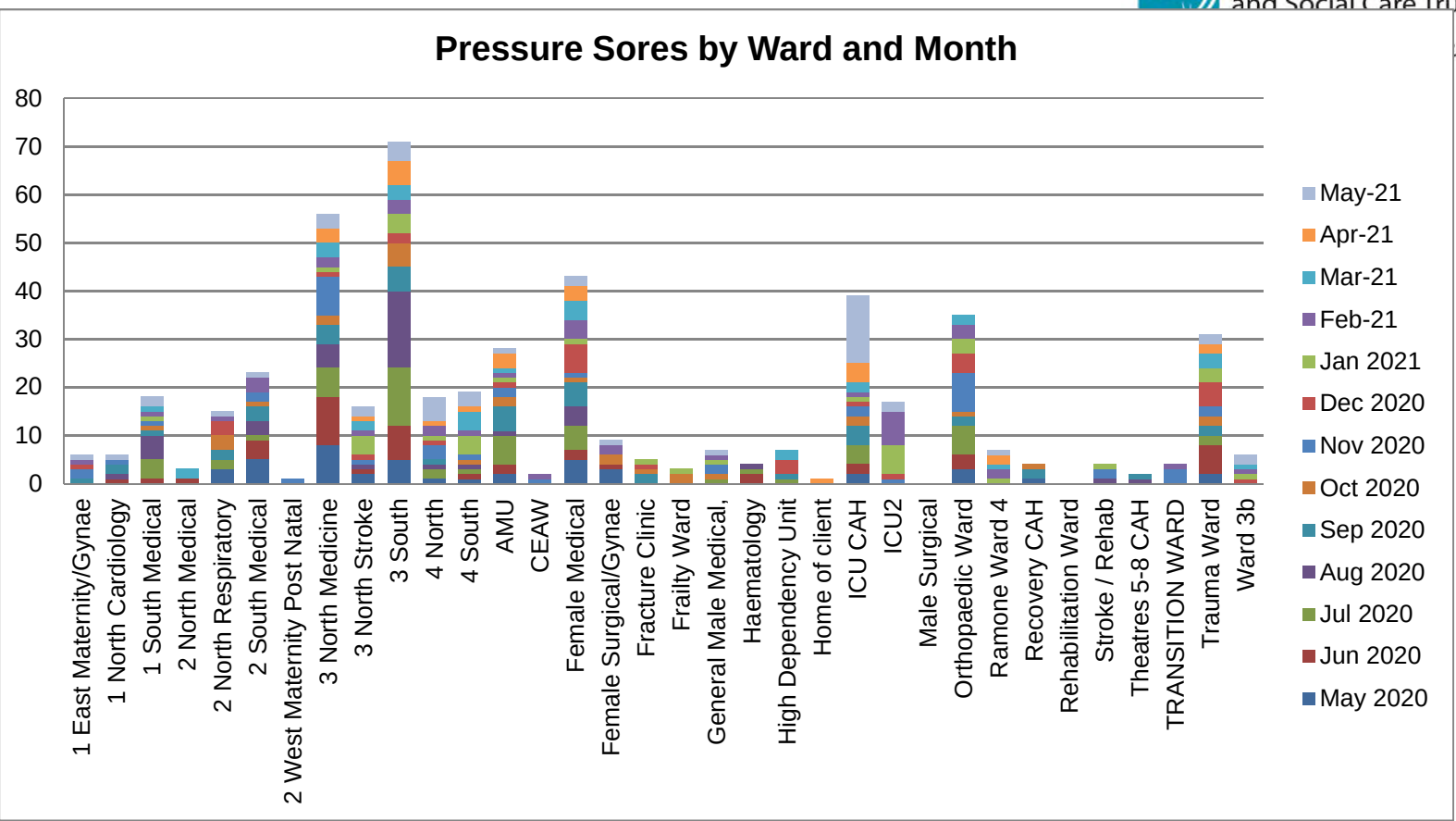
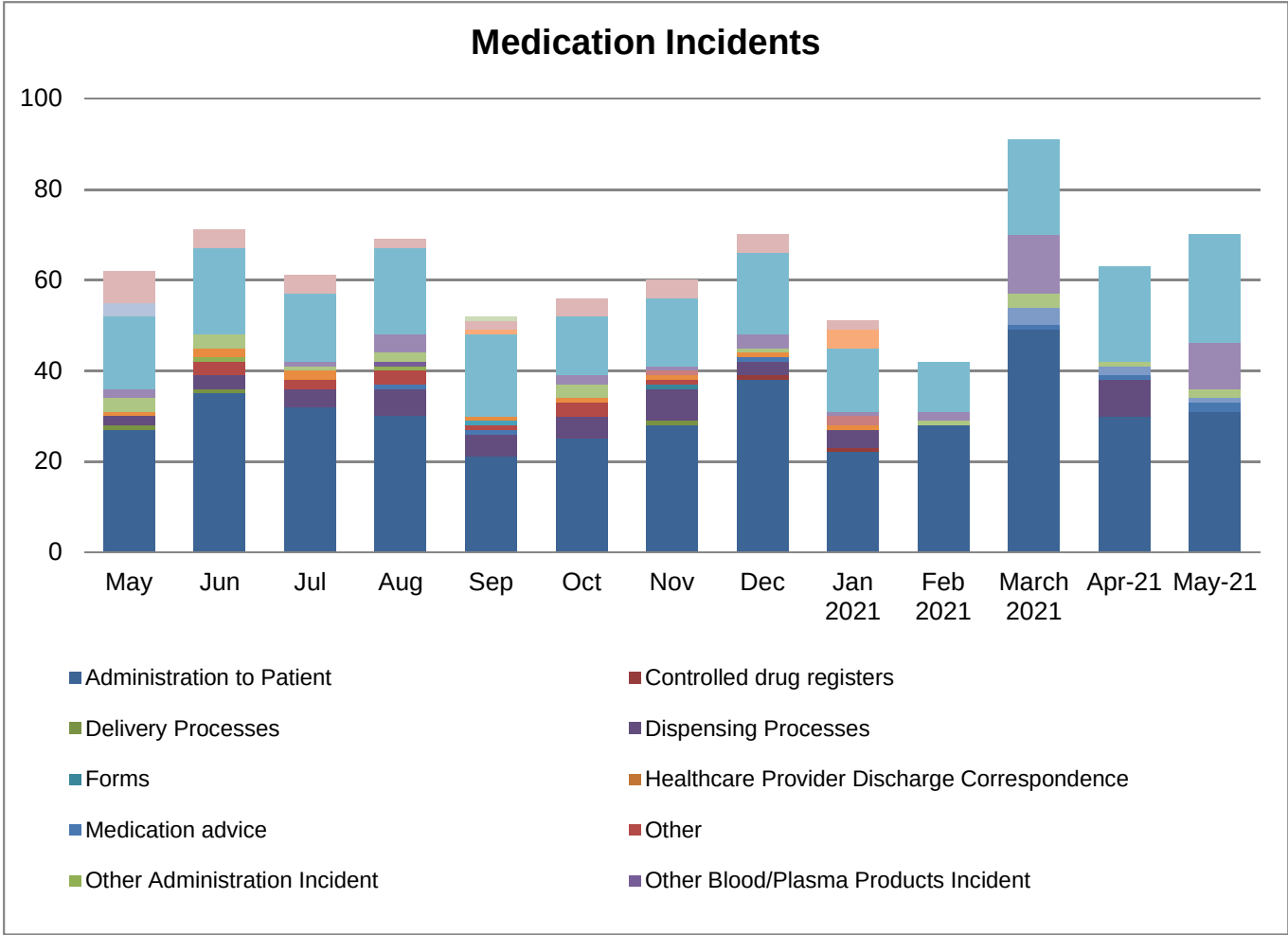
Complaint Response Times



Complaints by Severity April 20 to May 2021



ADVERSE INCIDENTS**Adverse Incidents****Top 10 Incidents - April 20 to May 2021****Violence and Aggression Incidents by Month and Type - Acute Services****Stages of Investigation****Severity of Falls May 20- May 2021****Adverse Incidents by Division****Staffing Incidents by Quarter and Location**



Abscinding Patients

	Sep 20	Oct 20	Nov 20	Dec-20	Jan 21	Feb 21	Mar 21	Apr-21	May 21	Total
1 East Maternity/Gynae	1	0	0	0	0	0	0	0	0	1
1 North Cardiology	0	0	0	0	0	0	0	0	0	0
1 South Medical	0	0	0	0	0	0	0	2	1	3
2 South Medical	0	0	0	0	0	0	0	0	0	0
2 West Maternity Post Natal	0	1	0	0	0	0	0	0	1	2
3 South	0	0	0	1	0	0	0	0	0	1
4 North	0	0	1	0	1	1	0	0	0	3
4 South	0	0	0	1	0	0	0	0	1	2
AMU	0	0	0	0	6	2	7	3	7	25
Car Park/Grounds	0	0	0	0	0	1	0	0	0	1
Coronary Care	0	0	0	0	0	0	2	3	1	6
Direct Assessment Unit	0	0	0	0	0	1	0	0	0	1
Emergency Department CAH	9	15	11	11	17	19	27	26	20	155
Emergency Department DHH	6	3	5	10	15	11	13	4	10	77
Entrance/Exit	0	0	0	0	0	0	1	0	1	2
Female Medical	0	0	1	2	0	0	2	2	2	9
Female Surgical/Gynae	0	0	0	0	1	0	0	0	0	1
Frailty Ward	0	0	0	0	2	0	0	0	0	2
General Male Medical,	1	4	0	0	2	0	1	0	9	17
High Dependency Unit	0	0	0	0	0	0	0	1	0	1
Maternity Assessment Unit	0	0	0	0	0	0	0	1	0	1
Reception/Waiting Area	0	0	0	0	1	0	0	0	0	1
Rosebrook	0	0	0	0	1	0	0	0	0	1
Stroke / Rehab	1	0	1	0	0	1	2	0	0	5
Theatres DHH	0	0	0	0	0	0	0	0	0	0
TRANSITION WARD	0	1	0	0	0	0	0	0	0	1
Total	20	25	19	25	46	36	55	42	53	321

Acute Complaints Report

May 2022

New Complaints



44

New Informals



5

Reopened



16

MLA Enquiries



37

Ombudsman



0

Acute Complaints

Acute Overview



Complaints Closed

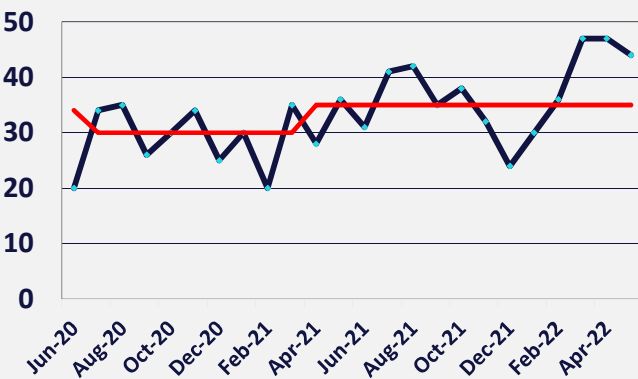
68



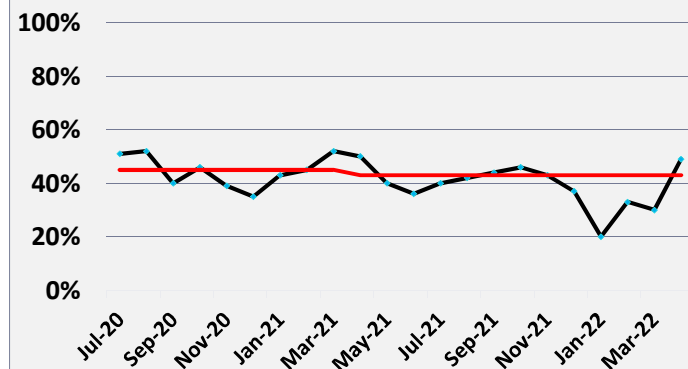
Response Time

49%

Formal Complaints



20 Day Response Time (%)



May 2022



Quality of Treatment

26%

Staff Attitude

33%

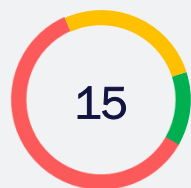
Communication

36%

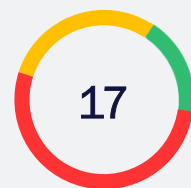
Division



SEC/ATTIC



Medicine



USC



IWMH



CCS



FSS

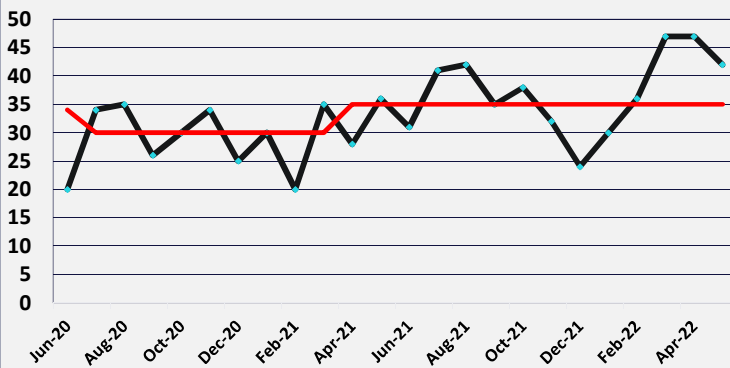
Past 12 Months



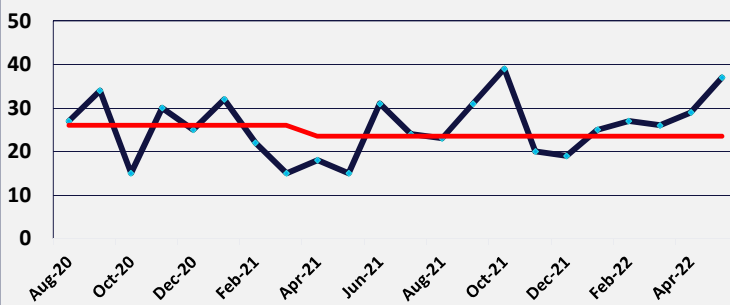
Quality of Treatment
Staff Attitude
Communication

Acute Complaints

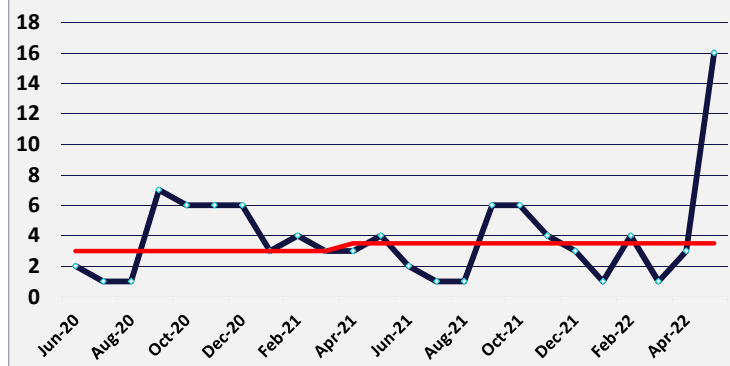
Formal Complaints



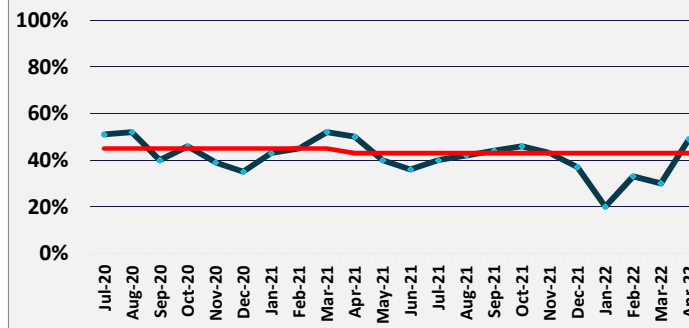
MLA



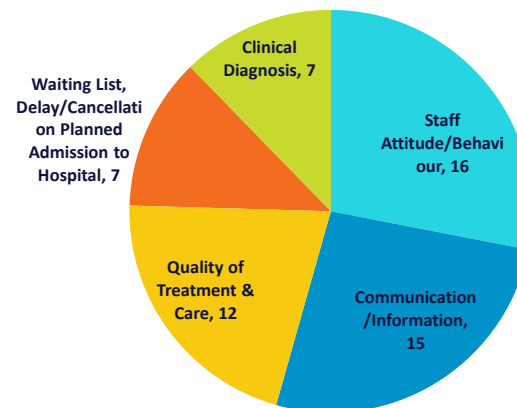
Reopened Complaints



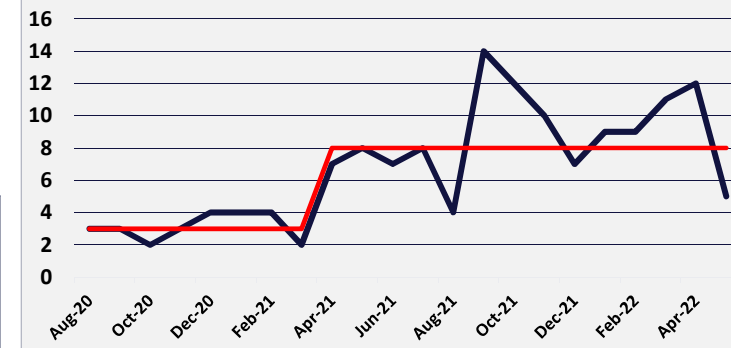
20 Day Response Time (%)



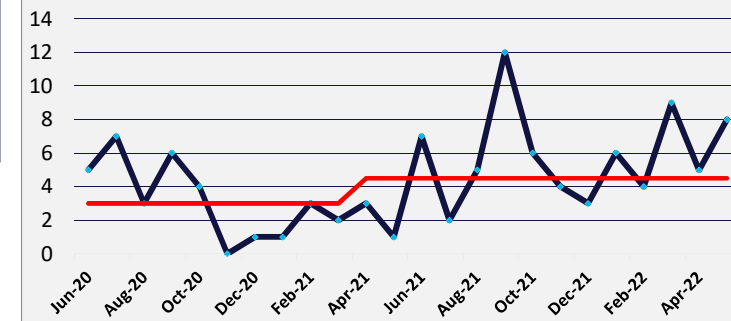
Top 5 Complaints for May 2022



Informal Complaints

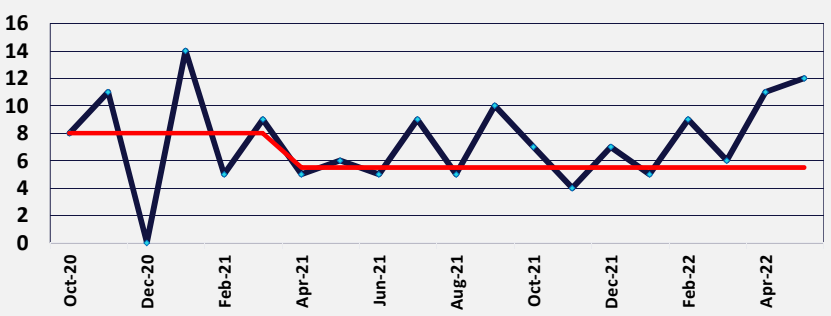


Awaiting Consent

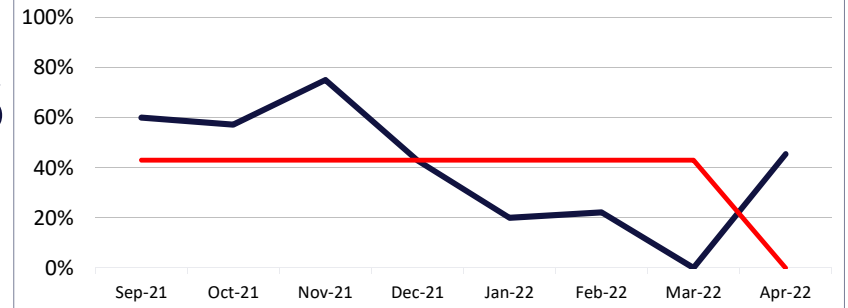


SEC/ATICS

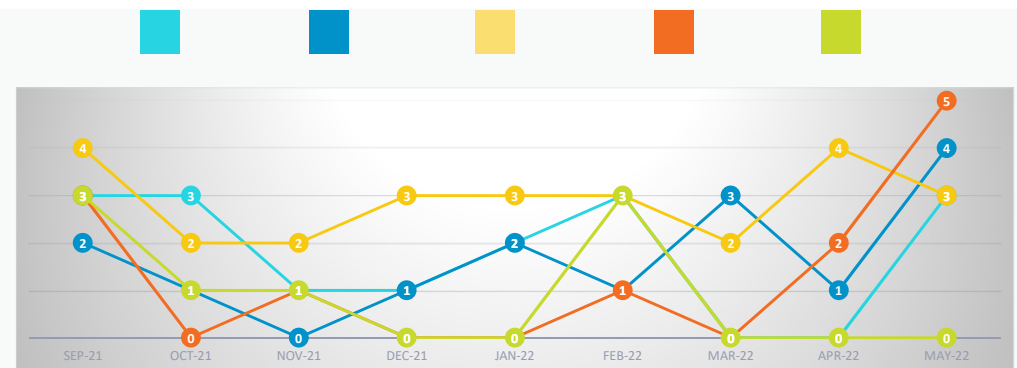
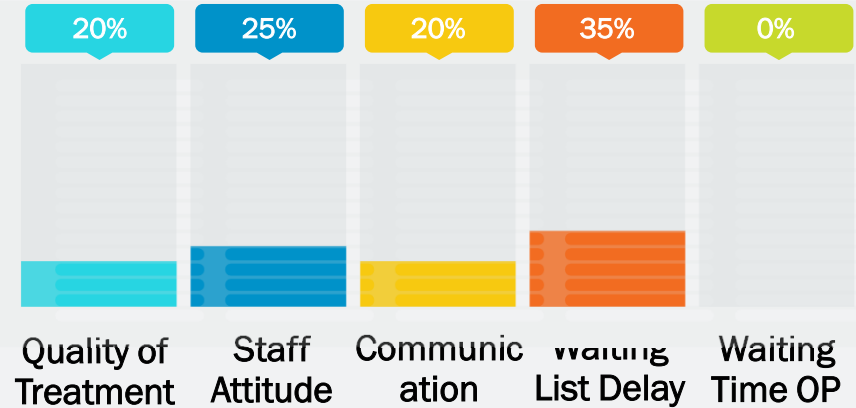
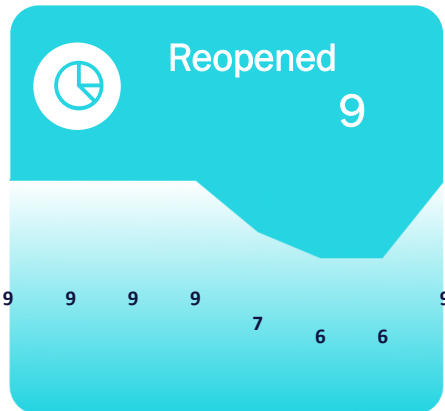
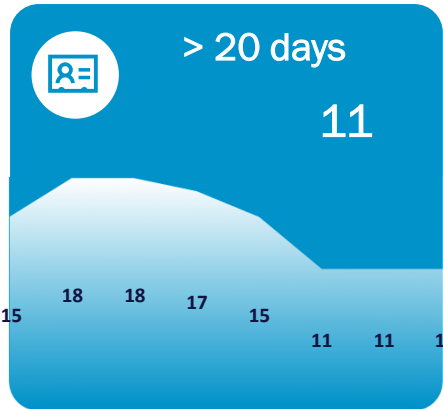
SEC/ATICS - Formal Complaints



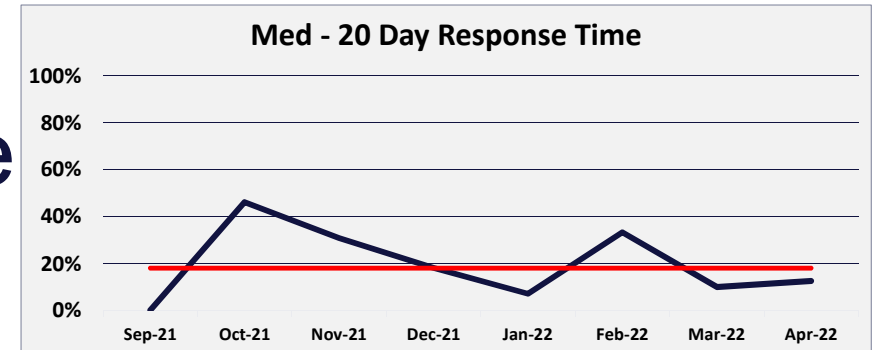
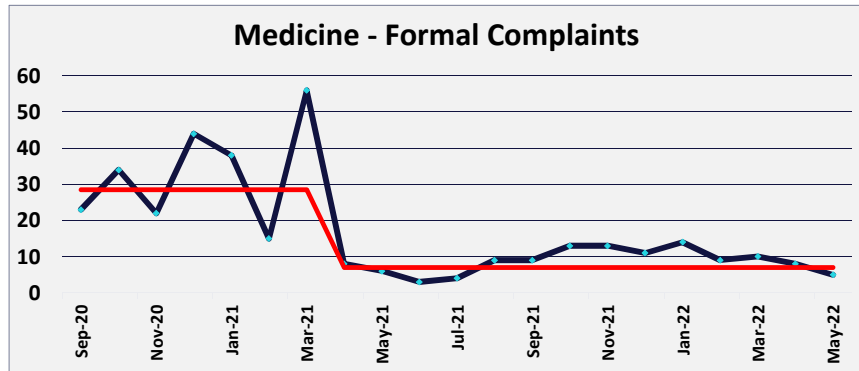
SEC - 20 Day Response Time



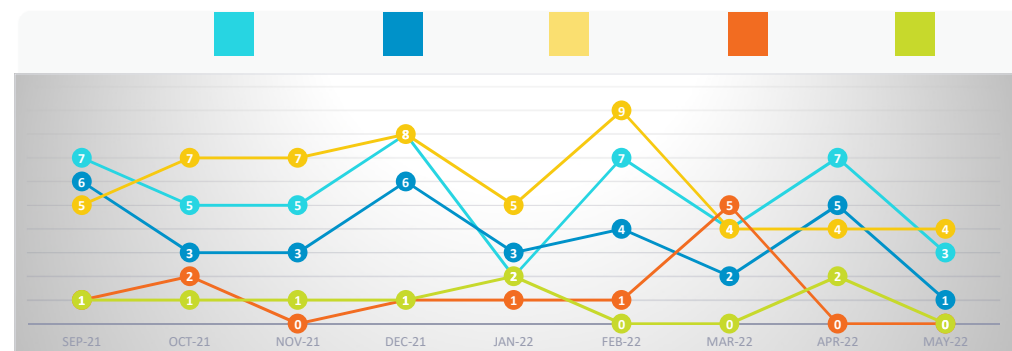
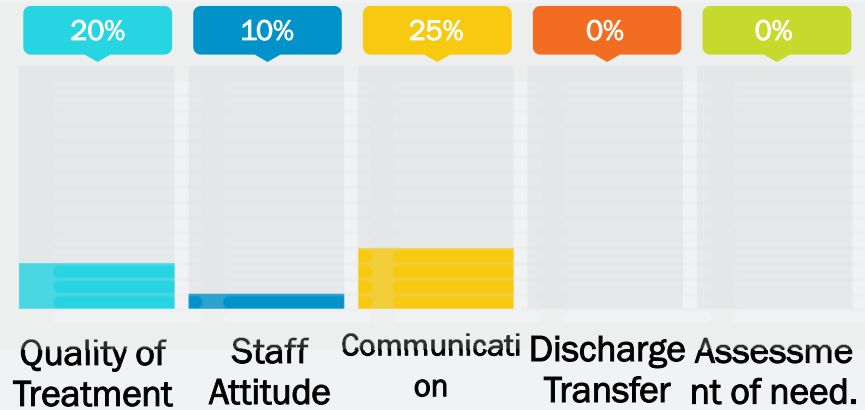
May 2022



Medicine

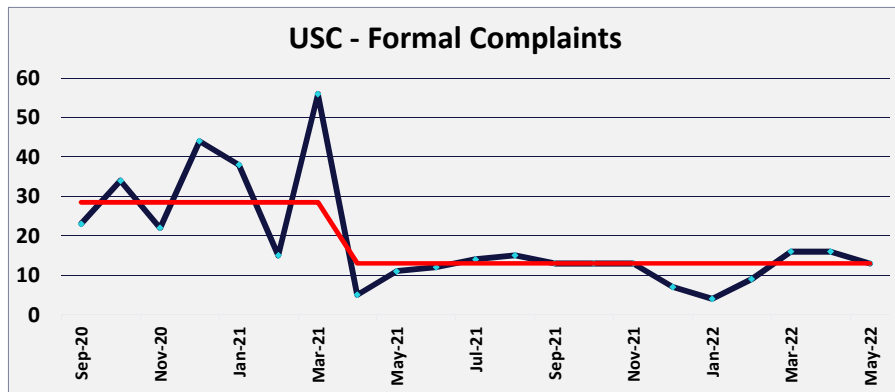


May 2022

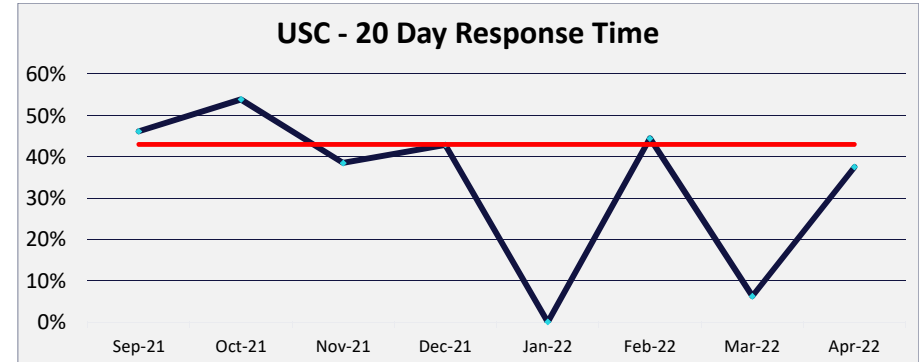


USC

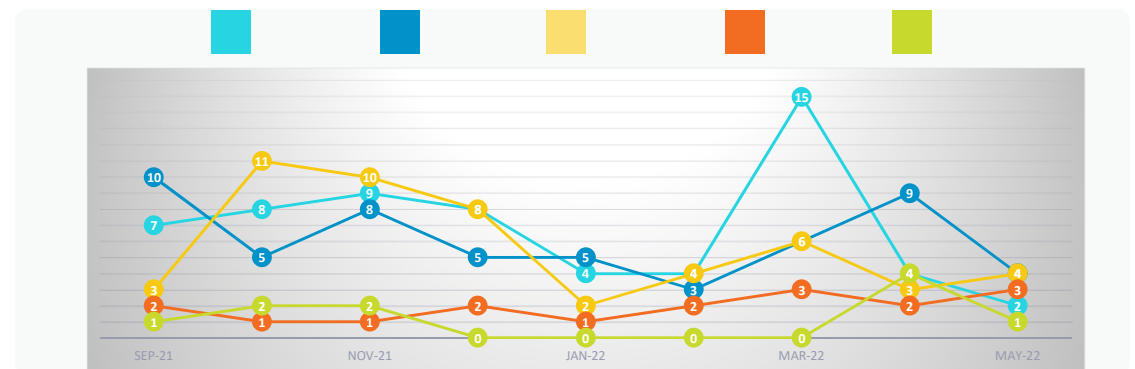
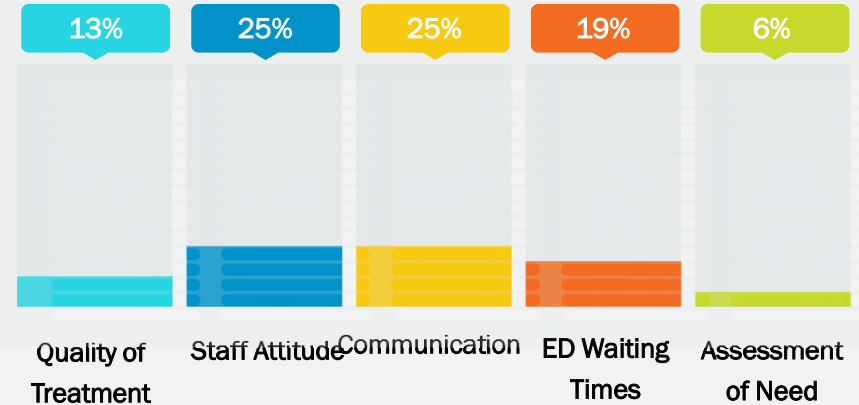
USC - Formal Complaints



USC - 20 Day Response Time

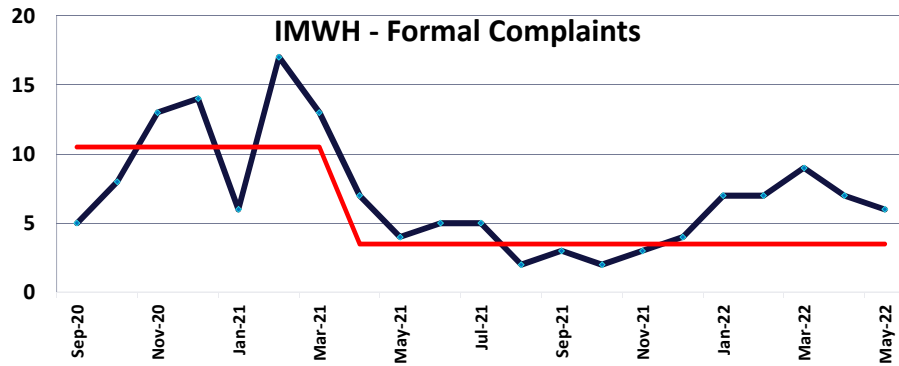


May 2022

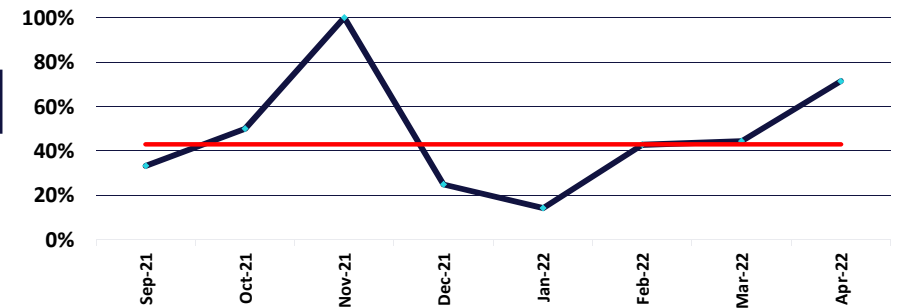


IMWH

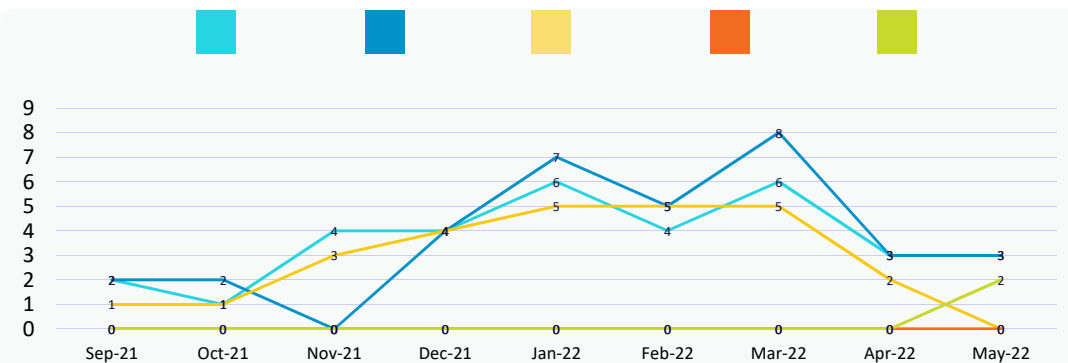
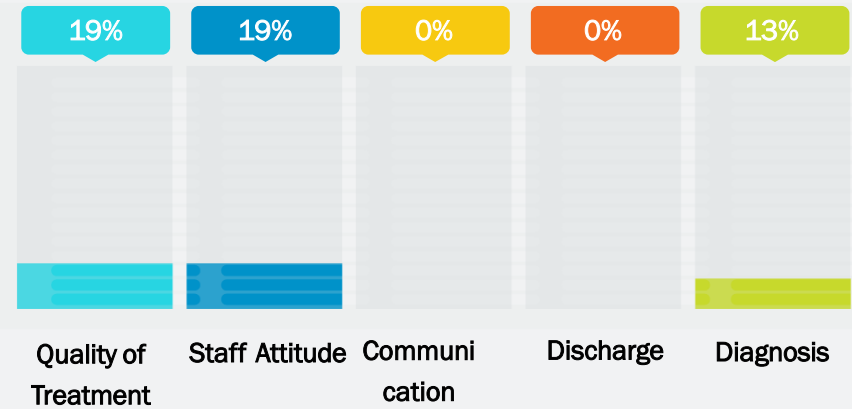
IMWH - Formal Complaints



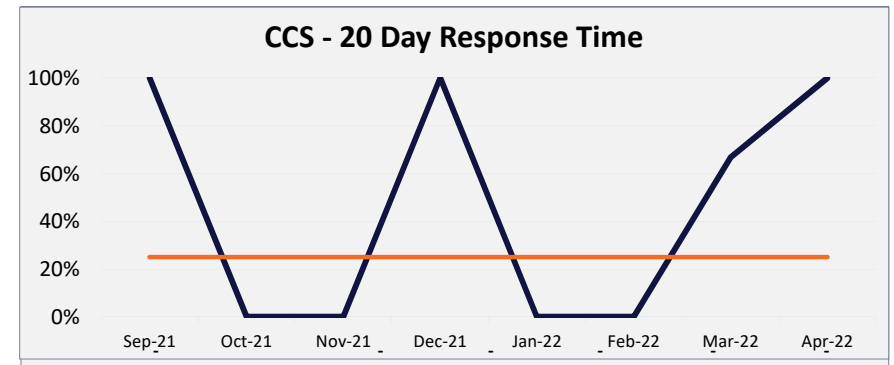
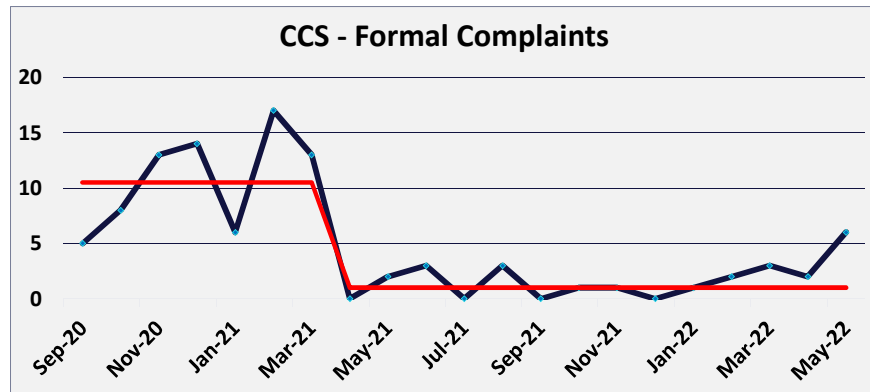
IMWH - 20 Day Response Time



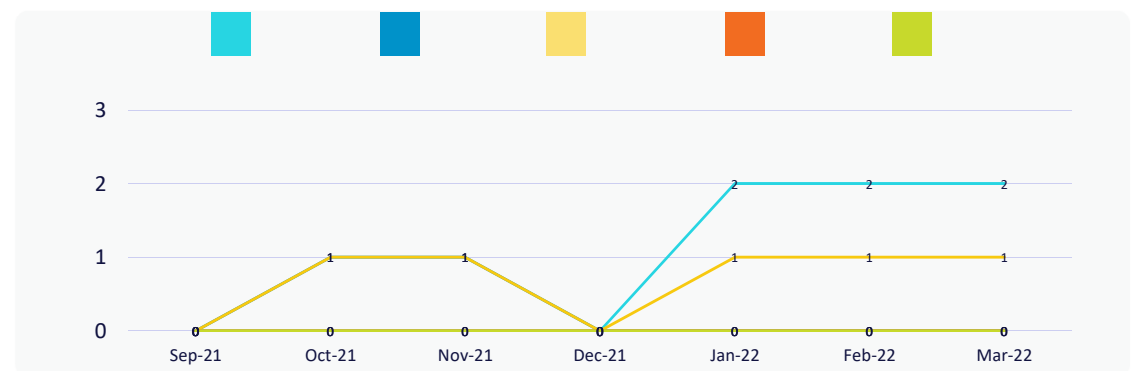
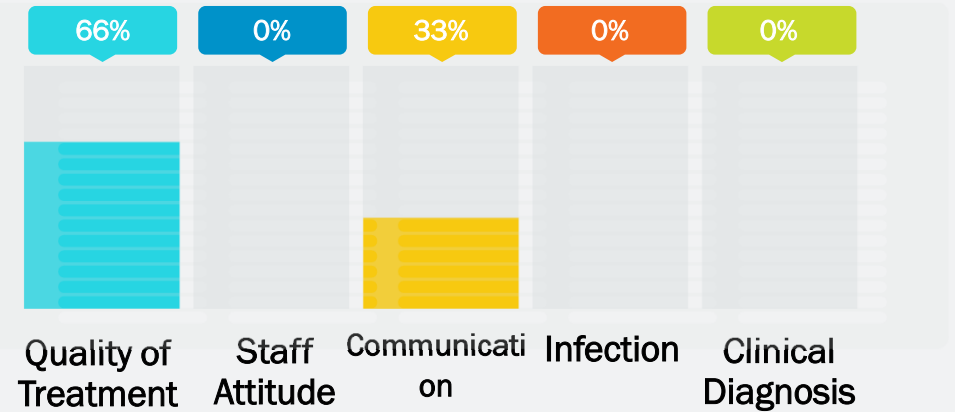
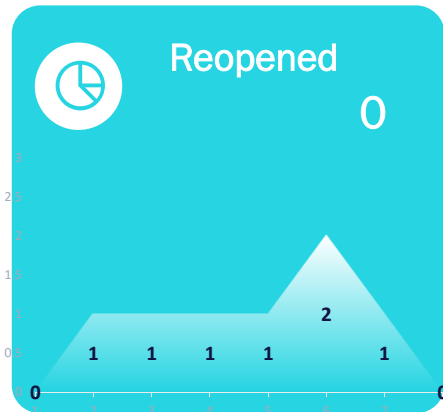
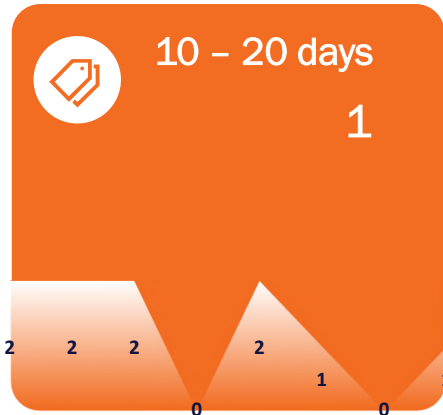
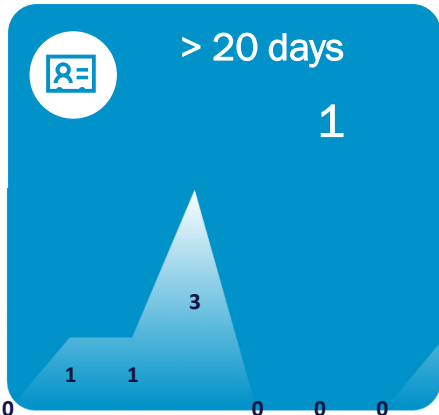
May 2022



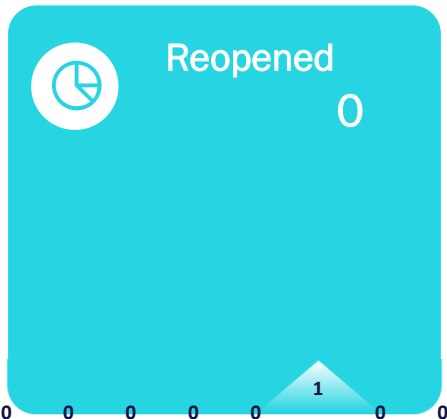
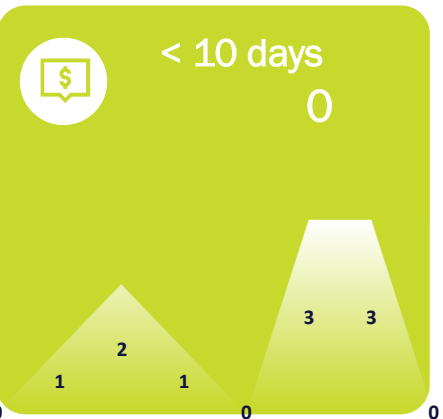
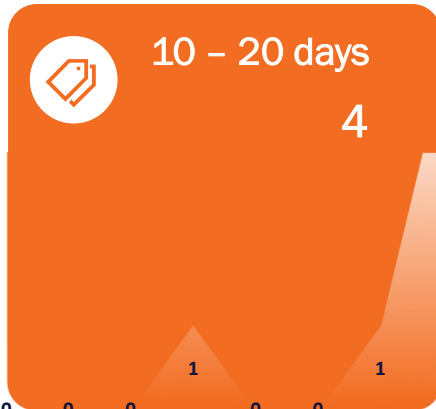
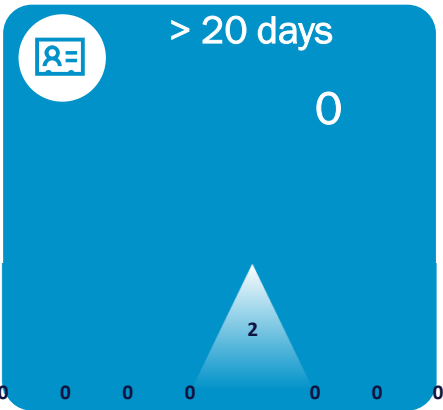
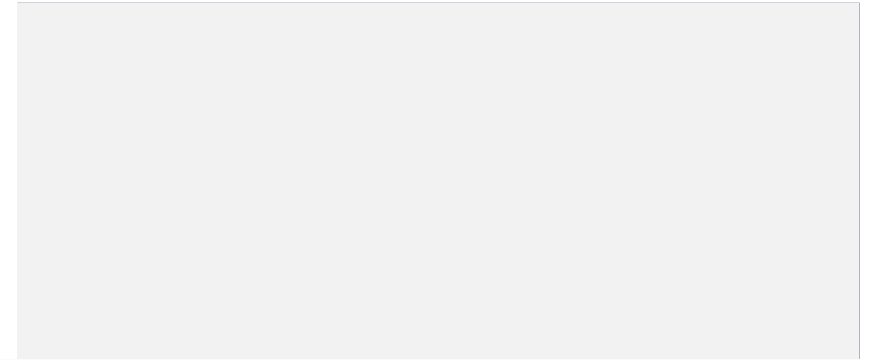
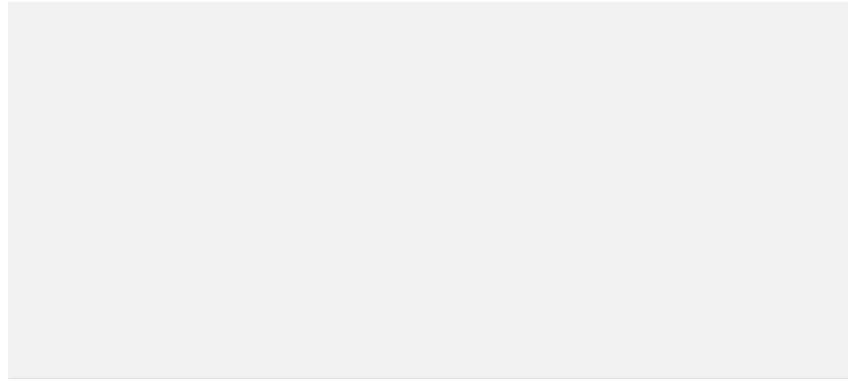
CCS



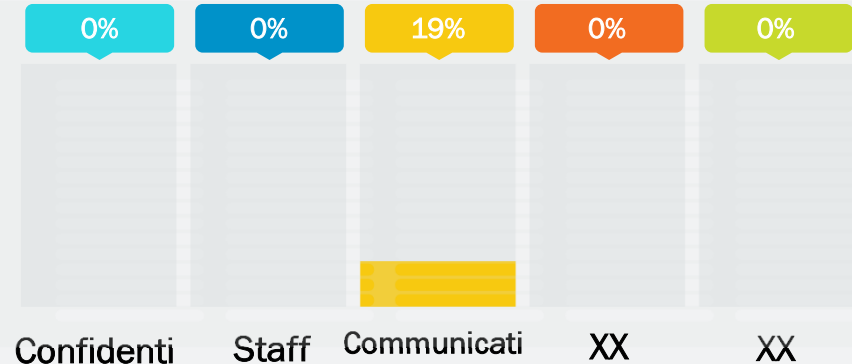
May 2022



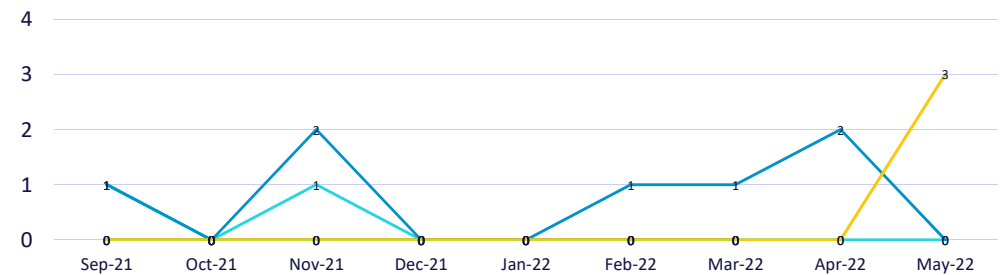
FSS



March 2022



Confidentiality Staff Attitude Communication XX XX



SEC/ATICS

No	Complaint summary	Learning	Actions
1	Patient advised he was to be sent to England for surgery however referral was not made. Patient not informed of this until he contacted hospital to enquire re waiting time. Patient wanting to know if he can be sent to ROI to receive surgery.	The HoLEP procedure is not now available to patients in NI by the Hospital in England, Trust not aware of this	Board is to be contacted by HOS to raise concerns over the response being given to patients regarding the funding for HoLEP. Patient to be offered review to discuss alternative surgical procedure as the HoLEP is not carried out in NI and now not in England for NI patients
2	Patient phoned a clinic regarding an appointment that she had missed and is unhappy with how she was spoken to on the phone by the staff member. She claims she was extremely rude and unhelpful	Staff member has reflected on her conduct.	Senior Management met with staff member and discussed complaint
3	Daughter admitted to ED with query appendicitis. Diagnosed with Gastroenteritis and discharged. Re-admitted 10 days later with appendicitis and required emergency surgery. Mum wants to know what happened and why. She wishes to know whether or not	The importance of listening to an anxious family Misinterpretation of US reports and the role of further imaging or laparoscopy for patients when diagnosis remains uncertain.	case was discussed at M&M meeting and learning emphasized to team

SEC/ATICS

No	Complaint summary	Learning	Actions
4	Claims room was below 16 degrees, she was not provided with pain relief or assisted with toileting. She states staff mocked her and accused her of hitting them. Patient left ward without medication and did not complete her treatment. She wants staff to be held accountable and an apology.	None required as patient received discharged herself against medical advice. No evidence of claims staff mocked her	Estates contacted to adjust temperature of Ward. Blankets and hot fluids offered to patient
5	Patient admitted 28.08.21. Differing information from Dr's. Went to Ortho ward and caught c-diff. Not given aids by palliative care. Witnessed staff indifference. Family were not informed where patient went after ED. Dad died without dignity and the ward was not suitable for palliative care.	None- Communication and updates were recorded regarding patient condition and management throughout None- Communication and updates were recorded regarding patient condition and management throughout Apology given to family regarding the experience of staff indifference a lot of agency staff and temporary staff who are not regular staff on this ward-	Apology given to family regarding the experience of staff indifference- staff have been reminded of the need for professionalism at all times. staff have been reminded of the need for professionalism at all times
6	unhappy with care and treatment when admitted to CAH in 2020, patient had surgeries but was unable to give consent.	None- Lady had abscess which needed debridement regularly to keep wound clean.	None required

SEC/ATICS

No	Complaint summary	Learning	Actions
7	Patient had breast surgery and implanted inserted. Iodine drip placed on wound by Breast Nurse despite surgeons advice re sensitive skin. Wound broke down and repeat surgery to remove implant was required. Lady feels this was negligence and could have been avoided. Also left a message on phone which was not returned. Poor communication.	None – Consultant attempted multiple times to contact patient when she did not attend for surgery Reconstruction was failing and further surgery required this was not a fault of anyone, it was just a common complication.	None required.
8	Denied painkillers during admission to Ward. States Sister implied she was annoying other patients. Claims she was offered no sympathy and staff were unresponsive and unsympathetic.	None as medication was administered 5 times in total and no more could be prescribed. Sister reflected on her attitude and will endeavour to change her practice- not the intention make patient feel that way.	Staff reminded of the importance of professionalism courtesy and empathy.
9	Patient believes he was removed from Urology waiting list and was first referred 9 years ago and has not been seen	None- patient changed address without informing anyone.	New referral has been sent by GP and is on the routine waiting list but the lists are extensive.

SEC/ATICS

No	Complaint summary	Learning	Actions
10	Patient attended for covid test and required results for procedure to go ahead. She was advised to carry on with prep if not contacted. She attended for procedure and was advised her covid sample had been misplaced. She underwent a rapid PCR and was found to be positive.	Scheduling team have been informed of the turnaround time for swab results and the need to book appointments in a timely manner.	The Lab has installed more automated equipment which will significantly reduce turnaround times for covid testing.
11			
12			

Medicine

No	Complaint summary	Learning	Actions
1	Daughter complaining that father attended ED and was sent home with steroids, she feels there was a delay in treatment commencing due to this. Father admitted to ward 8 days later after ED again, diagnosed with clot. Daughter states father was on the wrong oxygen and also transferred to a covid ward in error. She alleges a nurse gave her misleading information and staff just watched her father deteriorate over previous 8 days.	Breakdown between medical team and the referral to respiratory team.	Medical staff reminded of the importance of timely referrals to other specialties
2	Delay in MRI caused hip damage which has had lasting effect and loss of mobility. Lack of adequate pain relief. Communication of Middle Grade Doctor when family asked questions.	Delay in MRI was due to no MRI questionnaire being filled out by Ward Staff and also the breakdown of the bed lifts. Failure in the timely administration of pain relief. Lack of clear communication regarding treatment plan.	Staff reminded of the importance of timely administration of MRI checklists to not delay treatment. Staff to be more vigilant in the administration of pain relief Consultant to address the importance of clear communication to Middle Grades when explaining treatment to family members.

Medicine

No	Complaint summary	Learning	Actions
3	Misdiagnosed with IBS. Had cardiac symptoms. Patient queried diagnosis and kept in until Felt worse and reviewed by Cardiac Doctor told lucky to be still here as heart and kidneys failing. Transferred to RVH open heart surgery and 4 weeks inpatient treatment. Consultant misdiagnosed completely and should not be working. Must be an enquiry into this Consultants' abilities	All investigations were appropriate based on clinical presentation and were ongoing throughout stay as symptoms progressed or changed so did the investigation pathway. Doctor reflected on his communication should have been clearer and assurance given that discharge would not happen until diagnosis reached.	Doctor to reflect on communication skills and will be clearer as part of his clinical practice.
4	No handover to Nursing Home from Ward re discharge or needs missing sentimental items from inpatient stay including wedding rings and sapphire ring	None all appropriate ICS forms were filled out timely for package of care. Full handover given by ICS Team to Home. No items found- nothing was handed over for safe keeping	none

Medicine

No	Complaint summary	Learning	Actions
5	Communication was poor in relation to updates regarding their brothers health in his final days. The visiting restrictions were not consistent- were told 2 different versions of when visiting was to be permitted by the same ward	Failure in consistency regarding visiting Regarding communication the first contact was given all updates as per procedure introduced, but recognition given that first contact may not have informed other family members.	All staff briefed on the current visiting guidelines.
6	Unhappy regarding discharge- felt “bullied” into discharge and it was too early, patient needed readmitted. Discharge did not give family time to prepare. Felt bullied into discharge. No discussion regarding heart failure or new medication given. Lack of communication and could not get through to Ward. No updates given regarding changes .	None patient wished to be discharged and was deemed medically fit. POC was in place along with OT aids already at the patients home.	Complaint has been shared with Ward Team (1 South) for learning in relation to communication and providing updates to families.

Medicine

No	Complaint summary	Learning	Actions
7	Lost items during inpatient stay 3 North.	The importance of good record keeping of patient property	Consent form along with explanation of the policy for reimbursement sent to family
	Patient discharged without consultation with family - no adequate care plan in place and not enough support given. Discharged without being dressed Not happy with staff attitude. Lack of communication.	Acknowledgement of failure in communication between teams involved in patients care including social work, ward staff and medical staff. Acknowledgement of poor attitude, needs improvement	Discharging Nurse was spoken to by Lead about the manner in which patient was discharged- importance of dressing appropriately. Importance of clear and regular communication- complaint has been shared for learning. Internal meeting took place with Consultant and family. Staff reminded of importance of courtesv and professionalism

USC

No	Complaint summary	Learning	Actions
1	Attended ED CAH. told to wait in corridor with temperature over 41. Not kept informed of her clinical condition and made to feel like an inconvenience Had to ask staff to go to blossom for a cot for baby. Never seen Dr again until she demanded to see one prior to discharge or threatened to walk out. Left for 36 hours with no medication. Not enough toilet facilities Did not receive any food or water without asking for it and it was cold when received it.	Patients to be kept informed regarding their clinical condition - communication in this area was lacking Breakdown in communication between the ward staff and catering.	Support Services staff informed regarding cold food provided. Renovations are currently underway to address the deficit in toilet facilities.
2	Complaint regarding the standard of care of late mother in AMU. Difficult to get through to ward, family ringing on a number of occasions and telephone not being answered. Staff attitude was not acceptable. Nurse informed family in the morning that patient was going for scan on her back. Family found out later that night that it was the patient in the next bed that had	Better communication with families, more timely answering of calls. The Nurse has reflected on his attitude and his inappropriate comments and will endeavor to change his practice. Basic fundamentals of nursing care were not always carried out, more awareness of patient needs to be identified.	Staff reminded regarding the importance of timely answering of telephones. Nursing Staff spoken to regarding the duties required when patients need attended to.

USC

No	Complaint summary	Learning	Actions
4	Waited 8 hours despite GP saying child needed urgent nebulizer. Poor treatment by Doctors and Nurses and judgement because young parent and they made an assumption that child was given red bull which was not case.	Paeds Team assessed and did not require nebuliser. Doctor acknowledges his manner was not appropriate and caused offence- reflected on his conduct and has used it for learning. Delay in being seen due to large volumes of patients in ED.	none
5	Complainant attended DHH ED with his daughter on Friday 22/04/22 with a deep laceration on her back. Doctor refused any more pain relief. Doctor washed the site and proceeded to stitch without applying anesthetic causing the service user immense pain.	Lack of pain relief was not acceptable Anaesthetic should have been used	Doctor has reflected on his actions and feedback shared of the importance regarding professional assessment of need.
6	Waiting time in ED, sister waited 10 hours and was told she was urgent.	none required- overcrowding in ED is beyond control of trust	None required

USC

No	Complaint summary	Learning	Actions
7	Treatment by a doctor in DHH ED when she attended. he had a bad attitude and was not nice wants an	Complaint shared with Doctor and he has reflected on his attitude- will incorporate this learning into future clinical practice	None required
8	Patient had spinal injuries from previous and left her with no real sensation in her left foot. Felt pain in her heel and went to hospital for x-ray to be told no fracture. Went and had doppler no clot. rang by hospital to come back immediately and put in cast had a fracture and needed surgery on her heel.	No learning it was a difficult prognosis and was to be managed conservatively	None required
9	Cancer patient had a fall at home waited 10 hours with no pain relief went home. The patient was seen the following day in STH within one hour and was informed she had a broken ankle.	None as delay is beyond control. Patient declined analgesia in triage	none

USC

No	Complaint summary	Learning	Actions
11	Mother attended ED with her 14 year old daughter who is diagnosed with NEAD/FND. Mother felt there was no awareness of FND within the department and no one had ever heard of it. She claims no follow up plan or reassurance was provided to her daughter.	All staff to be briefed on NEAD/FND- Family to provided the leaflet and this will be shared with staff.	Case to be discussed at Multidisciplinary Meeting
12	Patient attended ED with injuries after an assault. Waited 5 Hours for pain relief. No communication and no one came to him He states he wasn't checked properly in triage.	None- triage was within 15 minutes and categorised as being safe to wait. Overcrowding in ED so delays. Importance of timely pain relief	None had appropriate treatment and care

IMWH

No	Complaint summary	Learning	Actions
1	Following a miscarriage on Personal Information redacted by the USI, Service User and baby attended ED (7pm) as advised by Maternity when husband called for advice. A Gynae Doctor came to examine the service user (10.30pm) who introduced herself. Following the loss of a large clot the Doctor checked her over and was happy to discharge. Baby was wrapped in a towel the whole time and when asked what they should do with the baby Doctor advised there was nothing she could do as the service user was only 13 weeks and they should take the foetus home. The service user was unsure what to do with the foetus and buried it in her back garden. The next day the service user was sick and attended her GP on Monday 21 February who arranged for her to be seen in Gynae. The placenta was found to be still in the womb which caused infection. The Doctors were shocked when service user advised she had been sent home from ED with the baby. lack of communication and that she was discharged without significant examination or advice. Service user wants an apology and an explanation of correct procedure that should have been followed.	US scan to be given regardless of lack of symptoms (pain and bleeding) after miscarriage to ensure there is no retained placenta. An earlier scan would have led to early surgical intervention.	Case to be discussed at the M&M meeting so that the learning arisen from this case can be shared widely as possible throughout the teams
2	Partner refused access to Maternity assessment on 2 occasions. Midwife was unsympathetic and rude. Patient not happy with how was treated.	Midwife reflected on conduct. Visiting restrictions in place	Lead midwife spoke with patient and she was content and withdrew complaint.

IMWH

No	Complaint summary	Learning	Actions
4	Patient attended DHH Maternity Department on 5th May 2022 for growth scan. After waiting over an hour she was advised she was waiting in the wrong area. After a 4 hour wait she was seen by a doctor.	Sister-in-Charge of Antenatal OPD apologises for experience at the Antenatal Clinic. Sister assures patient that the appointment was put on correctly but was not showing on doctor's clinic screen. Administration Manager states that staff member apologises for giving the wrong information on where to wait. Complaint has been shared with Admin Staff to ensure this does not happen again.	Complaint has been shared with all Admin Staff to ensure this does not happen again.
5	Patient advises that two separate midwives on two separate occasions have asked if she has had her Covid vaccine and when she answered no they both changed their tone and spoke down to her.	Acknowledge that it is patient choice re vaccine	Staff have been spoken to to advise but not enforce the vaccine as it is choice.

IMWH

No	Complaint summary	Learning	Actions
6	Despite voicing her concerns about infection was over 48 hours since waters broke until patient was moved from Delivery suite. Baby transferred to NICU with sepsis after birth.	Apologies to patient from Lead Midwife. Lead midwife apologises for discrepancies in clinical findings and for delay in transferring to Delivery Suite. Lead midwife discussed care with the Sister on duty and the plan was for transfer to Delivery Suite overnight for labour augmentation however the demand outweighed the capacity due to spontaneous labours and emergencies that required theatre.	More care required at all times regarding patient needs.
7	Patient attended OPD for follow up of miscarriage. Was asked to wait in waiting room with other pregnant women. This was very distressing. Would like a different arrangement to be put in place.	Midwifery Sister has asked Reception Staff to be vigilant when the Early Pregnancy Problem Clinic is running to ensure that anyone attending this clinic is sitting in the correct waiting area.	Staff reminded regarding correct areas to seat patients when attending this service

IMWH

No	Complaint summary	Learning	Actions
7		An invitation for an antenatal booking after a miscarriage had been confirmed - process to be reviewed urgently and strengthened	Post-procedure aftercare - discharge advice needs to be face-to-face and followed up with some written information and signposting on how to access support or advice following miscarriage in the following weeks. An invitation for an antenatal booking after a miscarriage had been confirmed - process to be reviewed urgently and strengthened

CCS

No	Complaint summary	Learning	Actions
1	Patient attended for 20 week scan. The Radiographer who was doing the scan asked if she could wear a mask and when she replied no the Radiographer explained that exemptions do not apply in the hospital.	Sonographer has reflected on conduct and the importance of understanding when implementing mask wearing	That is its not compulsory but to advise in a polite manner
2	Service user advises staff member was rude when completing breast screening in STH. The staff member shouted at service user and was abrupt and rude.	Lesson learned on how words and actions can be interpreted by service users.	Learning will be shared with breast team
3	SU advises she has been trying to contact the Audiology Department but has been unable to get through despite being provided with six different numbers. Wants someone to contact her and wants the issue addressed for other service users	That the extension numbers to the audiology service do not have the provision for SU to leave voicemail's.	Lead to contact Telecom's and get the extension number for Audiology to have the facility for SU to leave voicemail's .

CCS

No	Complaint summary	Learning	Actions
4	Patient attended for covid test and required results for procedure to go ahead. She was advised to carry on with prep if not contacted. She attended for procedure and was advised her covid sample had been misplaced. She underwent a rapid PCR and was found to be positive. Patient does not want an apology, but wants to know what happened and what is going to be done to prevent reoccurrence.		

FSS

No	Complaint summary	Learning	Actions
1	Patient advises she attended ED on 22 April 2022 and asked the receptionist if she could speak privately about her issues. she ignored her and proceeded to ask if her bleeding was vaginal or anal. Patient left feeling embarrassed, panicky and stressed.	Staff to accommodate requests from patients who wish to speak privately about their presenting condition as it can be a sensitive matter	All staff reminded of the importance of assisting with reasonable requests
2	Complainant states that an ED receptionist has shared information regarding her visits to ED and other personal and medical information to members of the public. She wants this addressed to the department and for staff to be reminded of confidentiality and of breaches that are being made.	none required- Health records are stored in secure records library with restricted access.	Data protection is part of mandatory training for all staff and all staff have completed this training. Staff reminded of the GDPR policy and confidentiality policy.

FSS

No	Complaint summary	Learning	Actions
3	Patient phoned consultant's secretary to ask for an update on scan results being sent to his GP. Patient was unhappy with how he was spoken to by consultant's secretary	Staff member has reflected on her manner and conduct and understands it was inappropriate	Following this complaint the Service Administrator has sent administrative staff an email advising them to be more sensitive and not be so sensitive.
4	tried to get through to the ward on number provided and it was dead. very frustrating when trying to get in touch regarding mother and cant even get a number to get through		Following complaint further staffing to these lines are now in place and the Southern Trust are in the process of developing an electronic system which will make the process much more accessible for visitors.

FSS

No	Complaint summary	Learning	Actions
3	Dissatisfied with explanation of phone first from receptionist. Does not understand why she couldn't be seen as an emergency. Would like some measures to be considered to deliver efficient and quality services for the future. Patient asked receptionist for water to take medication and was declined due to covid	Staff member has reflected on her manner and has been reminded of appropriate conduct and communication with patients. Receptionist has acknowledged this was unacceptable	None required Complaint shared with all admin staff the importance of assisting patients with reasonable requests.

Personal Information redacted by the USI						Personal Information redacted by the USI		Personal Information redacted by the USI			
184	Email	Formal HSC	28/07/2022	not required	9/10/08/2022			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
185	Email	Formal HSC	28/07/2022	not required	9/10/08/2022			PAN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			POLCD Policy/Commercial	POC 1 Acute Services-	REHAB Rehabilitation	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	REHAB Rehabilitation	different wt nurse doctor
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			WTAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
	Email	Formal HSC	25/07/2022	07/09/2022	0 response outstand			CLDIAG Clinical Diagnosis	POC 1 Acute Services-	AE Accident & Emergency	
106	Email	Formal HSC	01/08/2022	01/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
107	Email	Formal HSC	01/08/2022	01/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
12	Email	Formal HSC	01/08/2022	01/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
95	Email	Formal HSC	02/08/2022	not required	05/09/2022			COMINF	POC 1 Acute Services-	GYNAE Gynaecology	
96	Email	Formal HSC	02/08/2022	01/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	OBS Obstetrics	Doctor
97	Email	Formal HSC	02/08/2022	01/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	OBS Obstetrics	
98	Email	Formal HSC	02/08/2022	01/09/2022	0 response outstand			PAN Professional Assessment	POC 1 Acute Services-	OBS Obstetrics	Nurse
99	Complaints /	Formal HSC	16/08/2022	12/09/2022	0 response outstand			OTHER Other	POC 1 Acute Services-	GMED General Medicine	
140	Telephone	Formal HSC	28/07/2022	24/08/2022	28/08/09/2022			PAN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
127	Email	Formal HSC	01/08/2022	01/09/2022	0 response outstand			RECORD Records/Record	POC 1 Acute Services-	AE Accident & Emergency	
48	Complaints /	Formal HSC	29/07/2022	25/08/2022	29/09/09/2022			WLOPT Waiting List,	POC 1 Acute Services-	ENT ENT	
94	Complaints /	Formal HSC	15/08/2022	12/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
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147	Email	Formal HSC	08/08/2022	01/09/2022	0 response outstand			PAN Professional Assessment	POC 1 Acute Services-	GSUR General Surgery	
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117	Telephone	Formal HSC	11/08/2022	12/09/2022	0 response outstand			WTAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
186	Email	Formal HSC	05/08/2022	01/09/2022	0 response outstand			WLPAAH Waiting List,	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
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34	Telephone	Formal HSC	16/08/2022	10/10/2022	0 response outstand			COMINF	POC 1 Acute Services-	RADIO Radiology	
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221	Complaints /	Formal HSC	08/08/2022	01/09/2022	0 response outstand			ENVIRO Environmental	POC 1 Acute Services-	OTHER Other	
119	Email	Formal HSC	05/08/2022	12/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	different wt
120	Email	Formal HSC	05/08/2022	12/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
121	Email	Formal HSC	05/08/2022	12/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	Nursing
122	Email	Formal HSC	05/08/2022	12/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
141	Email	Formal HSC	08/08/2022	01/09/2022	32/15/09/2022			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
115	Complaints /	Formal HSC	10/08/2022	01/09/2022	22/12/09/2022			CLDIAG Clinical Diagnosis	POC 1 Acute Services-	AE Accident & Emergency	
70	Complaints /	Formal HSC	09/08/2022	01/09/2022	0 response outstand			WLPAAH Waiting List,	POC 1 Acute Services-	NURO Urology	
71	Complaints /	Formal HSC	09/08/2022	01/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	NURO Urology	
101	Email	Formal HSC	10/08/2022	01/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	OTHER Other	
181	Email	Formal HSC	10/08/2022	01/09/2022	0 response outstand			WTAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
111	Complaints /	Formal HSC	11/08/2022	01/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GSUR General Surgery	
93	Complaints /	Formal HSC	15/08/2022	12/09/2022	0 response outstand			WLPAAH Waiting List,	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
208	Letter	Formal HSC	16/08/2022	14/09/2022	0 response outstand			POLCD Policy/Commercial	POC 1 Acute Services-	DERM Dermatology	
27	Complaints /	Formal HSC	16/08/2022	12/09/2022	31/29/09/2022			QUALTC Quality of Treatment &	POC 1 Acute Services-	AE Accident & Emergency	
150	Complaints /	Formal HSC	24/08/2022	20/09/2022	0 response outstand			PAN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
113	Telephone	Formal HSC	15/08/2022	12/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
246	Complaints /	Formal HSC	16/08/2022	11/10/2022	0 response outstand			CONSENT Consent to	POC 1 Acute Services-	GMED General Medicine	
114	Telephone	Formal HSC	16/08/2022	15/09/2022	0 response outstand			WLPAAH Waiting List,	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
136	Email	Formal HSC	17/08/2022	12/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
139	Email	Formal HSC	17/08/2022	12/09/2022	0 response outstand			PAN Professional Assessment	POC 1 Acute Services-	GMED General Medicine	
110	Telephone	Formal HSC	17/08/2022	15/09/2022	28/23/09/2022			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
111	Telephone	Formal HSC	17/08/2022	15/09/2022	28/23/09/2022			COMINF	POC 1 Acute Services-	AE Accident & Emergency	
170	Telephone	Formal HSC	17/08/2022	15/09/2022	28/23/09/2022			CONFID Confidentiality	POC 1 Acute Services-	OTHER Other	
103	Telephone	Formal HSC	18/08/2022	14/09/2022	0 response outstand			CLDIAG Clinical Diagnosis	POC 1 Acute Services-	AE Accident & Emergency	
104	Telephone	Formal HSC	18/08/2022	14/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
53	Complaints /	Formal HSC	18/08/2022	14/09/2022	28/29/09/2022			WLPAAH Waiting List,	POC 1 Acute Services-	NURO Urology	
261	Email	Formal HSC	18/08/2022	14/09/2022	27/28/09/2022			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
252	Email	Formal HSC	18/08/2022	14/09/2022	27/28/09/2022			POLCD Policy/Commercial	POC 1 Acute Services-	AE Accident & Emergency	
194	Telephone	Formal HSC	19/08/2022	14/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	GMED General Medicine	
29	Email	Formal HSC	22/08/2022	14/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	AE Accident & Emergency	
58	Telephone	Formal HSC	22/08/2022	15/09/2022	24/27/09/2022			COMINF	POC 1 Acute Services-	AE Accident & Emergency	
213	Telephone	Formal HSC	22/08/2022	15/09/2022	24/27/09/2022			WTAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
218	Email	Formal HSC	24/08/2022	20/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
69	Email	Formal HSC	24/08/2022	20/09/2022	0 response outstand			COMINF	POC 1 Acute Services-	GYNAE Gynaecology	
104	Telephone	Formal HSC	24/08/2022	20/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
105	Letter	Formal HSC	24/08/2022	20/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	AE Accident & Emergency	
102	Letter	Formal HSC	25/08/2022	20/09/2022	0 response outstand			DISCTRN Discharge/Transfer	POC 1 Acute Services-	GMED General Medicine	
76	Telephone	Formal HSC	26/08/2022	23/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	GMED General Medicine	
142	Telephone	Formal HSC	30/08/2022	27/09/2022	0 response outstand			PEF	POC 1 Acute Services-	GMED General Medicine	
141	Telephone	Formal HSC	31/08/2022	27/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	GMED General Medicine	
107	Telephone	Formal HSC	31/08/2022	27/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	GMED General Medicine	
108	Telephone	Formal HSC	31/08/2022	not required	12/23/09/2022			WLPAAH Waiting List,	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
148	Telephone	Formal HSC	31/08/2022	28/09/2022	25/30/10/2022			OTHER Other	POC 1 Acute Services-	RADIO Radiology	
86	Complaints /	Formal HSC	31/08/2022	27/09/2022	0 response outstand			OTHER Other	POC 1 Acute Services-	GMED General Medicine	
84	Complaints /	Formal HSC	30/08/2022	27/09/2022	24/04/10/2022			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
197	Telephone	Formal HSC	30/08/2022	27/09/2022	0 response outstand			QUALTC Quality of Treatment &	POC 1 Acute Services-	AE Accident & Emergency	
204	Telephone	Formal HSC	30/08/2022	27/09/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
169	Telephone	Formal HSC	30/08/2022	27/09/2022	0 response outstand			PAN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
246	Complaints /	Formal HSC	31/08/2022	not required	12/21/09/2022			QUALTC Quality of Treatment &	POC 1 Acute Services-	AE Accident & Emergency	
208	Complaints /	Formal HSC	06/09/2022	10/10/2022	0 response outstand			COMINF	POC 1 Acute Services-	GMED General Medicine	
60	Complaints /	Formal HSC	07/09/2022	10/10/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	OTHER Other	
61	Complaints /	Formal HSC	07/09/2022	10/10/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	GMED General Medicine	
20	Complaints /	Formal HSC	07/09/2022	10/10/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
	Telephone	Formal HSC	07/09/2022	10/10/2022	0 response outstand			SAB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
	Telephone	Formal HSC	07/09/2022	10/10/2022	0 response outstand			CLDIAG Clinical Diagnosis	POC 1 Acute Services-	ALLHP Allied Health Professions	

Personal Information redacted by the USI						Personal Information redacted by the USI		Personal Information redacted by the USI					
77		Complaints /	Formal HSC	22/09/2022	11/10/2022	0	response outstanding	N		UALTC Quality of Treatment &	POC 1 Acute Services-	GSUR General Surgery	doctor nursing
109		Email	Formal HSC	08/09/2022	10/10/2022	0	response outstanding	Y		OLCD Policy/Commercial	POC 1 Acute Services-	NEUROSU Neurosurgery	
66		Email	Formal HSC	12/09/2022	10/10/2022	0	response outstanding	Y		OMINF	POC 1 Acute Services-	OBS Obstetrics	
67		Email	Formal HSC	12/09/2022	10/10/2022	0	response outstanding	Y		OMINF	POC 1 Acute Services-	OBS Obstetrics	
194		Complaints /	Formal HSC	12/09/2022	not required	5	20/09/2022	Y		UALTC Quality of Treatment &	POC 1 Acute Services-	OBS Obstetrics	
91		Telephone	Formal HSC	13/09/2022	11/10/2022	0	response outstanding	Y		LPAH Waiting List,	POC 1 Acute Services-	NURO Urology	
162		Telephone	Formal HSC	14/09/2022	11/10/2022	0	response outstanding	Y		LOPT Waiting List,	POC 1 Acute Services-	GSUR General Surgery	
30		Email	Formal HSC	14/09/2022	not required	6	23/09/2022	N		LDIAG Clinical Diagnosis	POC 1 Acute Services-	AE Accident & Emergency	
161		Email	Formal HSC	14/09/2022	not required	6	23/09/2022	N		OLCD Policy/Commercial	POC 1 Acute Services-	AE Accident & Emergency	
229		Email	Formal HSC	15/09/2022	11/10/2022	0	response outstanding	N		TAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
193		Letter	Formal HSC	02/09/2022	11/10/2022	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
164		Letter	Formal HSC	02/09/2022	11/10/2022	0	response outstanding	N		IFECT Infection Control	POC 1 Acute Services-	GMED General Medicine	
138		Complaints /	Formal HSC	16/09/2022	not required	12	05/10/2022	N		SCTRN Discharge/Transfer	POC 1 Acute Services-	GMED General Medicine	
63		Telephone	Formal HSC	16/09/2022	11/10/2022	0	response outstanding	N		LDIAG Clinical Diagnosis	POC 1 Acute Services-	AE Accident & Emergency	
243		Complaints /	Formal HSC	20/09/2022	not required	11	05/10/2022	Y		SCTRN Discharge/Transfer	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
9		Complaints /	Formal HSC	20/09/2022	not required	8	30/09/2022	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
4		Complaints /	Formal HSC	20/09/2022	not required	8	30/09/2022	Y		ISCRM Discrimination	POC 1 Acute Services-	AE Accident & Emergency	
234		Telephone	Formal HSC	20/09/2022	11/10/2022	0	response outstanding	N		TAE Waiting Times, A&E	POC 1 Acute Services-	AE Accident & Emergency	
101		Email	Formal HSC	22/09/2022	not required	3	27/09/2022	Y		UALTC Quality of Treatment &	POC 1 Acute Services-	GSUR General Surgery	
235		Telephone	Formal HSC	23/09/2022	not due	0	response outstanding	N		UALTC Quality of Treatment &	POC 1 Acute Services-	NURO Urology	
92		Telephone	Formal HSC	23/09/2022	not due	0	response outstanding	N		OMINF	POC 1 Acute Services-	GMED General Medicine	
230		Email	Formal HSC	23/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	ORTH Trauma & Orthopaedics	
291		Email	Formal HSC	23/09/2022	not due	0	response outstanding	Y		RNSPL Transport, Late or Non-	POC 1 Acute Services-	NURO Urology	
229		Email	Formal HSC	26/09/2022	not due	0	response outstanding	N		OMINF	POC 1 Acute Services-	NURO Urology	
270		Complaints /	Formal HSC	26/09/2022	not due	0	response outstanding	Y		ECORD Records/Record	POC 1 Acute Services-	PATHO Pathology (Laboratory Services)	
176		Complaints /	Formal HSC	26/09/2022	not due	0	response outstanding	Y		LOPT Waiting List,	POC 1 Acute Services-	CARD Cardiology	
257		Telephone	Formal HSC	27/09/2022	not due	0	response outstanding	N		LPAH Waiting List,	POC 1 Acute Services-	OTHER Other	
296		Telephone	Formal HSC	27/09/2022	not due	0	response outstanding	Y		RVDIG Privacy/Dignity	POC 1 Acute Services-	GMED General Medicine	
296		Telephone	Formal HSC	26/09/2022	not due	0	response outstanding	Y		LDIAG Clinical Diagnosis	POC 1 Acute Services-	RADIO Radiology	
169		Letter	Formal HSC	26/09/2022	not due	0	response outstanding	Y		LPAH Waiting List,	POC 1 Acute Services-	GSUR General Surgery	
225		Complaints /	Formal HSC	26/09/2022	not due	0	response outstanding	N		LPAH Waiting List,	POC 1 Acute Services-	NURO Urology	
226		Complaints /	Formal HSC	26/09/2022	not due	0	response outstanding	N		UALTC Quality of Treatment &	POC 1 Acute Services-	AE Accident & Emergency	
19		Complaints /	Formal HSC	26/09/2022	not due	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
62		Letter	Formal HSC	26/09/2022	not required	3	29/09/2022	Y		EF	POC 1 Acute Services-	NURO Urology	
19		Complaints /	Formal HSC	27/09/2022	not due	0	response outstanding	Y		AN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
38		Complaints /	Formal HSC	27/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	ANAE Anaesthetics & Pain Management	
38		Telephone	Formal HSC	28/09/2022	not due	0	response outstanding	Y		ONFID Confidentiality	POC 1 Acute Services-	ANAE Anaesthetics & Pain Management	
37		Telephone	Formal HSC	28/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
37		Telephone	Formal HSC	28/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
38		Telephone	Formal HSC	28/09/2022	not due	0	response outstanding	Y		AN Professional Assessment	POC 1 Acute Services-	AE Accident & Emergency	
15		Letter	Formal HSC	28/09/2022	not due	0	response outstanding	Y		Need	POC 1 Acute Services-	ACUTE	
16		Letter	Formal HSC	28/09/2022	not due	0	response outstanding	Y		OLCD Policy/Commercial	POC 1 Acute Services-	AE Accident & Emergency	
17		Letter	Formal HSC	28/09/2022	not due	0	response outstanding	Y		ecisions	POC 1 Acute Services-	ACUTE	
17		Letter	Formal HSC	28/09/2022	not due	0	response outstanding	Y		OMINF	POC 1 Acute Services-	CARD Cardiology	
244		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	Y		communication/Information	POC 1 Acute Services-	CARD Cardiology	
238		Complaints /	Formal HSC	29/09/2022	not due	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	CARD Cardiology	
166		Complaints /	Formal HSC	29/09/2022	not due	0	response outstanding	Y		UALTC Quality of Treatment &	POC 1 Acute Services-	CARD Cardiology	
8		Feedback Form	Formal HSC	29/09/2022	not due	0	response outstanding	Y		are	POC 1 Acute Services-	ACUTE	
7		Feedback Form	Formal HSC	29/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	AE Accident & Emergency	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	REHAB Rehabilitation	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	HAEM Haematology (Clinical)	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	N		UALTC Quality of Treatment &	POC 1 Acute Services-	GSUR General Surgery	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	CARD Cardiology	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	N		AB Staff Attitude/Behaviour	POC 1 Acute Services-	CARD Cardiology	
228		Telephone	Formal HSC	29/09/2022	not due	0	response outstanding	Y		AB Staff Attitude/Behaviour	POC 1 Acute Services-	OTHER Other	

**AMENDED DHSSPS GUIDANCE NOTES
FOR NEW CH8 RETURNS FOR TRUST COMPLAINTS**

1. INTRODUCTION

1.1 These notes are released to provide guidance on the amended CH8 codes and for completion of the CH8 Trust Complaints form. Relative to the previous guidance, the revised form incorporates the following changes, as

1.2 The purpose of the CH8 form is to record the number of complaints received by Trusts during the year, the subject areas to which they refer and Trust performance in relation to timescales at local level

1.3 The CH8 form should be returned quarterly by Trusts in respect of services for which they have responsibility. Deadline for receipt of figures by Hospital Information Branch is not later than 15 working days from the end of the quarter to which the return refers. In other words, figures for quarter April – June will be provided not later than 15

1.4 Part 1 and Part 2 returns will still be made quarterly and Part 3 made yearly, being completed in the last quarter of the year (i.e. the quarter ending March).

2. COMPLAINT

2.1 For the purposes of the CH8 return, a complaint may be understood as ‘an expression of dissatisfaction requiring

Communications criticising a service or the quality of care but not adjudged to require a response, should not be included on this form.

Only complaints received from/on behalf of patients/clients or other ‘existing or former users of a Trust’s services and facilities’ should be included. Complaints from staff should not be included.

Complaints should be recorded on this return only if made by those eligible to make complaints under the HPSS Complaints Procedure. (This will include certain third parties where eligible under the guidance).

Only complaints about services of the Trust returning the form should be recorded on this CH8 form. Complaints received by a Trust, which properly refer to the services of another Trust/agency, should not be recorded on the

This return should include information on all formal complaints only. Informal HPSS complaints and Informal/Problem Solving Children Order complaints should not be included.

A single communication may include more than one issue of complaint. In such cases each separate issue should be recorded separately on the return for POC and Subject.

Where separate communications in respect of a single patient/client refer to one episode, they should be treated as a single complaint for the purposes of this form.

In other words, if two relatives complain about the same subject/episode in respect of the same patient, this should be treated as one complaint only.

However, if two relatives complain about separate subjects/episodes but in the care of the same patient, these should be treated as separate complaints.

Where separate unconnected communications refer to the same episode/issue, they may be treated as separate

In other words, if separate individuals complain about a matter they have all experienced, this would be treated as separate complaints, e.g. if ten clients complain individually about conditions in a day centre, these should be treated as ten separate complaints.

The logic of the complaints procedure is that it should afford a speedy resolution of cases of individual dissatisfaction of service. This differs from the case of petitions where the concern is primarily the collective representation of views, e.g. if a single complaint is received from a group of users, it should be treated as a single

Where a complainant is dissatisfied with the Trust's response to his/her complaint and enters into further communications about the same matter/s, this is not a new complaint, rather it will be the same complaint reopened. Such a complaint would only be recorded once in the CH8, i.e. in the quarter it was initially received. However, if this complainant were to then complain about a separate/different matter, this would be a new

3. DATE OF COMPLAINT

The date of a complaint should be the date on which the communication requiring a response is received. Where consent or authorisation is required from the patient/client, the date of complaint will be the date on which consent or authorisation is received.

A criticism only becomes a complaint when it requires a response. Therefore, if a criticism of services/facilities is made which subsequently develops into a request for a response, the date of the complaint should be taken as the date on which communication requesting response was received (i.e. the date on which the 'criticism' became a 'complaint') and not the date on which the original criticism was made.

If a complaint is made verbally which the client/patient states he/she will place in writing, the date of receipt of the written complaint should be taken as the date of the complaint.

If a complaint is verbally but is put into writing for the complainant, the date of the complaint should be recorded as the date the complainant confirms the details are a correct/true representation of his/her complaint.

If a complaint is initially sent to the wrong party and then transferred to the relevant Trust, for the purposes of this return, the date of the complaint should be recorded as the date on which it was received by the relevant Trust.

4. PART 1: PROGRAMME OF CARE

The criterion here is that the complaint should be logged under the POC to which it properly refers. If the POC assigned looks inappropriate, this almost certainly means it is inappropriate.

If a patient/client makes a complaint on his/her own behalf the complaint should be logged under the POC of the patient/client unless there are overwhelming reasons to the contrary.

If an individual lodges a complaint on behalf of another party, the complaint should be lodged under the POC of that party on behalf of whom the complaint is made.

For example, if someone makes a complaint on behalf of a relative who is being treated under the Mental Health Programme, the complaint should be recorded under the 'Mental Health' POC.

If an individual who is a user of facilities but not a patient/client complains on his/her own behalf, the POC classification of the complaint should be as follows:

- o if the complaint specifically refers to a POC it should be logged under that heading; *failing which*
- o if the complaint can be meaningfully associated with a POC it should be logged under that heading; *failing which*
- o if the complaint cannot be meaningfully associated with any POC, it should be logged under 'No POC Assigned'.

Examples :

o After visiting his wife in a maternity ward a husband is on the way out of the hospital and decides to use the toilet before leaving. He goes into the (acute) Outpatients Department for this purpose as it is the nearest available at the time. His complaint about the state of the toilets in Outpatients would be logged under the 'Acute' POC as the complaint would refer specifically to an acute service/facility in this instance. This complaint is so specific to the 'Acute' POC that it would be misleading for it to be classed under the 'Maternal & Child Health' POC.

o A husband visiting his wife in a maternity ward has difficulty finding his way in the building and complains about signage. This can be meaningfully associated with the 'Maternal and Child Health' POC because it is directly linked to Maternal and Child Health services/facilities and should be logged under that POC.

o A husband visiting his wife in a maternity ward has his car stolen from the main car park. This is not specifically a Maternal and Child Health complaint nor is it meaningfully associated with it in that it could happen to a user in any POC. The complaint should therefore be logged under 'No POC Assigned'.

It should be noted that merely because the Trust is providing an acute service on a site, this does not necessarily mean that all complaints on that site will be recorded in the 'Acute' POC. For example, maternity complaints will be recorded in the 'Maternal and Child Health' POC and not under the 'Acute' POC.

Includes all activity by any health professional, relating to an inpatient episode in one of the following specialties: Obstetrics, Obstetrics Ante Natal, Obstetrics Post Natal, Well Babies Obstetric, Well Babies Paediatric, GP

It also includes all activity in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included, as long as the contact was not in relation to mental health; learning disability; physical and sensory disability; family

POC 3 Family and Child Care

This programme is mainly concerned with the activity and resources relating to the provision of social services support for families and/or children. This included Looked After Children; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels/Shelter and Family Centres. This is not a definitive list of the type of

This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

This Programme of Care is subdivided into two categories:

- (i) Complaints under Children Order and
- (ii) Complaints other than under Children Order

POC 4 Elderly Care

This programme covers all activity by any health professional, including all community contacts with those aged 65 and over, except where the reason for the contact was because of mental illness or learning disability.

All community contacts where the reason for the contact was dementia should also be included, regardless of the patient's age. However, Down's Syndrome patients who develop dementia should remain in the Learning Disability POC for any dementia related care or treatment. All physically and/or sensorily disabled patients aged 65 and over should be included, as well as work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Age alone is not the determining factor in allocating patients and clients to the Elderly Care POC – community contacts are allocated by the primary reason for the contact which could result in a person aged 65 or over being allocated to the Mental Health POC if the reason for the contact was because of mental illness.

POC 5 Mental Health

This programme covers all activity by any health professional, including all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity should be allocated to the Elderly Care POC. However, Down's Syndrome patients who develop dementia should remain in the Learning Disability Programme of Care. All work and resources relating to residential accommodation for the Elderly Mentally Infirm should be excluded; this is included in the Elderly Care POC.

POC 6 Learning Disability

This programme covers all activity by any health professional, including all community contacts where the primary reason for the contact was learning disability, regardless of age. All community contacts with Down's Syndrome patients who develop dementia should be included for any dementia related care or treatment. All contacts in learning disability homes and units should also be included.

POC 7 Physical & Sensory Disability

This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 or over are excluded. These contacts should be allocated to the Elderly Care programme.

POC 8 Health Promotion and Disease Prevention

This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and

POC 9 Primary Health and Adult Community

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

POC 10 No POC Assigned

This is a residual heading for any complaints, which do not fall into any categories listed above.

5. PART 2: SUBJECTS

This part deals with the subject of complaint. The subject of complaint is to be assigned on the basis of the subject that best describes the nature of the patient / client's concern.

Example:

o A patient complains about being in a mixed ward. Is this a complaint about a policy decision or about privacy/dignity? If the dominant concern as assessed from the patient is privacy/dignity, the complaint should be

Definitions of Subjects:

1. Access to Premises

This heading includes all issues concerning ease of movement inside and outside the buildings, e.g. signage, car parking, etc. Problems of wheelchair access / disabled parking etc. should also be included under this heading, if not covered under '*Discrimination*' (17).

2. Aids / Adaptations / Appliances

This heading refers to the suitability / availability of any aids / adaptations, once they have been recommended. Complaints about waiting for assessment should be included under '*Waiting Lists, Community Services*' (36).

3. Children Order Complaints

This heading refers to all formal complaints received under the Children Order Representations and Complaints Procedure, irrespective of their subject or content.

4. Clinical Diagnosis

This heading covers clinical diagnosis only and is to be distinguished from '*Professional Assessment of Need*'

5. Communication / Information

This heading includes all issues of communication and information provided to patients / clients / families / carers regarding any aspect of their contact with staff. However, this should be distinguished from complaints about the attitude of staff when communicating with patients / clients, which would be logged under '*Staff Attitude /*

6. Complaints Handling

This refers to handling of a complaint at any point up to and including the conclusion of local resolution stage, e.g. a complainant complains that he/she did not receive a response within the timescale. However, a complaint would not be included under this heading if it obviously falls under another heading, e.g. if the complaint is about attitude of staff handling the complaint, it would be logged under '*Staff Attitude / Behaviour*' (27).

7. Confidentiality

This heading includes any issues of confidentiality regarding patients / clients, e.g. (i) complaint by a patient regarding a breach of confidentiality or (ii) complaint by the parents of a young adolescent who are denied information by staff on the grounds of that adolescent's right to confidentiality.

8. Consent to Treatment/Care

This refers to complaints made regarding consent to treatment/care.

9. Contracted Regulated Children's Services

10. Contracted Regulated Domiciliary Agency

11. Contracted Regulated Residential Nursing

These three headings refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements. Establishments may be children's homes, nursing or residential homes, while Agencies may be a domiciliary care agency, fostering agency or nursing agency. For a full list of Regulated Establishments and Agencies please refer to 'Quality & Improvement Regulation NI Order 2003, Article 8'.

In the first instance, the service provider is expected to deal with complaints, however, where the complainant, Trust or RQIA wishes, the matter may be investigated by the Trust under the HPSS Complaint Procedure.

Examples: (i) the Trust (as the commissioner) is asked by either RQIA or a relative, to investigate a complaint about the care or treatment provided to a resident in a Residential Home; (ii) a patient / client asks the Trust (as the commissioner) to investigate a complaint about the attitude of a member of staff of a Voluntary Agency with whom the Trust has contracted a home care service (e.g. personal care).

12. Contracted Independent Hospital Services

This heading refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements with independent hospitals.

13. Contracted Services – Other

This heading refers to complaints about services that are provided by Trusts via contractual / commissioned arrangements that are not captured in '*Contracted Regulated Children's Services/Domiciliary Agency/Residential Nursing*' (9, 10 & 11). In the first instance, the service provider is expected to deal with complaints, however, where the complainant or Trust wishes, the matter may be investigated by the Trust under the HPSS Complaint

Example: Attitude of a member of staff of facilities services operating under contract on Trust premises, (e.g. car clamping company or catering).

14. Delay/Cancellation for Inpatients

This heading includes all aspects of delay or cancellation of operation or procedure once the patient is in hospital, e.g. Radiology investigation cancelled, or theatre cancelled due to lack of ICU beds, theatre overrun, no anaesthetist, etc. This should be distinguished from the cancellation or delay of admission for the procedure captured under '*Waiting List, Delay/Cancellation Planned Admission to Hospital*' (34).

15. Delayed Admission from A&E

This refers to patients waiting in Accident & Emergency, following decision to 'admit', before being allocated a bed in a ward. This should be distinguished from '*Waiting Times, A&E Departments*' (35) and '*Waiting List, Delay/Cancellation Planned Admission to Hospital*' (34).

16. Discharge / Transfer Arrangements

This heading refers to the adequacy of arrangements and includes early discharges or delayed discharges. It does not include failure to communicate discharge arrangements, which would be included under '*Communication /*

17. Discrimination

This heading refers to complaints regarding disadvantageous treatment. It includes discrimination under the 9 Equality categories (i.e. age, gender, marital status, political opinions, religious belief, racial group, sexual orientation, persons with or without a disability, persons with or without dependents) and under the Human Rights Act (e.g. Article 1, Right to Life; Article 3, Right to Freedom from Torture, Inhuman or Degrading Treatment; Article 8, Right to Respect for Private or Family Life). Complaints about patient choice should also be included under this

18. Environmental

Complaints referring to the general condition or repair of the premises should be included under this heading. It also covers wider environmental issues, e.g. smoking.

19. Hotel / Support / Security Services (Excludes Contracted Services)

This heading includes any complaint referring to ancillary or support services, e.g. portering, facilities, catering. It also refers to security issues, e.g. stolen vehicles parked on Trust property.

20. Infection Control

This heading refers to compliance with infection control standards, e.g. hand hygiene; aseptic procedures; inappropriate use of personal protective equipment; incorrect disposal of waste or soiled linen; equipment / furniture not decontaminated. It covers issues around all infections but especially resistant micro-organism infections, e.g. MRSA, VRE. However, complaints about lack of information or not being informed would not be included in this heading, but would be logged under '*Communication / Information*' (5).

21. Mortuary & Post-Mortem

This category refers to complaints in relation to the mortuary and/or post-mortem.

22. Policy / Commercial Decisions

This category refers to complaints related to policy and/or commercial decisions.

23. Privacy / Dignity

This heading includes complaints specifically relating to the privacy or personal dignity of patients/clients.

24. Professional Assessment of Need

This heading refers to the assessment of need in either clinical or non-clinical contexts, however, should be distinguished from '*Clinical Diagnosis*' (4).

25. Property / Expenses / Finance

This heading refers to issues of the personal property, expenses or finance of patients/clients, e.g. due money for fostering; issues around direct payments; concerns about Trust charging / invoicing for clients in Nursing/Residential Home (either Private or Trust Home); broken hearing aid; lost spectacles / dentures.

Property damaged by staff arising in the course of care / treatment would fall into this category; however, property stolen from a patient's locker (as not being entrusted to or in the custodianship of staff and not known to be attributable to staff) would come under the heading of '*Hotel/Support/Security Services (Excludes Contracted Services)*' (19). Complaints about stolen vehicles (visitor or patient) and property lost or stolen from visitors should similarly be logged as a '*Hotel/Support/Security Services (Excluding Contracted Services)*' (19).

26. Records / Record Keeping

This refers to cases where records (such as medical notes, case files, X-rays) are unavailable, e.g. records have been mislaid or misfiled. Complaints about access rights to deceased patients' health records (governed by Access to Health Records (1993) NI Order) should be included under this heading. Complaints about any aspect of content of records or right of access should only be included under this heading, if they are not more appropriately dealt with under other procedures, such as Data Protection Act or Freedom of Information Act appeals processes.

27. Staff Attitude / Behaviour

This category refers to complaints related to staff attitude and/or staff behaviour.

28. Transport, Late or Non-arrival / Journey Time

This heading refers to complaints about the late arrival or non-arrival of transport or about the length of journey.

29. Transport, Suitability of Vehicle / Equipment

This heading refers to the appropriateness of the vehicle assigned and will include issues such as comfort, ease of access for the client group served. Complaints about the appropriateness of equipment would also be logged

30. Quality of Treatment & Care

This refers to the quality or standard of treatment and care provided. It also covers complaints relating to patient safety. However, it is to be distinguished from '*Quantity*' of Treatment & Care, (31) which refers to the quantity or

31. Quantity of Treatment & Care

This refers to the amount of treatment and care provided or available, e.g. someone receiving good quality home help but feel they are receiving inadequate number of hours.

32. Waiting Lists, Delay/Cancellation Community Based Appointments

This heading refers to the time spent waiting for either assessment or for the delivery of services following assessment, e.g. waiting list for an OT assessment, waiting list for a care package. 'Unmet need' should also be logged under this heading. This heading should be distinguished from '*Waiting Times, Community Services*' (36).

33. Waiting List, Delay/Cancellation Outpatient Appointments

This heading refers to delay or cancellation in securing an outpatient appointment, i.e. outpatient waiting lists. It is to be distinguished from '*Waiting Lists, Delay/Cancellation Community Based Appointments*' (32) and '*Waiting Times, Outpatient Departments*' (37).

34. Waiting List, Delay/Cancellation Planned Admission to Hospital

This refers to delay or cancellation of a planned admission to hospital, e.g. waiting list for surgery. Delayed admissions from A&E should not be included in this category but under '*Delayed Admission from A&E*' (15).

35. Waiting Times, A&E Departments

Complaints regarding waiting time for initial assessment or waiting time to be treated, should all be logged under this heading. Complaints about delayed admission from A&E are not included here but should be listed under '*Delayed Admission from A&E*' (15).

36. Waiting Times, Community Services

This heading refers to waiting time during delivery of community services. It would include such issues as erratic timing, failure of professional staff to turn up at the specified time for an appointment. It should be distinguished from '*Waiting Lists, Delay/Cancellation Based Appointments*' (32).

37. Waiting Times, Outpatient Departments

This heading refers to the time waiting at an outpatient appointment, other than at A&E. It should be distinguished from '*Waiting List, Delay/Cancellation Outpatient Appointments*' (33).

38. Other

This is a residual heading for any complaints, which do not fall into any categories listed above.

Column1
POC 1 Acute Services-ACUTE
POC 2 Maternal and Child Health-MATCHL
POC 3A (i) Complaints under Children Order-FAMCC1
POC 3B (ii) Complaints other than under Children Order
POC 4 Elderly Services-ELD
POC 5 Mental Health-MH
POC 6 Learning Disability-LD
POC 7 Sensory Impairment and Physical Disability- SENS
POC 8 Health Promotion and Disease Prevention - PROM
POC 9 Primary Health & Adult Community-PRIM
POC 10 None (No POC assigned)-NONE
POC 11 Prison HealthCare-PRISON

AE Accident & Emergency	
ALLHP Allied Health Professions	
ANAE Anaesthetics & Pain Management	Primary Health & Adult Community-PRIM
BLOOD Blood Transfusion	
BRPLMX Burns, Plastic and Maxillofacial Surgery	
CARDSU Cardiac Surgery	
CARD Cardiology	
PSYC Child & Adolescent Psychiatry	
CHSERV Children and Young People Services	
CLGEN Clinical Genetics	
COMNUR Community Nursing/Midwives	
COMPAE Community Paediatrics	
DAYCAR Day Care Services	
DENT Dentistry	
DERM Dermatology	
DOMIC Domiciliary Services	
ENT ENT	
GMED General Medicine	
GSUR General Surgery	
GENITO Genito-Urinary Medicine	
GERI Geriatric Medicine	
GYNAE Gynaecology	
HAEM Haematology (Clinical)	
INFECT Infectious Diseases	
JOCC Joint Consultant Clinics	
LEARND Learning Disability	
MHACU Mental Health Acute	
MHCOM Mental Health Community	
NEONAT Neonatology	
NEPH Nephrology	
NEURO Neurology	
NEUROSU Neurosurgery	
NUCMED Nuclear Medicine	
OBS Obstetrics	
OCCHEA Occupational Health Medicine	
PSYO Old Age Psychiatry	
ONCOL Oncology	
OPTH Ophthalmology	
OTHER Other	
PNEURO Paediatric Neurology	
PSUR Paediatric Surgery	
PAEDS Paediatrics	
PALLCA Palliative Care	
PATHO Pathology (Laboratory Services)	
PHARM Pharmacology	
PDISSS Physical Disability/Sensory Support	
RADIO Radiology	
REHAB Rehabilitation	
RESID Residential Care	
SUPPLI Supported Living	
THORSU Thoracic Surgery	
ORTH Trauma & Orthopaedics	
NURO Urology	
VSUR Vascular	
UNK Unknown	

AE Accident & Emergency
ALLHP Allied Health Professions
ANAE Anaesthetics & Pain Management
BLOOD Blood Transfusion
BRPLMX Burns, Plastic and Maxillofacial Surgery
CARDSU Cardiac Surgery
CARD Cardiology
PSYC Child & Adolescent Psychiatry
CHSERV Children and Young People Services
CLGEN Clinical Genetics
COMNUR Community Nursing/Midwives
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ENT ENT
GMED General Medicine
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GYNAE Gynaecology
HAEM Haematology (Clinical)
INFECT Infectious Diseases
JOCC Joint Consultant Clinics
LEARND Learning Disability
MHACU Mental Health Acute
MHCOM Mental Health Community
NEONAT Neonatology
NEPH Nephrology
NEURO Neurology
NEUROSU Neurosurgery
NUCMED Nuclear Medicine
OBS Obstetrics
OCCHEA Occupational Health Medicine
PSYO Old Age Psychiatry
ONCOL Oncology
OPTH Ophthalmology
OTHER Other
PNEURO Paediatric Neurology
PSUR Paediatric Surgery
PAEDS Paediatrics
PALLCA Palliative Care
PATHO Pathology (Laboratory Services)
PHARM Pharmacology
PDISSS Physical Disability/Sensory Support
RADIO Radiology
REHAB Rehabilitation
RESID Residential Care
SUPPLI Supported Living
THORSU Thoracic Surgery
ORTH Trauma & Orthopaedics
NURO Urology
VSUR Vascular
UNK Unknown

ACCTP	ACCTP Access To Premises
AAA	AAA Aids/Adaptions/Appliances
CO	CO Children Order Complaints
CLDIAG	CLDIAG Clinical Diagnosis
COMINF	COMINF Communication/Information
COMPLT	COMPLT Complaints Handling
CONFID	CONFID Confidentiality
CONSNT	CONSNT Consent to Treatment/Care
CRCHLD	CRCHLD Contracted Regulated Children's Services
CRDOMC	CRDOMC Contracted Regulated Domiciliary Agency
CRRESN	CRRESN Contracted Regulated Residential Nursing
CIHS	CIHS Contracted Independent Hospital Services
CSOTHR	CSOTHR Other Contracted Services
DCINPT	DCINPT Delay/ Cancellation for Inpatients
DADMAE	DADMAE Delayed Admission from A&E
DSCTRN	DSCTRN Discharge/Transfer Arrangements
DISCRM	DISCRM Discrimination
ENVIRO	ENVIRO Environmental
HSSS	HSSS Hotel/Support/Security Services (Excludes Contracted Services)
INFECT	INFECT Infection Control
MORTPM	MORTPM Mortuary & Post-Mortem
POLCD	POLCD Policy/Commercial Decisions
PRVDIG	PRVDIG Privacy/Dignity
PAN	PAN Professional Assessment of Need
PEF	PEF Property/Expenses/Finances
RECORD	RECORD Records/Record Keeping
SAB	SAB Staff Attitude/Behaviour
TRNSPL	TRNSPLTransport, Late or Non-arrival/Journey Time
TRNSPS	TRNSPS Transport, Suitability of Vehicle/Equipment
QUALTC	QUALTC Quality of Treatment & Care
QUANTC	QUANTC Quantity of Treatment & Care
WLCBA	WLCBA Waiting List, Delay/Cancellation Community Based Appointments
WLOPT	WLOPT Waiting List, Delay/Cancellation Outpatient Appointments
WLP AH	WLP AH Waiting List, Delay/Cancellation Planned Admission to Hospital
WTAE	WTAE Waiting Times, A&E Departments
WTCOMM	WTCOMM Waiting Times, Community Services
WTOPT	WTOPT Waiting Times, Outpatient Departments
OTHER	OTHER Other

ACCTP Access To Premises
AAA Aids/Adaptions/Appliances
CO Children Order Complaints
CLDIAG Clinical Diagnosis
COMINF Communication/Information
COMPLT Complaints Handling
CONFID Confidentiality
CONSNT Consent to Treatment/Care
CRCHLD Contracted Regulated Children's Services
CRDOMC Contracted Regulated Domiciliary Agency
CRRESN Contracted Regulated Residential Nursing
CIHS Contracted Independent Hospital Services
CSOTHR Other Contracted Services
DCINPT Delay/ Cancellation for Inpatients
DADMAE Delayed Admission from A&E
DSCTRN Discharge/Transfer Arrangements
DISCRM Discrimination
ENVIRO Environmental
HSSS Hotel/Support/Security Services (Excludes Contracted Services)
INFECT Infection Control
MORTPM Mortuary & Post-Mortem
POLCD Policy/Commercial Decisions
PRVDIG Privacy/Dignity
PAN Professional Assessment of Need
PEF Property/Expenses/Finances
RECORD Records/Record Keeping
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QUANTC Quantity of Treatment & Care
WLCBA Waiting List, Delay/Cancellation Community Based Appointments
WLOPT Waiting List, Delay/Cancellation Outpatient Appointments
WLPAAH Waiting List, Delay/Cancellation Planned Admission to Hospital
WTAE Waiting Times, A&E Departments
WTCOMM Waiting Times, Community Services
WTOPT Waiting Times, Outpatient Departments
OTHER Other

	Type Of Complaint	First received	Closed	Reopened	Response time	Directorate	Service Area	Site	Speciality	Subjects (Subjects)	Description (Policies)	Outcome code	Outcome	Action taken (Investigation)	Lessons learned	Loc (Exact)	Loc (Exact)	Current Stage	No. of Linked Incidents	Independent Lay Person used Y/N	Deceased	SAI	
15649	Formal HSC Complaint	02/08/2022	11/08/2022	n/a		7	Acute Services	Midwifery and Gynaecology	Daisy Hill Hospital	Gynaecology	Communication/Information	Resolved	Patient attended Gynae Clinic on Person A . On Person A she received two voicemail's from DHH. The first was to contact them ASAP and the second was to inform her that a prescription had been ordered on her behalf. Patient is annoyed over the time it took to advise her she had an infection and wants a full explanation as to why it took so long and also information of the type of infection.	apology for the delay in the results and subsequent delay in receiving antibiotics. The result was viewed and doctor on Person A and Dr asked secretary to contact GP for antibiotics to be prescribed. This did not occur until the Person A as the GP practice was only open for emergencies and secretary did not get through to GP beforehand. assurance given that if there had have been any serious infection the secretary would have contacted the consultant covering emergencies for advice and the OOH GP service for antibiotics but this is not necessary for a vaginal swab with a normal skin organism growth.	The Department is moving towards electronic reporting of results.	The communication could have been better. There was no clinicians name added to the swab which led to the delay in receiving result. this has been shared for learning with the medical staff the importance of adding a contact name on all lab samples.	Gynae Clinic	Gynae Clinic	Closed	0	n	n	
15590	Formal HSC Complaint	25/07/2022	01/08/2022	n/a		5	Acute Services	Emergency Department Services	Craigavon Area Hospital	Accident and Emergency	Quality of Treatment & Care	Resolved	Complainant attended ED CAH on Person A regarding mental health concerns and deliberate self harm. She advises Doctor did not treat her wounds correctly and the majority have now reopened and she is now at risk of infection.	Consultant in Emergency Medicine is sorry that patient does not feel that wounds were not managed appropriately. The Consultant advises that there are numerous ways to close wounds and at the time of attendance the Doctor who assessed patient felt that the wounds were best managed with tissue adhesive and steristrips. The Consultant explains that sometimes inserting stitches applies tension to nearby wounds making it more difficult to close all of them. The Doctor felt steristrips and tissue adhesive would work best and the wounds were not deep enough to require a suture or staple. The Consultant sincerely apologises that the majority have reopened as this is not the outcome they would want but is a recognised complication.	No action to be taken.	None.	Emergency Department CAH	Emergency Department CAH	Closed	0	n	n	
15632	Formal HSC Complaint	28/07/2022	10/08/2022	n/a		9	Acute Services	Emergency Department Services	Daisy Hill Hospital	Accident and Emergency	Staff Attitude/Behaviour	Resolved	Complainant attended ED DHH on Person A with her young son. She felt that a Doctor did not take her seriously when explaining her sons symptoms and was very patronising. She had to return to ED on Person B with her son with the same symptoms and her son has since been admitted to RVH.	Dr acknowledges that his intention to reassure came across as being dismissive. Your feedback is a helpful reminder that an ill-judged attempt to calm a worried parent can come across as disregarding their concerns, especially if all concerns haven't been explored in sufficient depth. Furthermore, it is useful evidence of the importance of a worried parent when assessing an unwell child. The Consultant advises he is working on introducing a more structured assessment and documentation for young children who present with a febrile illness as per NICE Guideline NG51 and NG143 (attachments provided). The Consultant advises that the complaint should help with identifying subtle clues that suggest that a child is not as well as they seem and prompt for further investigation. The Consultant notes that since your complaint patient has been discharged from The Royal Belfast Hospital for Sick Children and would like to wish him well as he continues to recover.	Consultant is working on a more structured assessment and documentation for children presenting with febrile illness as per NICE guidance.	Doctor has reflected on his manner and will endeavour to be more empathetic to patients and their parents concerns.	Emergency Department DHH	Emergency Department DHH	Closed	0	n	n	
15632	Formal HSC Complaint	28/07/2022	10/08/2022	n/a		9	Acute Services	Emergency Department Services	Daisy Hill Hospital	Accident and Emergency	Professional Assessment of Need	Resolved	Complainant attended ED DHH on Person A with her young son. She felt that a Doctor did not take her seriously when explaining her sons symptoms and was very patronising. She had to return to ED on Person B with her son with the same symptoms and her son has since been admitted to RVH.	Dr acknowledges that his intention to reassure came across as being dismissive. Your feedback is a helpful reminder that an ill-judged attempt to calm a worried parent can come across as disregarding their concerns, especially if all concerns haven't been explored in sufficient depth. Furthermore, it is useful evidence of the importance of a worried parent when assessing an unwell child. The Consultant advises he is working on introducing a more structured assessment and documentation for young children who present with a febrile illness as per NICE Guideline NG51 and NG143 (attachments provided). The Consultant advises that the complaint should help with identifying subtle clues that suggest that a child is not as well as they seem and prompt for further investigation. The Consultant notes that since your complaint patient has been discharged from The Royal Belfast Hospital for Sick Children and would like to wish him well as he continues to recover.	Consultant is working on a more structured assessment and documentation for children presenting with febrile illness as per NICE guidance.	Doctor has reflected on his manner and will endeavour to be more empathetic to patients and their parents concerns.	Emergency Department DHH	Emergency Department DHH	Closed	0	n	n	
15674	Formal HSC Complaint	03/08/2022	04/08/2022	n/a		1	Acute Services	Diagnostic Services	Craigavon Area Hospital	Imaging - All other	Quality of Treatment & Care	Closed - other reasons	Patient went into hospital with a lung infection. On Person A he was sent for an x-ray and to have feeding tube repositioned. The tube was put directly into his lung instead of his stomach. Patient is now in ICU. Complainant wants to know how all protocols failed, how this happened and why the x-rays were not looked at properly.	Going through the SAI process.	none required	none required	X-ray Dept (Radiology)	X-ray Dept (Radiology)	Closed	0	n	n	yes Person A
15479	Formal HSC Complaint	01/07/2022	04/08/2022	n/a		23	Acute Services	General Medicine	Craigavon Area Hospital	General Medicine	Staff Attitude/Behaviour	Resolved	Patient not happy with attitude of junior doctor when she recently attended CAH ED by ambulance following an epileptic seizure.	apology for the dismissive nature of the doctor and the doctor has reflected on their behaviour.	Doctor spoken to by Senior Consultant	Doctor has reflected on attitude and will endeavour to improve this for others.	Emergency Department CAH	Emergency Department CAH	Closed	0	n	n	
15528	Formal HSC Complaint	13/07/2022	10/08/2022	n/a		20	Acute Services	Emergency Department Services	Craigavon Area Hospital	Accident and Emergency	Other	Resolved	Patient was an inpatient on Person A and advises he was informed by one of the other patients that during the night a male patient from the next room had entered the ward and crawled around the floor then sat on the floor until found by a Nurse. Patient spoke with ward sister and was advised this is normal behaviour and nothing could be done to prevent it happening again.	The Sister reported that as this incident happened on a night shift it was brought to her attention the following day and the Sister advised she apologised to service user for the incident and for the other patient's behaviour. Requested that she provide 1:1 nursing or else provide security, the Sister assured you that this was not required. The Sister apologised and agreed that although the other patient's behaviour was indeed very strange, he had caused no actual harm to anyone. The Sister reported she also told you that she would endeavour to ensure it did not happen again. The Sister added she spoke to you in a professional and mannerly tone at all times and provided you with a copy of the complaints procedure. The Sister stated that patient also requested to speak to the Ward Manager and she relayed this request. The Ward Manager was informed of the issue by the Sister and the Ward Manager spoke to you and listened to your concerns. The Ward Manager provided reassurance, empathised and explained the situation. The Sister confirmed she apologised that you had to encounter this and felt that the issue had been resolved at the end of the conversation.	none required	none required	AMU	AMU	Closed	0	n	n	



GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	8 th September 2022	
Agenda item	Clinical and Social Care Governance Report	
Accountable Director	Interim Medical Director - Dr Damian Scullion	
Report Author	Name	Caroline Doyle
	Contact details	Personal Information redacted by the USI
This paper is presented for: Information		
Links to Trust Corporate Objectives	☒	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

	<i>This report cover sheet has been prepared by the Accountable Director.</i> <i>Its purpose is to provide the Trust Committee with a clear summary of the paper being presented, with the key matters for attention and the ask of the Committee.</i> <i>It details how it impacts on the people we serve.</i>
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1. Detailed summary of paper contents:

The purpose of this paper is to provide a report to Governance Committee (September 2022) on a number of Trust Clinical and Social Care Governance Performance Indicators. This report provides information on Incident Reporting, SAIs, Catastrophic Incidents, Patient Safety and Quality Measures, Service User Feedback and Ombudsman cases.

- The format of this report to Governance Committee will evolve during 2022/23 as the assurance mechanism to Governance Committee is revised with the introduction of a Quality and Safety Group. The purpose of that group is to provide intelligence, rather than data, to the Governance Committee; to assist with the triangulation of data by drawing links and associations between data from different sources; to ensure that issues of concern are highlighted to the Governance Committee and to answer the question 'is healthcare getting safer across your organisation and what measures do you have to show this?'
- The first development to date is the introduction of Appendices B, C and D to this report - Breakdown of all CCS2 codes by Severity; SPC Charts detailing length of time to submit SAI report by Directorate and Cancer Access Standard Performance Data. These introductions provide useful performance indicators to Governance Committee.

2. Areas of improvement/achievement:

- Appendices B, C and D are newly introduced to this report

3. Areas of concern/risk/challenge:

- Seek approval to review the MEAN in the SPC to reflect the increase in incident reporting, particularly after April 2021
- In relation to Moderate Maternity incidents (Page 8), an additional SPC chart was run which displayed 2 Upper Control Limit breaches in May and June 2022. In addition to this the SPC has shown a "Shift" which means that since June 2021, there were more than 7 sequential points which fall above the MEAN. This is unusual and indicates a significant change in process.
- Major graded incidents (Page 9) the SPC chart has shown a 'Shift' which means that, up until May 2022, there were more than 7 sequential points which fall above the MEAN. This is unusual and indicates a significant change in process.

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	This links to the risk of harm to the SHSCT population through inability to access safe, timely and appropriate care.
Board Assurance Framework	Yes
Equality and Human Rights	No

Clinical and Social Care Governance Report September 2022



Contents

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2.0 Incident Reporting – Page 4

3.0 Service User Feedback (Complaints) – Page 35

4.0 Service User Feedback (Compliments) – Page 47

Appendix A – Patient Safety Indicators

Appendix B – Breakdown of all CCS2 codes by Severity

Appendix C – SPC Charts detailing length of time to submit SAI report by Directorate

Appendix D – Cancer Access Standard Performance Data

Appendix E – Emergency Care Waiting Times

Appendix F – Healthcare Complaints Analysis Tool (HCAT)

1.0 Purpose of Report

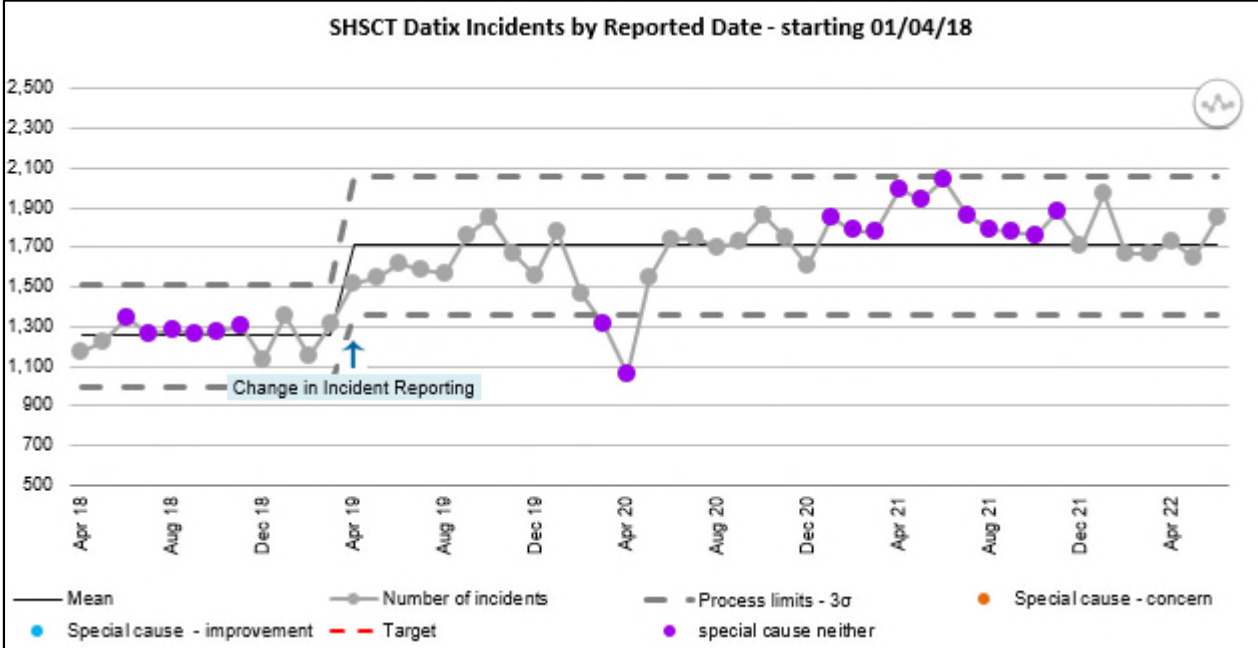
This report is to provide information to Trust Governance Committee regarding the Clinical and Social Care Governance performance indicators agreed by the Trust Senior Management Team:

- ❖ **Incident monitoring to include Serious Adverse Incident and reporting timeframes**
- ❖ **Patient safety & quality measures**
- ❖ **Complaint monitoring**
- ❖ **Compliment monitoring**

The report analyses activity for the period **1st April 2022 – 30th June 2022 (Quarter 1)**, with the exception of Patient Safety & Quality measures which are for the previous quarter **1st January – 31st March 2022 (Quarter 4)**, please see Appendix A. Incident reporting is essential for the Trust to learn about unintended or unanticipated occurrences in patient care. Recognising and reporting an incident (or near-miss), no matter the level of harm, is the first step in learning to reduce the risk of recurrence.

To set the wider context, this quarterly reporting period – **01/04/2022 to 30/06/2022** - reports on Clinical and Social Care Governance performance indicators during the CoronaVirus pandemic period.

2.0. Incident Reporting (via Datix)¹

2.1 Total No. Incidents Logged via Datix	Figure 1.0 – Total SHSCT Incidents by Month 01 April 2018 – 30 th June 2022.
Overall Trust Position In Q1 2022/23 - SHSCT directorates reported: 5234 IR1 incidents - Forecast for 2022/23 – 20,936 IR1 incidents 2021/22 – 22,045 IR1 incidents 2020/2021 – 20,153 IR1 incidents 2019/2020 - 19,207 IR1 incidents 2018/2019 - 15,043 IR1 incidents The reporting of incidents in this quarter shows normal variation with no significant change. However, compared to pre April 2021, there has been an increase in incident reporting which suggests the mean in the SPC needs to be reviewed.	 SHSCT Datix Incidents by Reported Date - starting 01/04/18 Legend: - Mean - Number of incidents - Process limits - 3σ - Special cause - improvement - Target - Special cause - concern - special cause neither

¹ Monthly incidents are now reported on the basis of the date on which the incident was reported via Datix and not the date that the incident occurred.

Figure 2.0 Operational Directorate Monthly Datix Incidents 01 April 2018 – 30th June 2022.

Directorate Position

Acute share 41% of the 5234 incidents reported this quarter (n=2145).

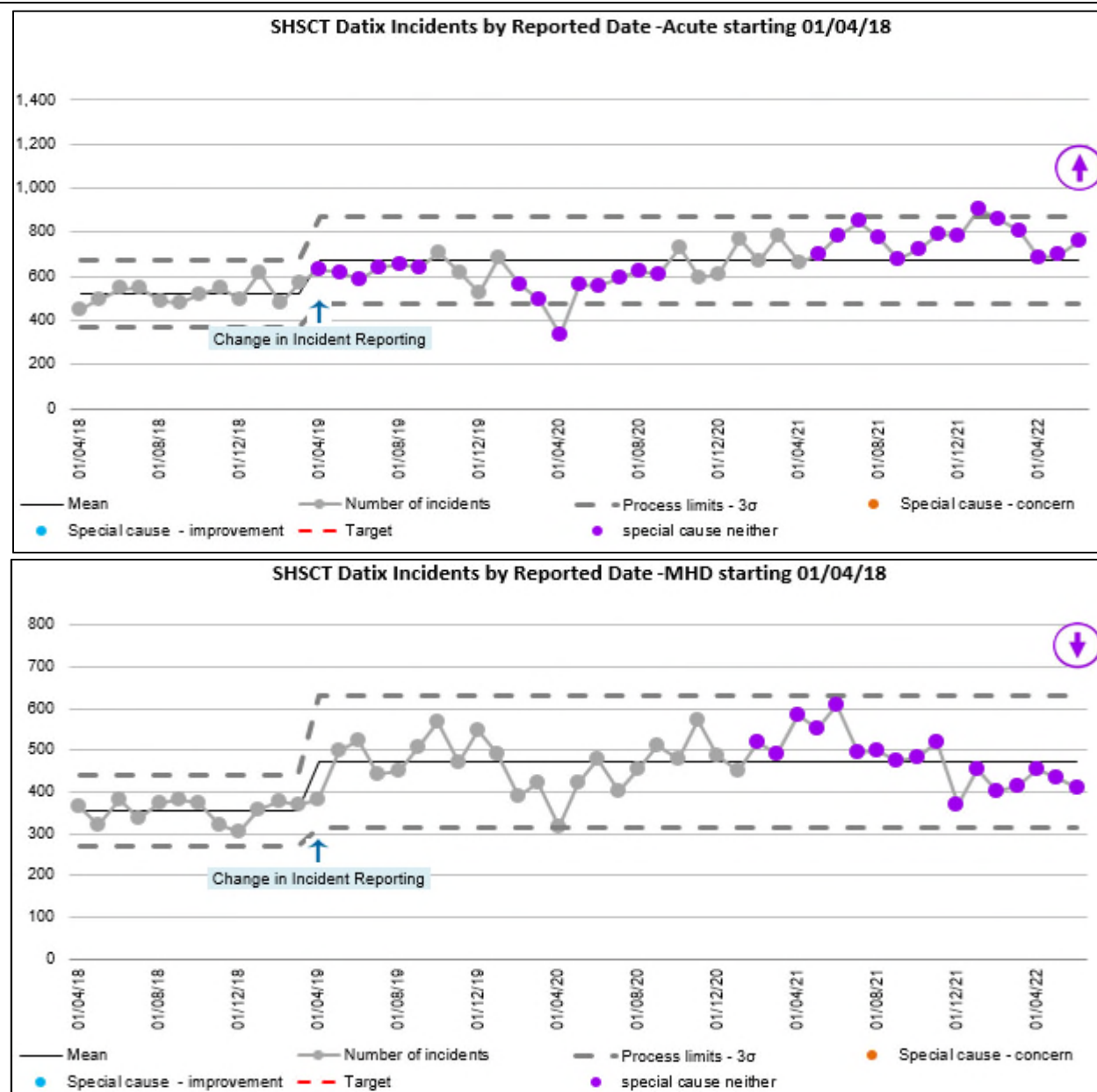
There has been a decrease in reporting within Acute services in this quarter from 2571 to 2145 (16.6% decrease). Incidents numbers return to within the Upper and Lower control limits, however the SPC chart has shown a 'Shift' which means there are more than 7 sequential points which fall above the MEAN, this is unusual and indicates a significant change in process.

Within the Acute services reporting has been consistently above the mean for an extended time period (18 consecutive months). This would reflect a culture of improved reporting within the directorate.

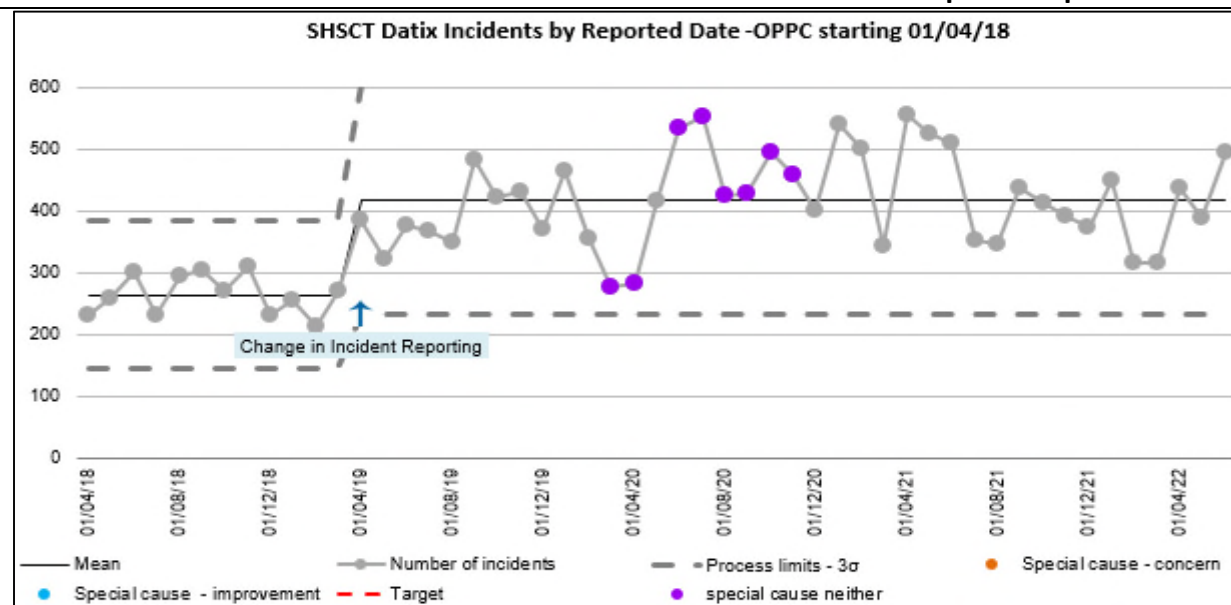
Within the time period there has been 18 months consecutively above the mean 13760 incidents have been reported. Of these incidents 88% were graded as insignificant or minor, 10% were graded as moderate and 2% graded as major or catastrophic.

MHD share 25% of the 5234 incidents reported this quarter (n=1297).

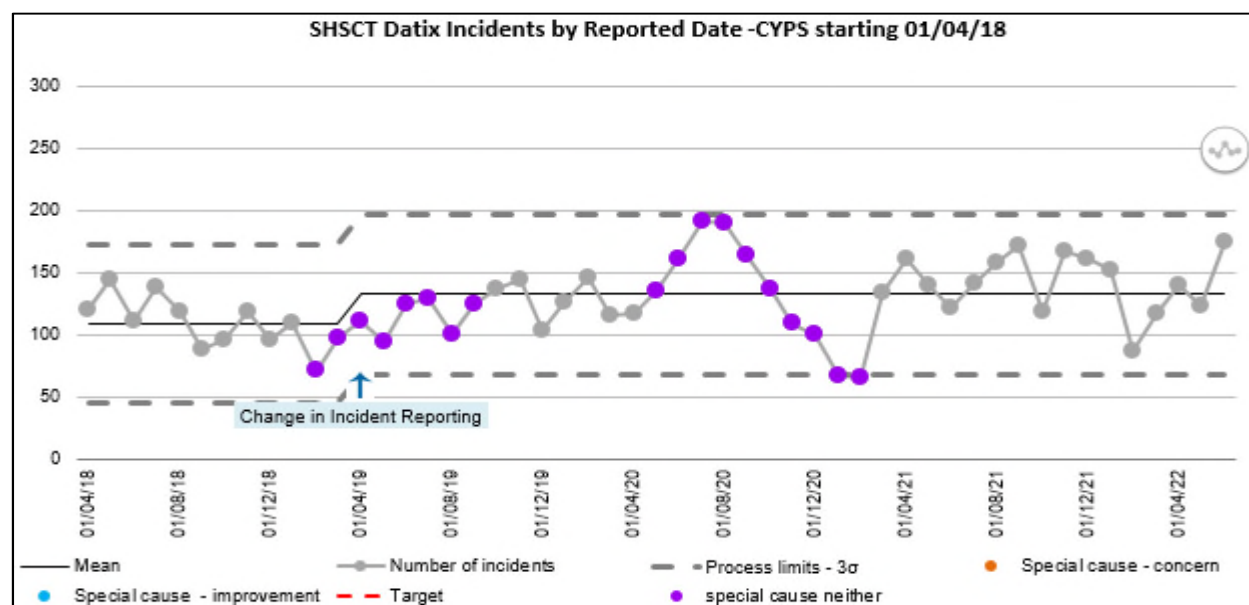
There is no change in the number of incidents reported this quarter and numbers remain within normal variation. The SPC chart illustrates 7 consecutive points below the MEAN, which followed a previous shift above the MEAN. This indicates instability in reporting but with an overall significant decrease in the past 7 months.



OPPC share 25% of the 5234 incidents reported this quarter (n=1325).
The reporting of incidents in this quarter shows normal variation with no significant change.



CYPS share 8% of the 5234 incidents reported this quarter (n=439).
The reporting of incidents in this quarter shows normal variation with no significant change.



2.2 Incident Severity²³**Q1 2021/2022 (April - June 2022)****51.1% of SHSCT IR1 Incidents categorised as severity 'Insignificant'**

In this quarter the number of Insignificant incidents remained within a normal variation. However, 583 (21.7%) out of 2680 incidents remain uncoded which means they cannot be themed appropriately:

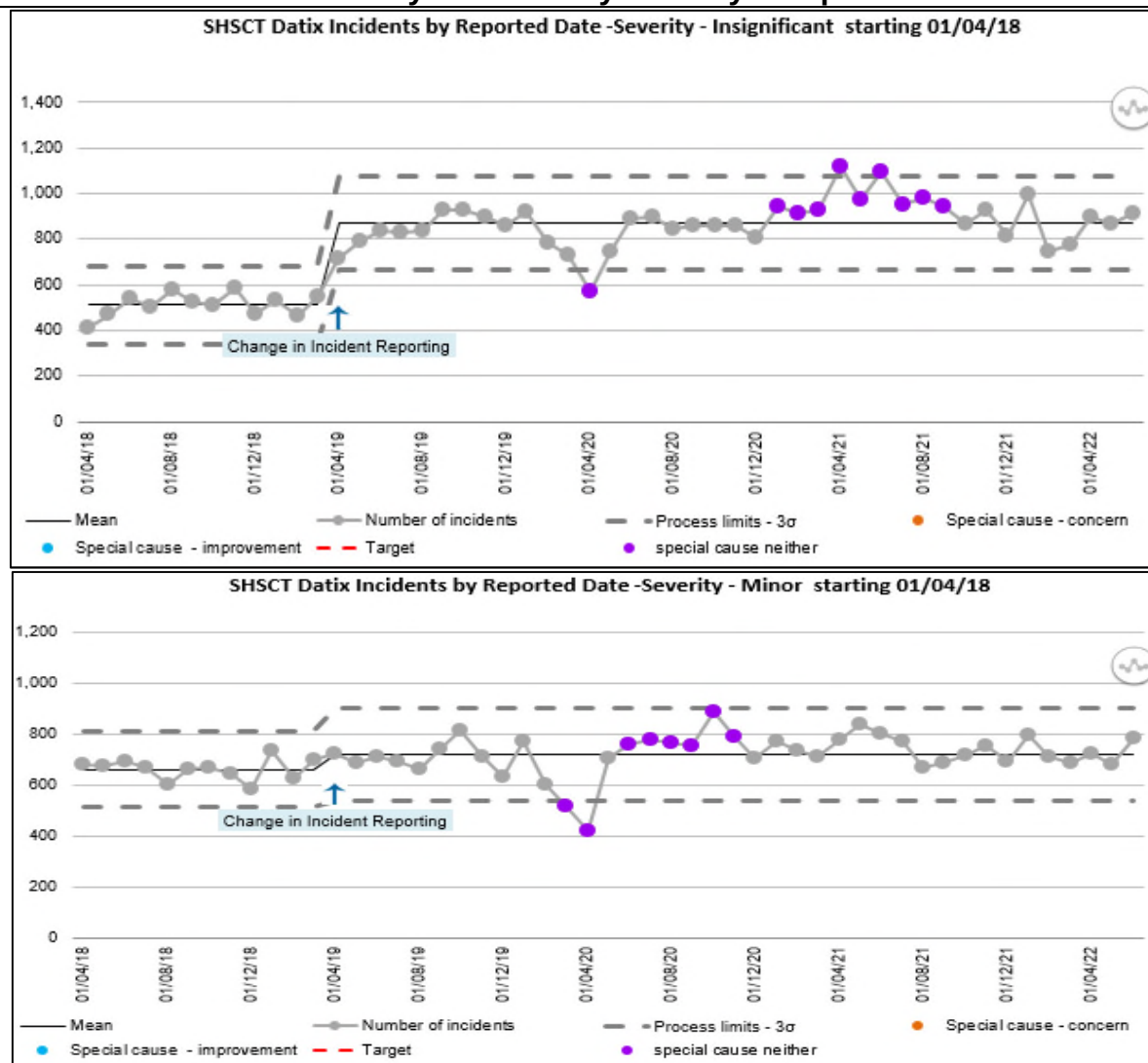
- Patient Behaviour – 677
- **Uncoded – 583**
- Patient Accidents/Falls – 505
- Violence and Aggression against staff – 260
- Medication – 240

The number of uncoded incidents makes comparison of how themes have moved from previous quarters difficult. On this occasion the top 5 themes remain consistent to the previous quarter.

41.8% of SHSCT IR1 Incidents categorised as severity 'Minor'

In this quarter the number of Minor incidents remained within a normal variation. However, 503 (23%) out of 2187 of these incidents remain uncoded which has impacted on the top 5 themes:

- **Uncoded – 503**
- Patient Accidents/Falls – 314
- Patient Behaviour - 281
- Medication – 192
- Pressure Ulcers – 153

Figure 3.0 - Total SHSCT Monthly Incidents by Severity 01 April 2018 – 30th June 2022

² Includes incident Severity for 'unapproved incidents' (2021) which could be subject to change on final approval of the incident

³ A full breakdown of all CCS2 codes by Severity is detailed in Appendix B

As previously stated, the number of uncoded incidents makes comparison of how themes have moved from previous quarters difficult. In this, quarter the number of Exposure to Environmental Hazards (n-117) has decreased from last quarter and does not appear in the top 5, however this has potentially been impacted by the volume of uncoded incidents.

5.8% of SHSCT IR1 Incidents categorised as severity 'Moderate'

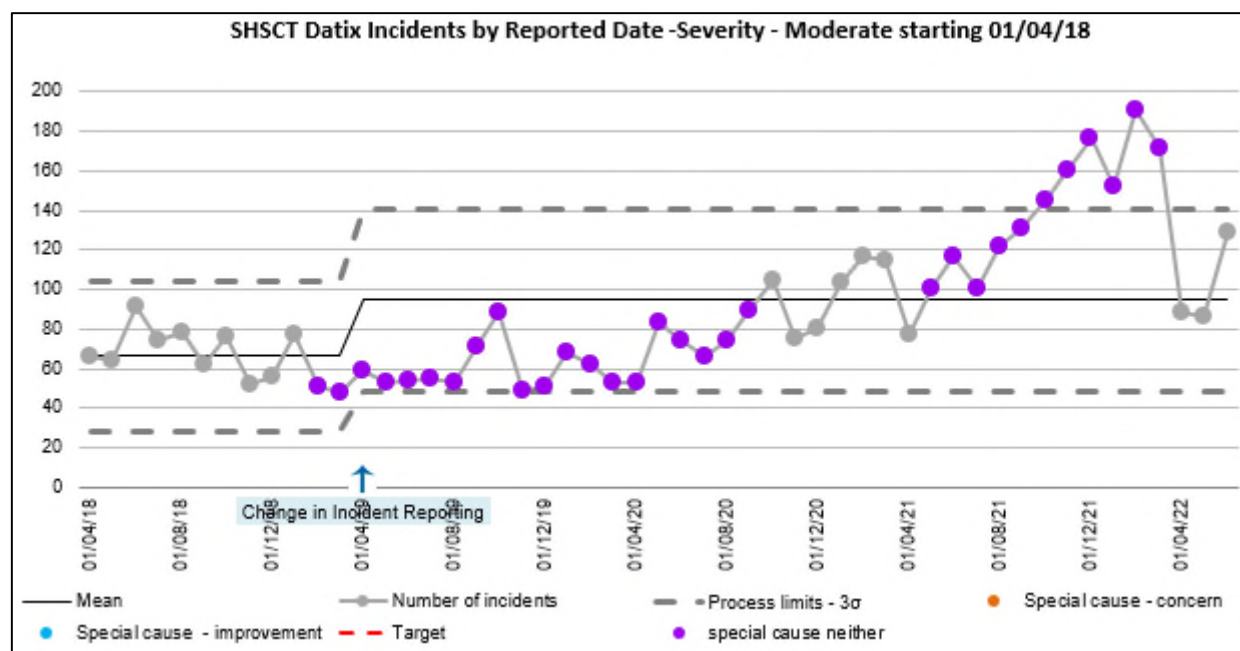
In this quarter the number of Moderate incidents remained within a normal variation. However, 111 (36.6%) out of 303 of these incidents remain uncoded which has impacted on the top 5 themes:

- **Uncoded - 111**
- Maternity Care – 40
- Exposure to Environmental Hazards - 16
- Patient Accidents/Falls – 22
- Patient Behaviour - 11

As previously stated, the number of uncoded incidents makes comparison of how themes have moved from previous quarters difficult. The potential impact of uncoded incidents could change any of the above themes when coded as illustrated in Appendix B.

In this quarter incident reporting of Moderate incidents has decreased compared to the last quarter., This is attributable to the number of Exposure to Environmental Hazards incidents which have decreased from 192 in the previous quarter to 16 in this reporting quarter. There were 40 Maternity Care incidents reported in the last quarter.

Obstetrics is a high risk service area and therefore has a greater potential for higher graded incidents. The Royal College of Obstetricians and Gynaecologists (RCOG) have a set trigger list of Obstetric events which require to be logged on



Datix, many of these would reach the grading of moderate.

0.9% of SHSCT IR1 Incidents categorised as severity 'Major'

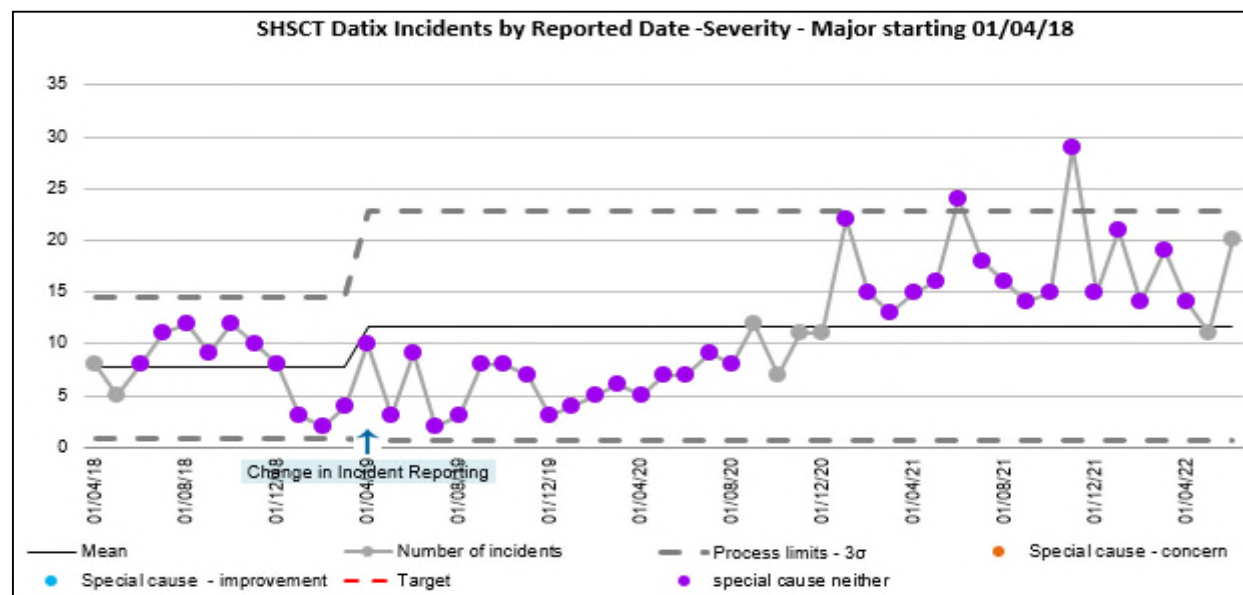
In this quarter the number of Major incidents remained within a normal variation. However, 26 (57.7%) out of 45 of these incidents remain uncoded which has impacted on the top 5 themes:

Top 5 themes for Major graded incidents:

- **Uncoded – 26**
- Therapeutic Processes/Procedures – 4
- Diagnostic Processes – 4
- Medication – 4
- Maternity Care - 3

Of the remaining 4 incidents, 2 are attributed to Behaviour, 1 to Patient Accident/Falls and 1 to 'Other'. Unfortunately the majority of these incidents are not coded but an initial analysis confirms these incidents are for the Acute Directorate and range over a number of themes including service pressures, incidents from commissioned activity, and hospital acquired Covid.

The SPC chart has shown a 'Shift' which means that, up until May 2022, there were more than 7 sequential points which fall above the MEAN. This is unusual and indicates a significant change in process.



0.4% of SHSCT IR1 Incidents categorised as severity 'Catastrophic'

In this quarter the number of Catastrophic incidents remained within a normal variation, with 2 (10.5%) out of 19 incidents uncoded, which would not significantly impact on the Top 5 themes.

Top 5 themes for Catastrophic graded incidents:

- Patient Behaviour – 7
- Unexpected Death/Severe Harm – 6
- **Uncoded – 2**
- Other – 2
- Therapeutic Processes/Procedures – 1

The remaining incident in this category relates to Anaesthesia Care (1). A breakdown of the Catastrophic incidents is provided in Table 2 below, which includes the 2 uncoded incidents.

Table 1.0 provides the breakdown of all SHSCT catastrophic incidents by Directorate since April 2020.

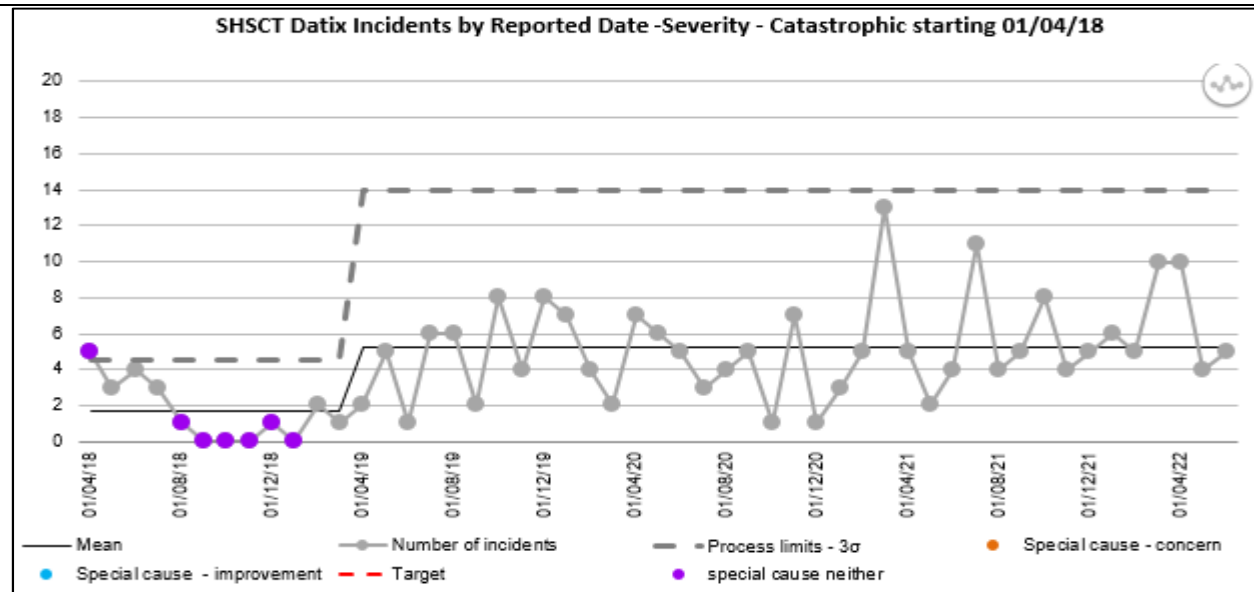


Table 1.0 SHSCT Catastrophic incidents by Directorate (Apr 2020 – Jun 2022)

Catastrophic Incidents	Apr - Jun 20	July - Sept 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21	July - Sept 21	Oct - Dec 2021	Jan - Mar 2022	Apr - Jun 22	Grand Total
Acute Services	4	3	3	9	6	14	10	9	7	65
CYPS	0	1	0	2	0	1	0	0	1	5
MHD	11	8	6	6	4	5	6	8	10	64
OPPC	2	1	0	4	1	0	1	4	1	14
Grand Total	17	13	9	21	11	20	17	21	19	148

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Table 1.1 details overall proportion of incidents in each severity category from 2017/18 to 2021/22 and forecast for 2022/23

Table 1.1 Percentage Incidents per Severity (2017/18 – 2022/23)

Year % Severity	Insignificant	Minor	Moderate	Major	Catastrophic
% 2017/18	35.34%	57.75%	6.13%	0.57%	0.20%
% 2018/19	40.85%	52.96%	5.32%	0.61%	0.13%
% 2019/20	52.48%	42.93%	3.87%	0.35%	0.30%
% 2020/21	49.93%	43.30%	5.69%	0.74%	0.34%
% 2021/22	50.80%	40.44%	7.46%	0.98%	0.31%
% 2022/23	51.20%	41.78%	5.79%	0.86%	0.36%

Table 1.2 Details Total Trust Incidents by year, by severity.

Table 1.2 Total Incidents per Year by Severity (2017/18 – 2022/23)

FY	Insignificant	Minor	Moderate	Major	Catastrophic	Unallocated	Grand Total
2017/18	4671	7634	810	75	27	2	13219
2018/19	6145	7967	801	92	20	18	15043
2019/20	10080	8245	743	68	58	13	19207
2020/21	10063	8728	1146	149	69	1	20156
2021/22	11199	8915	1645	216	69	1	22045
2022/23	10720	8748	1212	180	76	0	20936

2.2 Incident Severity Cont'd - Catastrophic Incidents and SAI Notifications

Between 1st April 2022 – 30th June 2022 – 19 catastrophic incidents (0.4%) were recorded. A total of 26 SAI Notifications have been submitted to HSCB.

Summary: Total Number 34

Catastrophic Incidents during this reporting timeframe, not SAI – 8 (one of these is a BHSCT led SAI)

Catastrophic Incidents during this reporting timeframe and reported as an SAI – 11

Catastrophic Incident reported on Datix outside of this reporting timeframe and reported as an SAI – 3

Other, non-catastrophic Incidents reported during this timeframe as SAI's – 12 (1 insignificant, 5 minor, 4 moderate and 2 major)

Table 2.0 – Catastrophic Incidents and / or SAI's notified to the SPPG by Directorate

ID	Incident date	Date Notification Sent to External Agency	Explanation for Delay of reporting of incident if applicable	Description	Directorate	Severity	SAI	Immediate Learning and/or Actions Taken
Personal information redacted	Personal information redacted by the USI							
		27/05/2022	Internal review of incident through governance and professional lines of allegation against medical staff.	Patient alleges sterilisation at CS was completed without her consent.	Acute Services	Moderate	Yes	Internal review of theatre processes and culture. Reviewing the number of cases over the last 3 years where both procedures have taken place at the same time. Escalated to Doctors and Dentists oversight group.
		15/04/2022	Screening Process ⁴	Unresponsive 4.5 year old Patient brought to ED by ambulance, intubated and decision for time critical transfer to PICU made at 01.20hours, transfer did not happen until 04.10 hours. Patient Personal information redacted by the USI in PICU	Acute Services	Catastrophic - reported last period	Yes	This is a complex case which will require a detailed joint review by SHSCT and BHSCT.

⁴ In the Acute Directorate incidents are screened on a weekly basis for each division. Each division has a separate screening meeting. To ensure the screening process is rigorous the screening teams consist of DMD/AD/CDs/HOS and Acute Governance Co-ordinator/Manager. The screening process involves collating all relevant information to enable the screening teams to make a rationale decision whether the incident meets the threshold for SAI criteria. At times the screening team may request expert assistance from other bodies within the Trust to assist with the screening process. Many of the Trust's incidents are interlinked with other Departments/Directorates/ Trusts and often require additional time to collate further information before a formal decision can be agreed.

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Personal information redacted by the USI	21/06/2022	Screening Process ⁴	Delays in the management of a patient attending with a suspected transient ischaemic attack (TIA). Subsequent medication error identified.	Acute Services	Moderate	Yes	None
Personal information redacted by the USI	06/06/2022	The Trust is undertaking a review audit of the Cardiac Investigations referrals from April 2021 to April 2022.	Omitted cardiac investigations referrals to the TOMCAT system; 1104 managed cardiac investigations outside of prescribed timeframe	Acute Services	Minor	Yes	1) Inadequate checks within the referral process, new checks and balances processes now implemented. 2) A review audit of the Cardiac Investigations referrals from April 2021 to April 2022. 3) The operational and informatics teams have developed a report that captures the time sensitive detail within the managed referral category. This will facilitate early identification of managed tests outside of their specified timeframe and allow the implementation of action plans to prevent a similar backlog occurring in the future.

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Personal information redacted

Personal information redacted by the USI	21/06/2022	This is a 2019 case. It was managed at the time by the Clinical Director and discussed at M&M. Subsequent screening in 2022 identified this is a never event.	Patient had thoracic pain and suspected diagnosis of metastatic lung malignancy. Wrong lung aspirated and pneumothorax caused.	Acute Services	Major	Yes	Case discussed with doctor at the time of incident. Reflective practice carried out.
	18/05/2022	The BHSCT recently brought this 2019 incident to the attention of the SHSCT through an interface incident report. The SHSCT reviewed the case through its normal screening process and a decision was made to complete a level 2 SAI.	Cancer patient who was being managed by BT attended a ST ED. Patient not commenced on pathway to manage chemotherapy related diarrhoea. No communication with the treating Oncology team in Belfast regarding admission or ongoing management.	Acute Services	Catastrophic	Yes	All patients are educated on side effects of treatment prior to commencing Systemic Anti-Cancer Therapy (SACT) and what symptoms they should report immediately. Staff re-educated in relation to processes which should be followed if a patient presents with side effects of SACT.
	27/05/2022	Datix 27/01/2022 Complaint 18th May 2022 Screening of incident from 19/05/2022. Timeline of incident created and presented at	Delay in the recognition of chorioamnionitis on CTG, baby admitted to neonatal unit and treated for sepsis.	Acute Services	Minor	Yes	Learning will be identified through SAI process.

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			next screening meeting – SAI confirmed.					
Personal information redacted	Personal information redacted by the USI	27/05/2022	Screening Process ⁴	Elective C Section returned to theatre for small bowel obstruction = loop of small bowel herniation.	Acute Services	Moderate	Yes	Learning to be identified during SAI.
		28/06/2022	Recent complaint received by the SHSCT highlighted incident. Previously reviewed under a Datix review at time of incident however extent of injuries and potential learning therefore completing level 1 SAI	Baby handed to mother to feed, mother feel asleep and baby feel on floor. Diagnosed bilateral depressed skull fracture and bilateral subgaleal haemorrhages. Baby has since meet developmental milestones	Acute Services	Minor	Yes	No learning as management was appropriate with transfer to RBHSC.
		21/06/2022	Screening Process ⁴	Patient required to have a TOE procedure, during same procedure patient had 6mg of midazolam administered by accident (using high concentration midazolam vial 5mg/ml), post administration patient became vague resulting in 150mcg flumazenil to be administered to reverse drowsiness.	Acute Services	Minor	Yes	Patient given medication to reverse the effects of midazolam.

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Personal information redacted by the USI	15/06/2022	Notification prepared for 29/4/2022 but due to staff absences notification not forwarded to corporate office.	Patient attended ED 22 weeks pregnant and was discharged with oral Antibiotics. Contacted to re-attend ED following morning, pt admitted to ICU with sepsis, Personal Information redacted by the USI .	Acute Services	Moderate	Yes	Early recognition of signs of sepsis in pregnancy, poster being designed for pts/staff. All pregnant women must attend Maternity Assessment Unit for triage unless presenting in a collapsed state or being unable to converse due to SOB
	N/A	N/A	Patient transferred from ward 3 south with icu team for resuscitation and possible transfer to ct for scan and maybe possible laparotomy. Patient was critically ill. Unfortunately patient's condition deteriorate very rapidly and icu consultant withdrew treatment. Patient's husband was with her when she Personal Information redacted by the USI .	Acute Services	Catastrophic	No	29.06.22 -Discussed at SEC screening. No issues re management of a futile situation. Has been reviewed by 2 ICU consultants. Plan: To be discussed at ICU M&M. Will possibly need to go to other M&M's depending on the outcome of ICU M&M.
	N/A	N/A	This case was presented by the Medical M&M Chair Dr Andrew Murdock on behalf of the locum consultant who is no	Acute Services	Catastrophic	No	13/06/2022 Discussed at Medicine screening. Agreed a thorough review was completed through

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				longer working within the Trust. The Chair outlined the clinical background was outlined as above on this patient who was admitted with extreme weight loss due to self-neglect over previous few months, to extent the patient's teeth had been falling out. Supportive feeding was commenced and a CTPA showed three pulmonary nodules within the left lower lobe and recommended follow-up. An OGD was performed which revealed oesophagitis. While in Ramone Ward 4, the patient tested positive for C Difficile and oxygen requirements also increased. The patient was not suitable for ICU intervention and comfort care was commenced. Personal information redacted by the USI				Post Infection Review (PIR), learning identified and has been actioned and shared. It was agreed completing a SAI was not required as PIR process review was completed and learning identified and shared.
Personal information redacted by the USI	Personal information redacted by the USI	N/A	N/A	Patient transferred from 1 north with cardiogenic shock. PCI carried out which resulted in acute stent thrombosis resulting in no flow in the	Acute Services	Catastrophic	No	Personal information redacted by the USI lady 11.4.22 - Discussed at MUC and ED screening - Patient should have been sent to Cath Labs. Most stable patient

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				coronary artery. Patient had a cardiac arrest and subsequently Personal Information redacted by the USI .				should have been moved to allow transfer. For Cardiology and ED M&M. Issue with transfer to ward. Await M&M outcome
Personal information redacted	Personal Information redacted by the USI	N/A	N/A	Interface incident. Personal Information redacted by the USI with history of Alzheimer's disease, type 2 diabetes mellitus and falls (previous fall-related traumatic subarachnoid and subdural haemorrhage). Commenced on clopidogrel in 2020 after a TIA. Patient attended Lagan Valley ED with leg swelling on Personal Information redacted by the USI and was given enoxaparin and to return for imaging. According to GP OOH and Craigavon ED the patient returned to Lagan Valley for a second dose of enoxaparin on the evening of Personal Information redacted by the USI. Later that evening the patient had a severe onset headache and vomiting and "fell asleep". Admitted to CAH ED with catastrophic intracranial haemorrhage.	Acute Services	Catastrophic	No	Interface incident raised with the SPPG with proposal for SEHSCT to lead on the investigation of this incident. SPPG have reviewed and confirmed this incident will not require an SAI review.

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				Fatal haemorrhage following enoxaparin therapy for suspected DVT Datix aligned to IMES d/b number (3020)				
Personal information redacted by the USI	Personal information redacted by the USI	N/A	N/A	Patient transferred from operating table to ICU bed. Noted that the arterial line trace was poor. Observations consistent with peri arrest.	Acute Services	Catastrophic	No	11/05/2022 discussed at SEC screening, case reviewed. [redacted], very frail pt, upper GI bleed, all treatment and care appropriate, present case at ICU M&M.
		N/A	N/A	Summary details taken from notes as staff gone off duty - night shift: Patient admitted from ED to Emergency Theatre @20:05 [redacted] for intubation and ventilation following suicide attempt patient self reported ingested weedkiller Praquat & Bleach & alcohol consumption. OGD, Flexible Bronchoscopy Direct laryngoscopy. ENT assessment. CT scan & consultation with Belfast- following advice & discussion insurmountable	Acute Services	Catastrophic	No	29.06.22 -Discussed at SEC screening. Catastrophic for patient who consumed weed killer, bleach and alcohol, No issues re management of a futile situation. Pt was lying at home for 12 + hours before coming into hospital, severe larynx burns and went for CT. Outcome would not have been any different for patient no matter where he was cared for or in which hospital he was in. To be discussed at ICU

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				damage no surgical intervention, NOK informed. Personal Information redacted by the USI				M&M.
Personal Information redacted by the USI	Personal Information redacted by the USI	24/06/2022	Establishing level of services involved and CYPs SMT approval process of notification	A Personal Information redacted by the USI , attended Craigavon Area Hospital Emergency Department (ED) on the evening of Personal Information redacted by the USI following an attempted hanging at his home. XX was in cardiac arrest and was intubated in ED prior to being transferred to PICU, Royal Belfast Hospital for Sick Children on the same day. XX Personal Information redacted by the USI .	Children and Young Peoples Services	Catastrophic	Yes	None
		06/04/2022	No Delay - includes weekend	Suspected suicide of a male patient in the community who was known to Mental Health Services.	Mental Health and Disability	Catastrophic	Yes	None
		13/06/2022	Was sent to Western Trust prior to SHSCT and Director of MHD was on leave	Suspected suicide of a male member of the community who was known to Mental Health Services.	Mental Health and Disability	Catastrophic	Yes	None
		09/06/2022	No delay	Suspected suicide of service user in the community, known to Mental Health services.	Mental Health and Disability	Catastrophic	Yes	None

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Personal information redacted	Personal information redacted by the USI		No delay	Suspected suicide of a male patient in the community who was known to Mental Health Services.	Mental Health and Disability	Catastrophic	Yes	None
			No delay	Serious physical assault on members of the public by a male known to Mental Health Services.	Mental Health and Disability	Major	Yes	Debriefs ongoing using SELT
			No delay	Suspected suicide of a male patient in the community who was known to Mental Health Services	Mental Health and Disability	Catastrophic	Yes	None
			Delay in receiving SD1 from PSNI. Received SHSCT 22/06/2022. RIP 19/06/2022.	Suspected suicide in the community of a male service user known to mental health services.	Mental Health and Disability	Catastrophic	Yes	None
			Delay in response from Coroner re cause of death unexpected/unexplained – cause of death undetermined at this time.	Unexpected/unexplained death in the community. Post Mortem not available at this time.	Mental Health and Disability	Catastrophic	Yes	None
			Delay in response from Coroner re cause of death unexpected/unexplained –	Unexpected/unexplained death in the community. Post Mortem not available until June	Mental Health and Disability	Catastrophic	Yes	None

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Personal information redacted by the USI	Personal information redacted by the USI		cause of death undetermined at this time.	2022.				
		05/04/2022	Delay in response from PSNI. Received SD1 on 05/04/2022	Suspected suicide of a female patient in the community who was known to Mental Health Services.	Mental Health and Disability	Catastrophic - reported last period	Yes	None
		N/A	N/A	Patient suddenly deteriorated during a review appointment in a Trust community facility and sadly passed away despite emergency interventions.	Mental Health and Disability	Catastrophic	No	n/a
		N/A	N/A	Suspected suicide in the community of a male patient who was known to Mental Health Services in BHSCT and referred to SHSCT MHS.	Mental Health and Disability	Catastrophic	No	BHSCT leading on SAI review. No update from SPPG or BHSCT regarding the progress of this SAI.
		10/05/2022	Incident date District Nursing informed 11.4.22 SAI Notification sent 14.4.22	Death of [Personal Information redacted by the USI] - massive urethral haemorrhage and misplaced urinary catheter.	Older People and Primary Care	Catastrophic	Yes	The staff involved have reflected on the incident and they are being supported through this by the appropriate senior staff. The learning is being reinforced at training sessions and appropriate

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							learning shared through Nurse Governance channels
Personal Information redacted by the USI	Personal Information redacted by the USI	11/04/2022	The incident was reported on Personal Information redacted by the USI although the detail was not clarified until 11/04/2022 to allow screening against the SAI criteria, at which point the incident was notified.	2 Nurses were administering a control drug (morphine sulfate) as prescribed PRN at 09.20am to a patient. Oral morphine sulfate was administered subcut to the patient in error	Older People and Primary Care	Minor	Yes Incident included in safety brief for staff handover There is already a safety mechanism in place in that the product for oral use has a purple bung and purple syringe to highlight medication is for oral administration rather than for injection. This will be considered as part of the investigation. An action plan to include review of nurses training needs around the administration of medications and supervised practice will be put in place.

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Personal information redacted	Personal information redacted by the USI	12/05/2022	Delay in reporting DATIX by Nursing home due to COVID Unable to make contact with NOK to advise of SAI investigation.	Personal information redacted by the USI fall in nursing home, rushed to hospital via ambulance for surgery sadly died 7 days post-surgery	Older People and Primary Care	Catastrophic - reported last period	Yes	None
		12/04/2022	This SAI notification has been delayed due to a backlog of DATIX investigations within the service team. It was a review of the delayed investigations within DATIX prompted a SAI alert. Whilst this SAI notification was delayed, this situation including care needs was followed up when Resident X was in hospital and on discharge by the Community Care Team.	CH NOTIFICATION: Personal information redacted by the USI	Older People and Primary Care	Insignificant	Yes	The Resident was unhappy in her new home and has since been moved and has settled well. Any learning established from the SAI will be shared appropriately.

In order to minimise the risk of delay in implementing immediate learning due to investigations not being completed within HSCB timescales, all adverse incidents that meet or have the potential to meet the SAI criteria are subject to an internal screening process. Incidents are screened by the appropriate Assistant Director and Clinical Lead along with the Governance Coordinator. This process identifies any areas of immediate learning resulting from incidents to ensure they are acted upon

2.3 Incidents Classification⁵

Datix reporting introduced a new classification system which was adopted regionally by all HSCTs on 15/04/2019. This has introduced changes to categorisation and also requires an allocation of 'who' the incident involved.

Tables 3.0 and 4.0 below summarised:

- ❖ Total incidents (across all directorates) for the period April – June 2022, by who was involved.
- ❖ Trust Top 10 categories
- ❖ **23.4% (1224) incidents – uncategorised at the time of reporting, this number remains consistent with last quarter.**

Table 3.0 below provides a breakdown of Incidents broken down by 'Who was involved'

Incident Involved	Q1 22/23	% Total	Q4 21/22	% Total	Q3 21/22	% Total	Q2 21/22	% Total	Q1 21/22	% Total	Q4 20/21	% Total
Patient & Service User	3187	60.89	2952	55.6	2979	56	3118	57	3545	59	3178	59
Staff	640	12.23	977	18.4	647	12	779	14	711	12	891	16
Public / Visitors	20	0.38	20	0.4	27	1	31	1	52	1	30	1
Organisational	163	3.11	131	2.5	168	3	232	4	183	3	181	3
Uncategorised (Involved)	1224	23.39	1226	23.1	1520	28	1267	23	1480	25	1134	21
Total	5234		5306		5341		5427		5971		5414	

Table 4.0 below provides a breakdown of the Top 10 Incident areas by Category.

Categorised/Themed incidents account for 73% of Incidents as detailed below.

Qu 1 SHSCT 'Top 10' By Incident Category	Insignificant	Minor	Moderate	Major	Catastrophic	Total
Behaviour (Including Violence and Aggression)	937	401	15	2	7	1362
Uncategorised at time of Reporting	583	503	111	26	2	1225
Accidents/Falls	533	359	14	1	0	907
Medication/Biologics/Fluids	244	192	39	4	0	479
Other	79	89	8	1	2	179
Pressure Ulcers	15	153	10	0	0	178
Exposure to Environmental Hazards	41	117	16	0	0	174
Maternity Care	5	74	40	3	0	122
Diagnostic Processes/Procedures	32	68	8	4	0	112
Service Disruptions (environment, infrastructure, human resources)	62	28	8	0	0	98
Other Categories outside Top 10	149	203	34	4	8	398
Grand Total	2680	2187	303	45	19	5234

In this quarter the categories remain consistent with previous quarters. The noticeable difference from the previous quarter is the significant decrease in Exposure to Environmental Hazards which was detailed above in the Severity section.

The categories assigned to the 8 catastrophic incidents which did not appear in the Top 10 Categories included: Unexpected/Unexplained Deaths (n=6), Therapeutic

⁵ Incident classification is now reported at the aggregated category level, accumulating all relevant smaller sub-categories. This themes incident classification at the highest level with further sub-category drill down available.

Processes/Procedures (n=1) and Anaesthesia Care (n=1).

Tables 5.0 – 8.0 provide a further drill down listing the top 10, by involvement, category and severity⁶.

Table 5.0. Incidents involving Service Users – 60.9%. There has been a 5% increase since the last quarter, but consistent to historical quarters. Falls and pressure ulcers are key patient safety areas further reported in Appendix A. Whilst table 5.0 provides details on all pressure ulcer and patient falls, section 3.0 reports on hospital acquired pressure ulcers and injurious fall sub-categories.

Q1 Apr - June 2022 Patient/Service User Incidents by Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Behaviour	670	278	11	1	6	966
Patient Accidents/Falls	505	314	11	1	0	831
Medication/Biologics/Fluids	233	183	39	4	0	459
Other	79	89	8	1	2	179
Pressure Ulcers	15	153	10	0	0	178
Maternity Care	5	74	40	3	0	122
Diagnostic Processes/Procedures	32	68	8	4	0	112
Communication	23	43	7	0	0	73
Documentation	16	26	2	0	0	44
Injury of unknown origin	11	27	5	0	0	43
Other Categories outside Top 10	49	98	20	5	8	180
Grand Total	1638	1353	161	19	16	3187

There is no noticeable change in the Top 10 categories from the previous quarter.

Table 6.0. Incidents involving Staff – 12.2%

This quarter a decrease in the percentage share of staff related incidents is noted. This is attributed to the significant decrease in the number of Exposure to Environmental Hazards incidents which decreased from 558 to 155. This number is on trend to previous quarters.

Q1 Apr-June Staff Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Behaviour (Including Violence and Aggression)	260	120	4	384
Exposure to Environmental Hazards	36	105	14	155
Accidents/Falls	28	42	3	73
Property	19	8	1	28
Grand Total	343	275	22	640

An SPC chart to show the numbers of incidents coded as Exposure to Environmental Hazards, since April 2019 is provided below in Figure 4 below.

⁶ Datix data quality impacts the categorisation, e.g. if IR1 incorrectly associates the incident to a staff member when a patient is the 'involved' person. Datix training investment is required for improvement alongside data quality processes.

Figure 4: SHSCT Datix Incidents by Reported Date – Exposure to Environmental from 01/04/2019

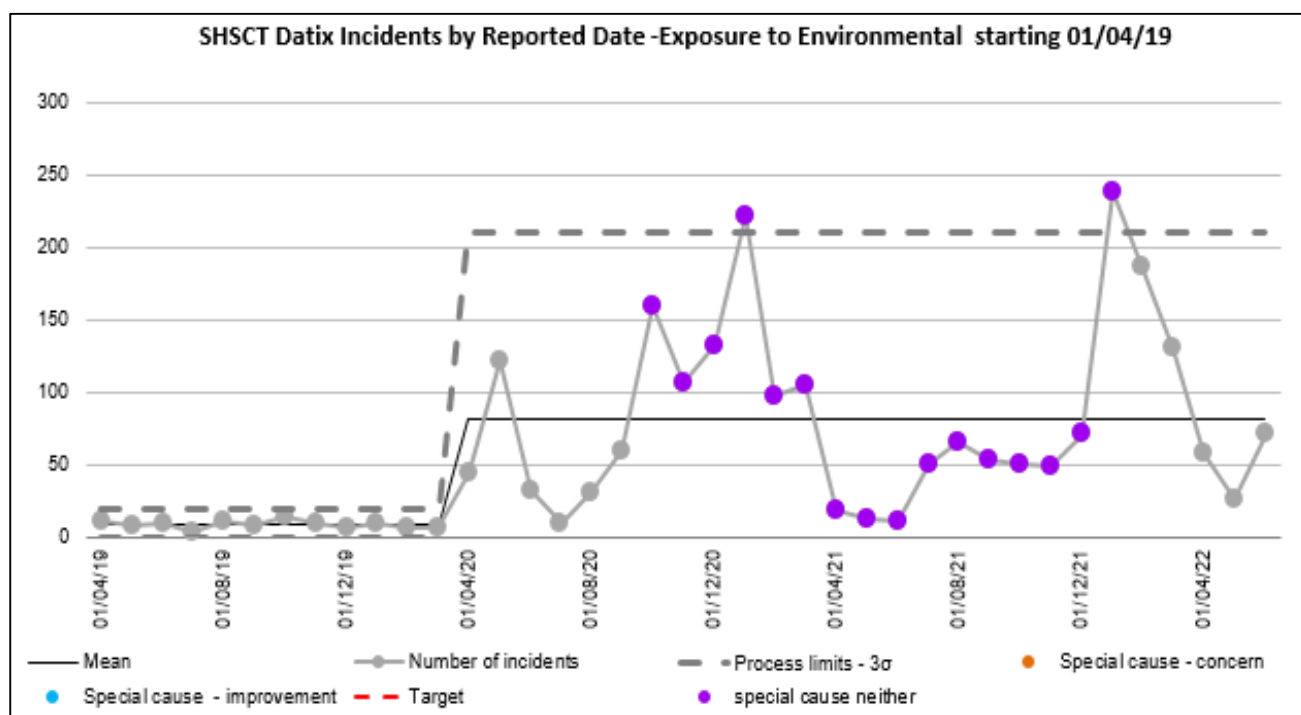


Table 7.0. Incidents at an Organisational Level – 3.1%.

Q1 Apr - Jun 2022 Organisational Incidents by Category	Insignificant	Minor	Moderate	Grand Total
Service Disruptions (environment, infrastructure, human resources)	62	28	8	98
Medication/Biologics/Fluids	11	9	0	20
Fires, Fire Alarms and Fire Procedures	17	2	0	19
Security of Organisation's Property, Data and Buildings	12	5	0	17
IT Systems	4	4	0	8
Public Order/Crowd Control	0	0	1	1
Grand Total	106	48	9	163

There has been no significant change regarding the categories or the percentage share of Organisational Incidents.

Table 8.0. Incidents involving the visitor/public – 0.4%

There is nothing of significance to report on these incidents. The major incident involved a service user physically assaulting members of the public. There is no appropriate CCS2 code for this so it has been reported as incident involving the public. The catastrophic incident was incorrectly coded and has since been amended.

Table 8: Incidents involving the visitor/public by Category

Q4 Jan - March 2022 Public Incidents by Category	Insignificant	Minor	Major	Catastrophic	Grand Total
Behaviour	7	3	1	1	12
Accidents/Falls	0	3	0	0	3
Property	2	1	0	0	3
Exposure to Environmental Hazards	1	1	0	0	2
Grand Total	10	8	1	1	20

2.4 Incidents of Behaviour / Abuse including Self Harm

The following three tables (Tables 9.0 – 11.0) provide a further breakdown, by the person affected groups, of the 1362 recorded incidents of Behaviour / Abuse by Severity.

Table 9.0

There were 5 incidents incorrectly coded in the “Inappropriate/Aggressive Behaviour towards a Patient by Staff”.

The 7 incidents correctly coded as “Inappropriate/Aggressive Behaviour towards a Patient by Staff” included incidents of alleged verbal and physical abuse, mainly within the Independent Sector.

Table 9: Incidents of Behaviour / Abuse including Self Harm – Patient/Service User

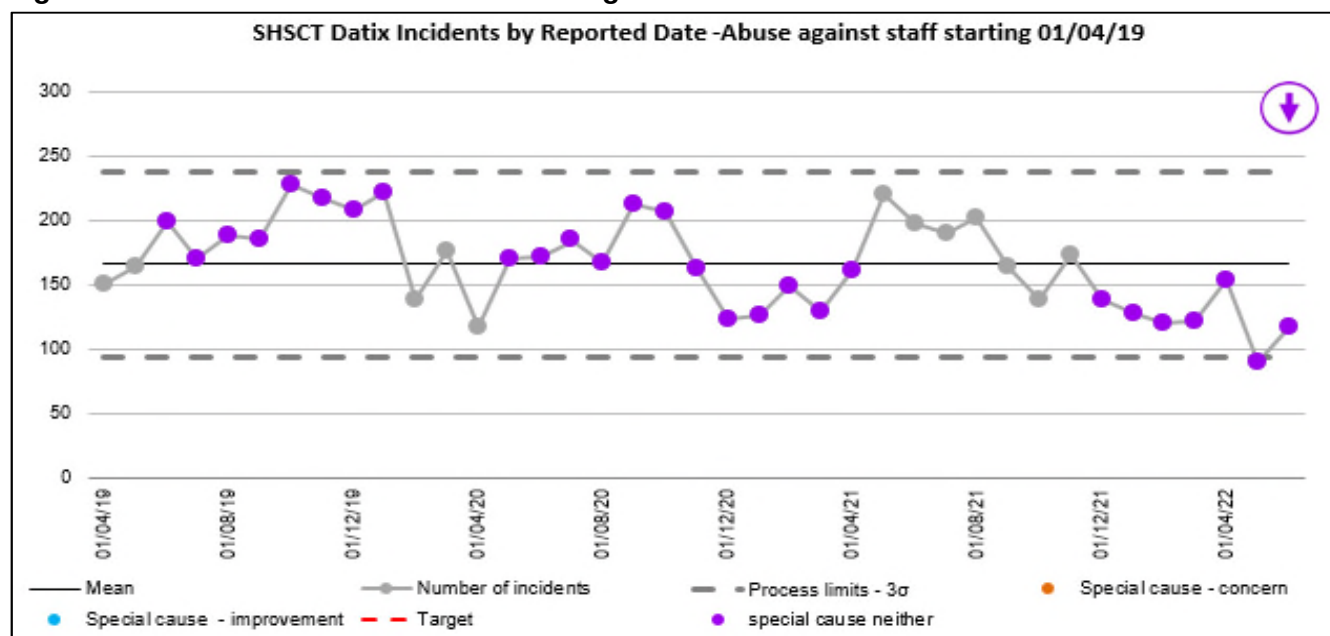
Person Affected - Patient/Service User	Severity					Grand Total
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Catastrophic	
Patient Behaviour that challenges	221	77	4	0	0	302
Missing Patient (absconded/abducted patient)	200	75	3	0	0	278
Self-harming Behaviour	100	65	2	1	6	174
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	63	19	1	0	0	83
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	60	23	0	0	0	83
Inappropriate/Aggressive Behaviour towards a Patient by Staff	6	6	0	0	0	12
Use/Possession of Prohibited/Stolen Goods	9	2	1	0	0	12
Patient refusal of diagnostic/therapeutic recommendations/interventions	5	7	0	0	0	12
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	2	4	0	0	0	6
Persons Performing Unauthorised Acts	2	0	0	0	0	2
Patient Restraint Processes	2	0	0	0	0	2
Grand Total	670	278	11	1	6	966

Table 10.0

The number of abuse incidents against staff members has increased by 18.5% this quarter from 324 to 384. A further breakdown since April 2019 has been provided at figure 5 which illustrates a significant decrease in incidents over the past 7 months as indicated by a shift with 7 data points below the mean.

Table10: Incidents of Behaviour / Abuse including Self Harm – Staff Member

Person Affected - Staff Member	Severity			
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Grand Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	238	110	3	351
Other	11	7	1	19
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	6	2	0	8
Persons Performing Unauthorised Acts	2	0	0	2
Use/Possession of Prohibited/Stolen Goods	2	0	0	2
Inappropriate/Aggressive Behaviour towards Staff by Staff	1	1	0	2
Grand Total	260	120	4	384

Figure 5: SHSCT Datix Incidents – Abuse against staff from 01/04/2019**Table 11.0: Incidents of Behaviour / Abuse including Self Harm - Visitor**

Person Affected - Visitor	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Major	Catastrophic	Grand Total
Other	5	2	0	1	8
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	2	1	1	0	4
Grand Total	7	3	1	1	12

2.5 Incidents coded as 'Missing Patient'

Table 12.0 below provides a further breakdown, by category and severity of the 278 recorded incidents of missing, absconded or AWOL patients or service users.

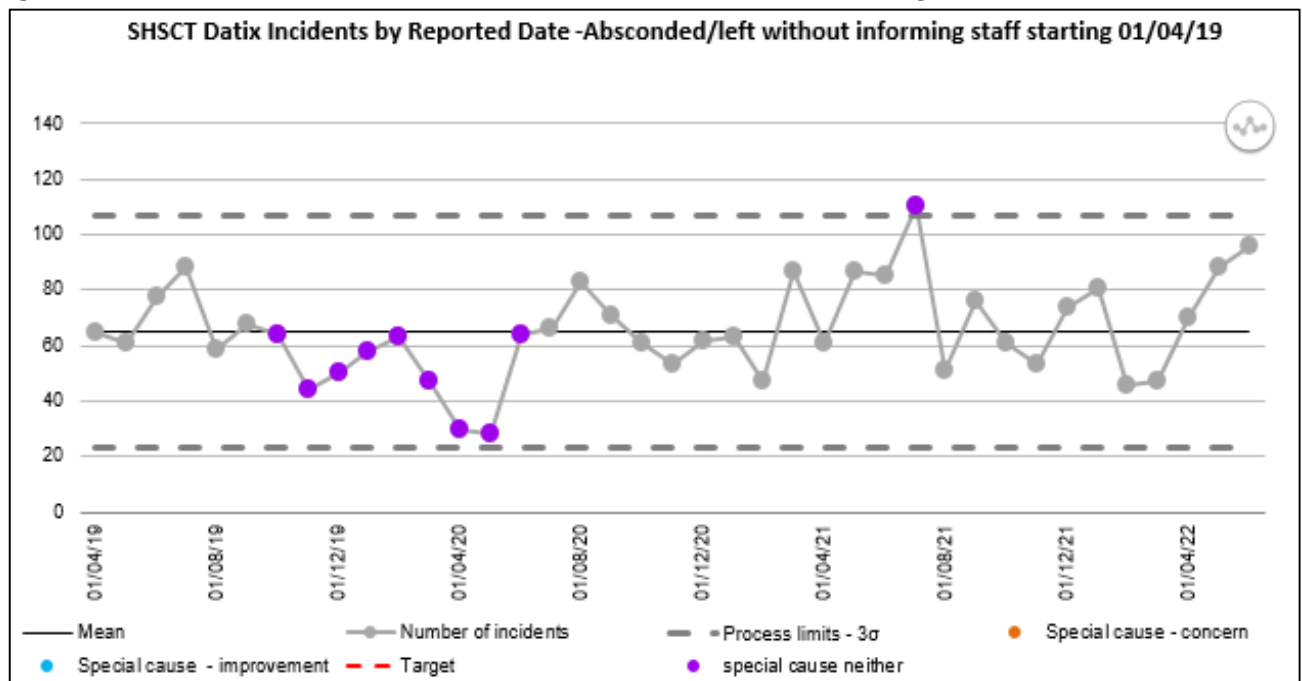
This quarter the percentage share of "Absconded/left without informing staff" incidents is within normal variation with no significant change. This quarter 252 (90%) compared to last quarter 167 (87%).

Table 12: 'Missing Patient' incidents by Severity

Person Affected - Patient	Severity			
Type of Missing Patient	Insignificant	Minor	Moderate	Grand Total
Absconded/left without informing staff	183	66	3	252
Attempted to abscond/leave without informing staff	6	0	0	6
AWOL / Absconded (detained patients only)	6	3	0	9
Failed to return from authorized leave	4	6	0	10
Blank	1	0	0	1
Grand Total	200	75	3	278

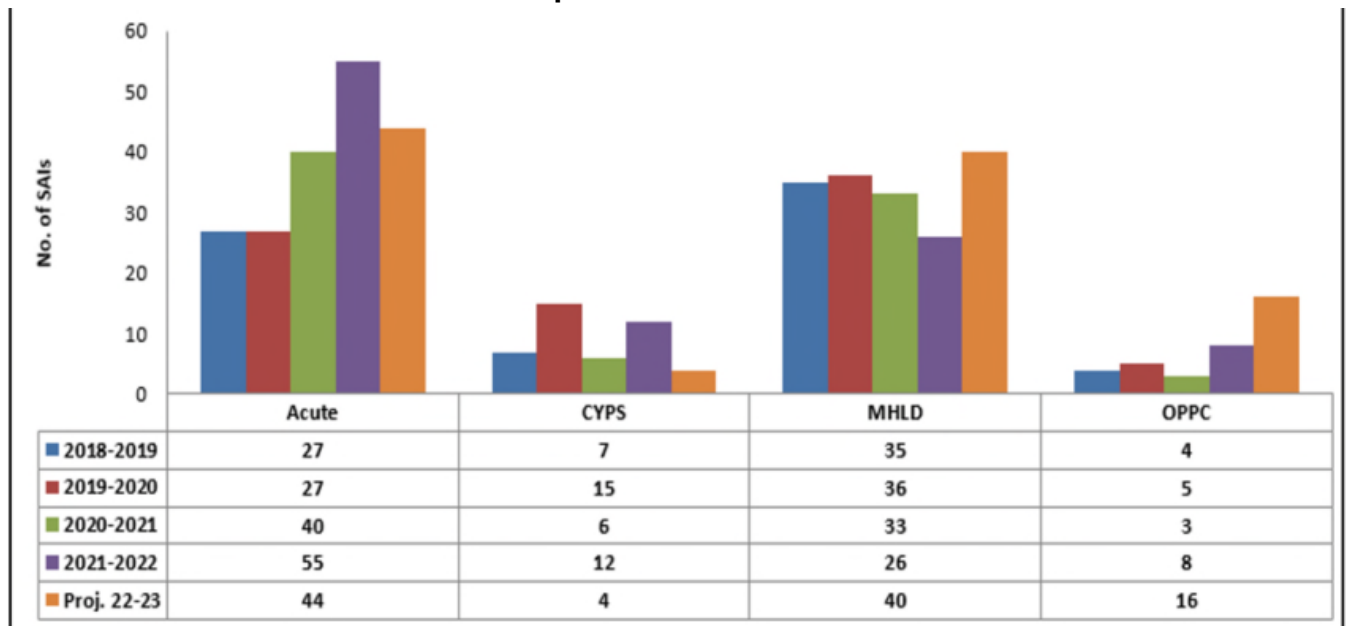
Figure 6 below shows the number of incidents coded as “Absconded/left without informing staff” since April 2019.

Figure 6: SHSCT Incident – Absconded/left without informing Staff from 01/04/2019



2.6 Serious Adverse Incident Investigations submitted to SPPG as at 30th June 2022 (Table 13.0).

Table 13: SAIs submitted to SPPG up until 30/06/2022



2.7 Trust Performance against Regionally Agreed Timescales

Timescales for the completion of Serious Adverse Incidents are set out by S P P G :

- ❖ Level 1 - 8 weeks
- ❖ Level 2 - 12 weeks
- ❖ Level 3– timescales are agreed between the reporting organisation and the SPPG/PHA DRO

Table 14.0

SHSCT currently have:

	In Timescale	Outside Timescale	Total
Acute	14	41	55
CYP	0	1	1
MHD	8	23	31
OPPC	3	9	12
On Hold	n/a	n/a	2
Total	25	74	101
%	25	73	

101 SAI investigations in progress⁷, 2 of which have been paused due to ongoing investigations by external bodies such as Safeguarding Board Northern Ireland.

25 SAI investigations (25%)⁸ remain within the HSCB timescales for submission.

74 are outside of timescales. This is

broken down by Directorate in table 15 below.

There are a number of contributory factors which influence the compliance of completion of SAI reports within the timescales identified in the SPPG Serious Adverse Incident

⁷ SAIs notified in a period will vary from the number actively in progress or paused at any particular point in time.

⁸ Compared with 24% in the previous quarter.

Procedures.

- ❖ The most common theme across Directorates is the availability of panel members due to operational pressures
- ❖ Appropriate team configuration to ensure relevant level of clinical independence and expertise.
- ❖ Difficulties in obtaining external chairs / review team members.
- ❖ The prioritisation of SAI investigations within existing workloads.
- ❖ Necessary engagement with service users and their families, particularly where a death has occurred.
- ❖ Where the SAI investigation spans across 2 or more Trusts
- ❖ Capacity constraints on Clinical and Social Care Governance Teams, compared with current demand and complexity

To assist with some of these issues the Trust has a dedicated SAI Chairs and have secured external SAI Chair training, some of which has been delivered, to increase the pool of available staff to participate with the progression of SAIs.

SPPG recently proposed to source an external resource to assist all Trusts with the backlog of Level 1 SAIs. Trusts were asked to undertake a scoping exercise and confirm whether resource was required.

As above there are 101 open SAIs as at 30th June 2022, this is compared to 96 in the previous quarter. A breakdown of the SAI activity has been provided below.

Ongoing SAIs last quarter	96
Add New SAI notifications:	26
Less SAI reports submitted:	-21
Ongoing SAIs as at 30/06/2022	101

Table 15.0 sets out the detailed position on the progress of the 99 SAI investigations currently on-going as at 30/06/2022 (2 of the 101 SAI investigations currently paused).

SAI Level	ACUTE			CYPs			MHD			OPPC		
	Within SPPG Timescales	Outside SPPG Timescales week 26 >	Outside SPPG Timescales weeks 26 <	Within SPPG Timescale	Outside SPPG Timescale weeks 26 >	Outside SPPG Timescales weeks 26 <	Within SPPG Timescale	Outside SPPG Timescales weeks 26 >	Outside SPPG Timescales weeks 26 <	Within SPPG Timescale	Outside SPPG Timescales weeks 26 >	Outside SPPG Timescales weeks 26 <
Level 1	7	10	19	0	1	0	2	2	8	2	6	3
Level 2	3	8	4	0	0	0	3	4	9	1	0	0
Level 3	4	0	0	0	0	0	3	0	0	0	0	0
Totals	Within SPPG Timescales	Outside SPPG Timescales		Within SPPG Timescale	Outside SPPG Timescales		Within SPPG Timescale	Outside SPPG Timescales		Within SPPG Timescale	Outside SPPG Timescales	
	14	18	23	0	1	0	8	6	17	3	6	3

SPC Charts have been provided in Appendix C to show the length of time from Date of Notification to completion of SAI investigation.

submission of SAI report per Directorate. This does not include any SAIs which are ongoing.

2.8 Approval Status of Incidents

Figs 7.0 & 8.0 highlights the number of incidents in each Directorate 'awaiting review' or 'being reviewed'. Incidents in the review process are not categorised by subject and the final severity rating has not been approved. In this quarter the number of unapproved incidents has not changed significantly.

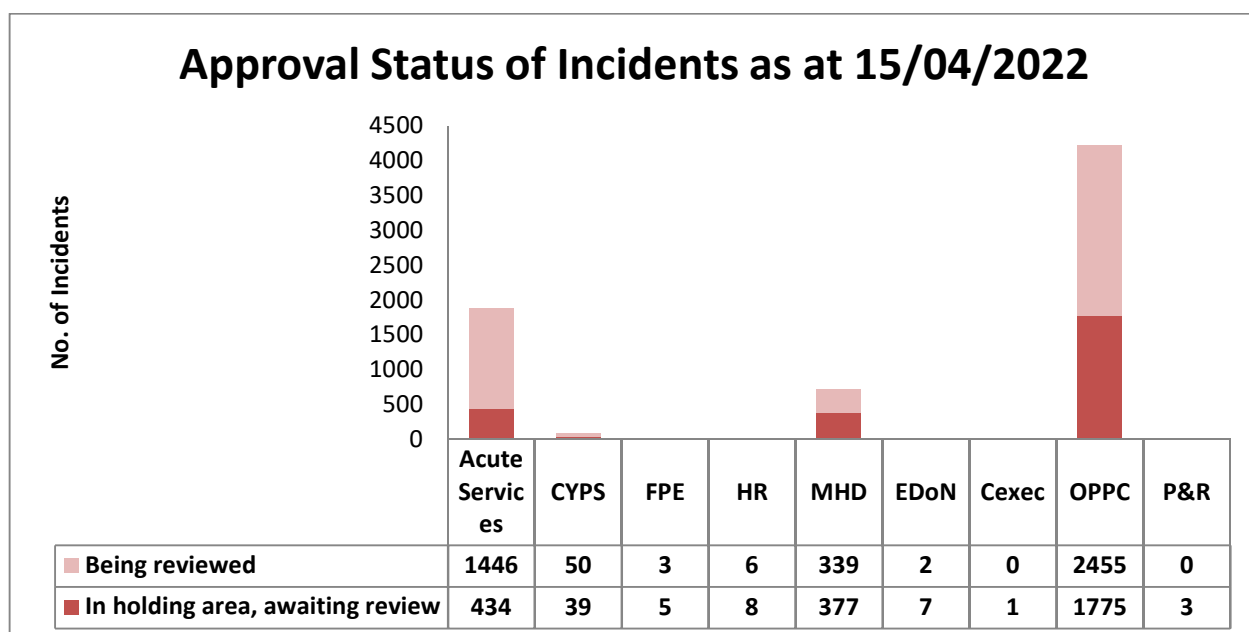
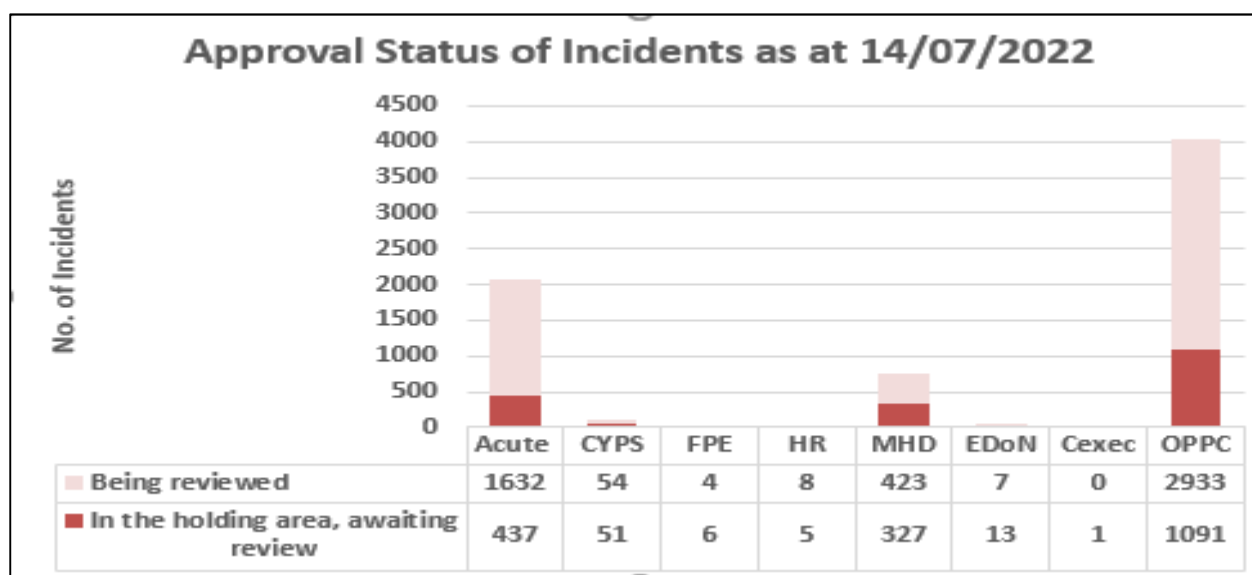


Fig. 9.0 Details the retrospective time frame for unapproved incidents.⁹

All Directorates submitted an action plan to address the delay in approving incidents. Since the last quarter, all 2018 incidents have been approved. Corporate CSCG team is seeking resources to assist in addressing this backlog.

Incidents recorded on Datix in 2011, 2015 and 2017 are all Urology cases.

14/07/2022	2011	2015	2017	2019	2020	2021	2022	Total
Acute Services	1	1	1	24	74	581	1387	2069
Children and Young Peoples Services	0	0	0	0	0	0	105	105
Finance Procurement & Estates	0	0	0	0	0	2	8	10
Human Resources and Organisational Development	0	0	0	0	0	7	6	13
Mental Health and Disability	0	0	0	7	32	201	510	750
Nursing, Midwifery and AHP	0	0	0	0	0	1	19	20
Office of the Chair and Chief Executive	0	0	0	0	0	0	1	1
Older People and Primary Care	0	0	0	335	981	1648	1060	4024
Total	1	1	1	366	1087	2440	3096	6992

2.9 Early Alerts Submitted by the Southern Health and Social Care Trust

Between 1st April 2022 and 30th June 2022 there have been 39 (41% in relation to GP OOH) Early Alerts submitted to the DoH. 28 of these were new alerts; 11 were updates on previously submitted Early Alerts. A breakdown of these Early Alerts is provided below.

Theme of Early Alert	Number of Early Alerts/Updates
GP OOH	16
Litigation	6
MHD Incident	4
Independent Sector	3
Public Inquiry	2
CYPS Incident	1
Service Pressures	1
District Nursing Incident	1
Safeguarding Referral	1
HR Incident	1
IPC	1
Acute Incident	1
Cardiac System	1
Grand Total	39

⁹ Any open SAIs will remain on this report until the SAI report is submitted

3.0. Service User Formal Complaints

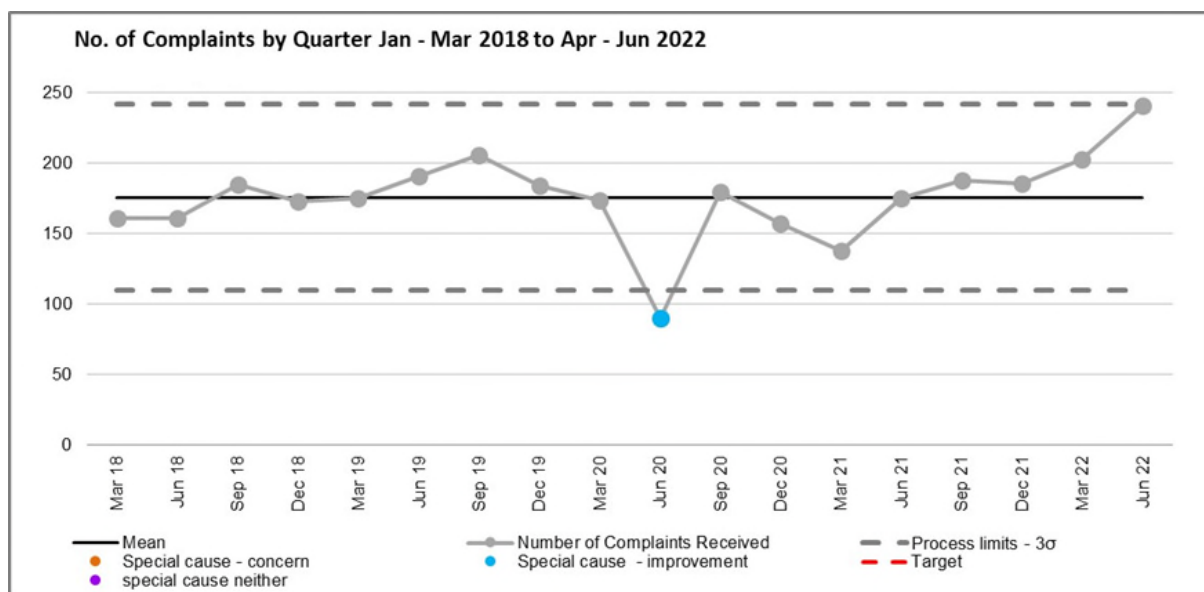
3.1 Complaints received

Regionally complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects.

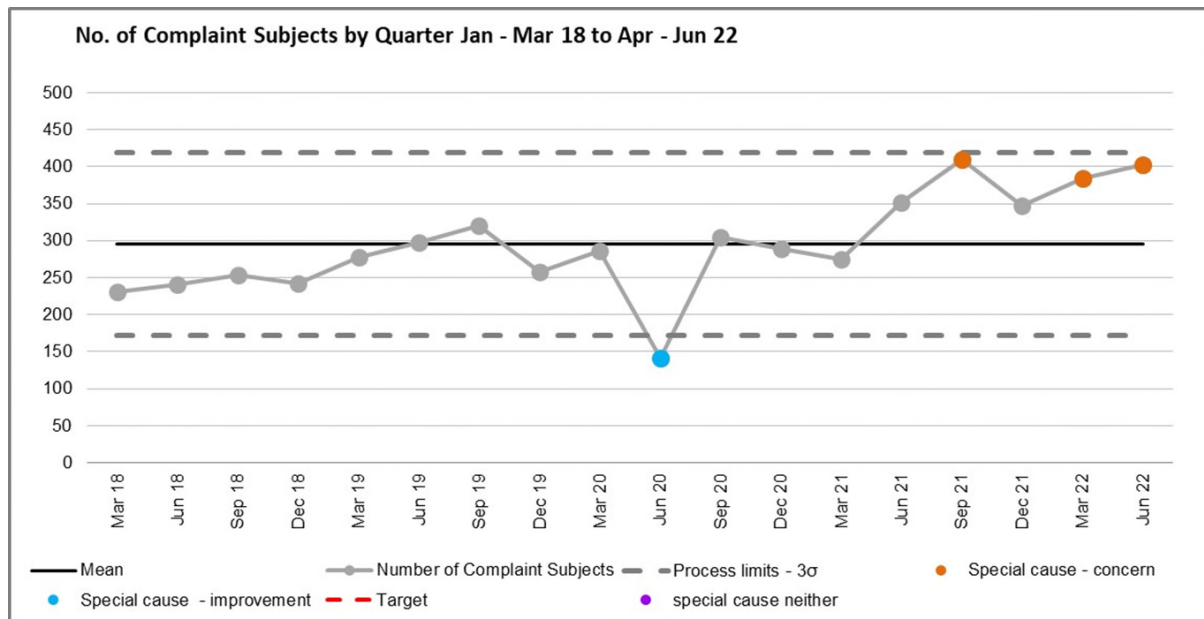
- April – June 2022: 241 complaints received
- January – March 2022: 203 complaints received
- October – December 2021: 186 complaints received
- July – September 2021: 188 complaints received
- April – June 2021: 175 complaints received

In this reporting period **241 complaints** were received, **19% increase** on January - March 22 and a 38% increase (additional 66 complaints) on the same reporting quarter for 2021. The number of complaints received this quarter remains within normal variation, albeit at the upper limit of this variation.

Figure 10.0 Number of Complaints



Of the 241 complaints, **402 complaint subjects** were identified, **an increase of 5% compared to the previous quarter.**

Figure 11.0 Number of Complaint subject levels

3.2 Complaint Subjects

The following table details the top 10 complaint subjects for the period Apr - Jun 2022, and compares with previous quarters. Also detailed is the percentage share of each complaint subject (Table 16.0).

Complaint Subject	Apr Jun 21	Jul Sep 21	Oct Dec 21	Jan Mar 22	Apr Jun 22	Diff + or previous Quarter	Subject %
Staff Attitude/Behaviour	59	82	63	73	80	+7	20%
Communication/Information	98	78	92	83	70	-13	17%
Quality of Treatment & Care	65	81	71	82	67	-15	17%
Waiting Times	28	41	25	40	53	+13	13%
Professional Assessment of Need	43	30	23	19	28	+9	7%
Clinical Diagnosis	11	22	7	11	18	+7	4%
Policy/Commercial Decisions	6	17	10	7	17	+10	4%
Quantity of Treatment & Care	6	10	12	12	14	+2	3%
Discharge and Transfer Arrangements	3	5	6	12	8	-4	2%
Property/Expenses/Finances	9	11	12	8	8	0	2%

¹⁰Waiting Times continue to appear within the top 5 subjects, and has increased significantly

¹⁰ Waiting times are an amalgamation of complaints relating to Outpatients, Community Services, A&E Departments and

compared to the last 2 quarters. Waiting Times in ED and in relation to Cancer Access Standards are collated by the Informatics team. This data was obtained by the Corporate CSCG team and developed to display in SPC charts which can be viewed in Appendix D and E.

Staff Attitude/Behaviour, Waiting times, Professional Assessment of Need, Quality of Treatment and Care, Clinical diagnosis and Policy/Commercial decisions have all increased this quarter. In relation to Staff Attitude/Behaviour, a large number of complaints received described staff as being rude and referred to a range of staff which included, Consultants, nurses, midwives and admin staff. On review of a number of complaints, apologies were offered to the complainant, the staff reflected on their behavior and in some cases further training for staff was introduced and memos issued to all staff reminding them of correct protocol. Within Communication, a number of complaints related to unanswered calls within departments and lack of updates in relation to Service Users care. Complaints aligned to Quality and Treatment of Care, referred to issues during examination and monitoring. In this quarter, no themes have been identified as the complaints fell across a number of service areas and stages of care during admission, examination, and discharge.

3.2.1 Top 5 Complaint Subjects

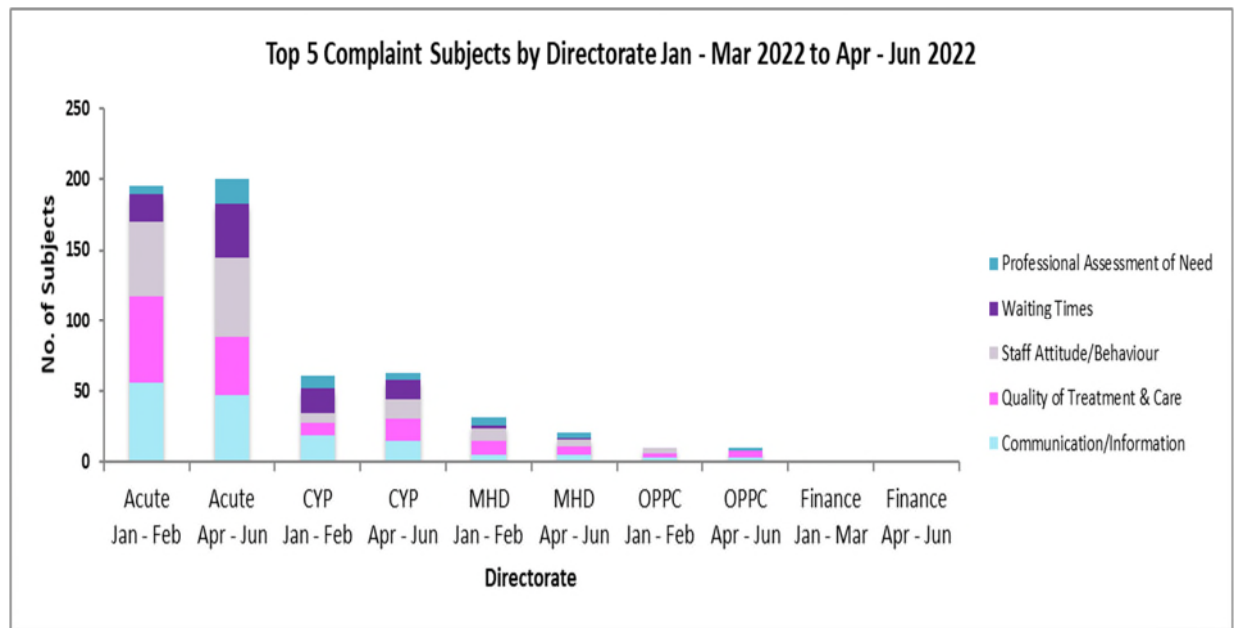
A further analysis of the top 5 complaint subjects, accounting for 74% of the 402 overall complaint subjects as detailed in Table 17.0, identified that in this quarter, the percentage share of these subject areas, with the exception of Quality of Treatment and Care, have all increased on comparison to last quarter. Of the top 5 complaint subjects this quarter, 50% fall within the Acute Directorate.

Complaint Subject	Jan Mar 21	Apr Jun 21	Jul Sep 21	Oct Dec 21	Jan Mar 22	Apr Jun 22	Diff + or previous Quarter	Subject %
Staff Attitude / Behaviour	19%	17%	20%	18%	19%	20%	+7	1%
Quality of Treatment & Care	16%	18%	20%	20%	21%	17%	-13	-4%
Communication / Information	24%	28%	19%	27%	22%	17%	-15	-5%
Waiting time	5%	8%	10%	7%	10%	13%	+13	3%
Professional Assessment of Need	9%	12%	7%	7%	5%	7%	+9	2%

The top 5 subject areas, with a comparison to the previous quarter, broken down within each

Delay, Cancellation and Planned Admission to hospital.

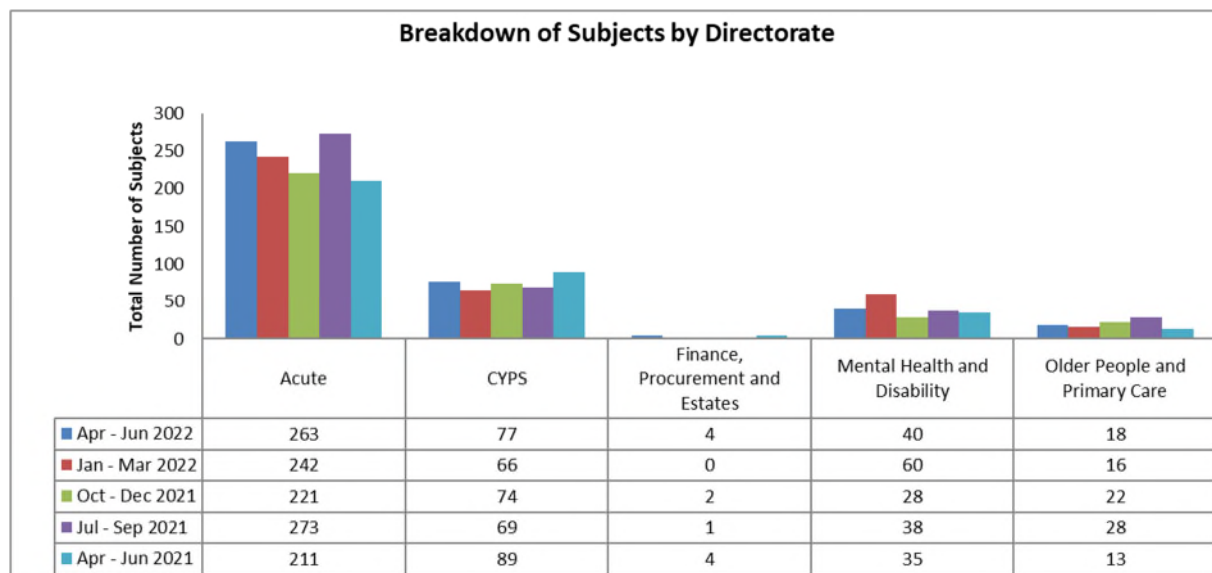
Operational Directorate can be viewed in **Figure 12.0** below



*There was 1 complaint subject for Finance in April – June 22.

3.3 Complaints % by Directorate¹¹

Figure 13 - Total number of Complaint Subjects received by Directorate from April – June 2021 to April - June 2022.



*No complaints were received for this Quarter via the Chief Executive's Office, Performance and Reform, HROD or the Medical Directorate

¹¹ A breakdown by Division is available through the relevant Directorate Governance Team

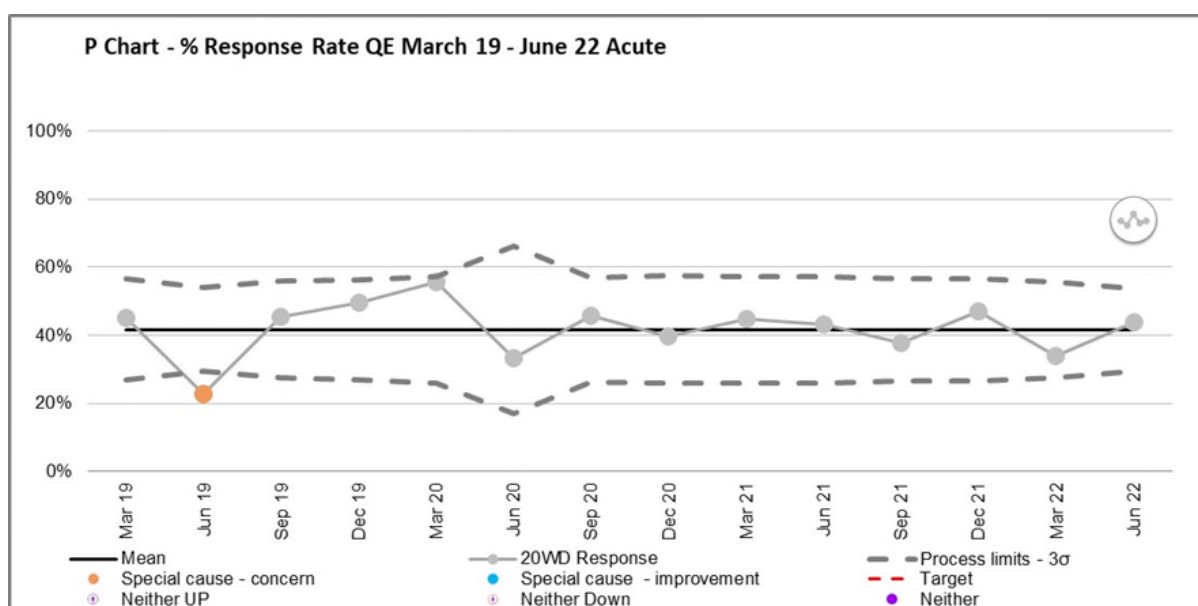
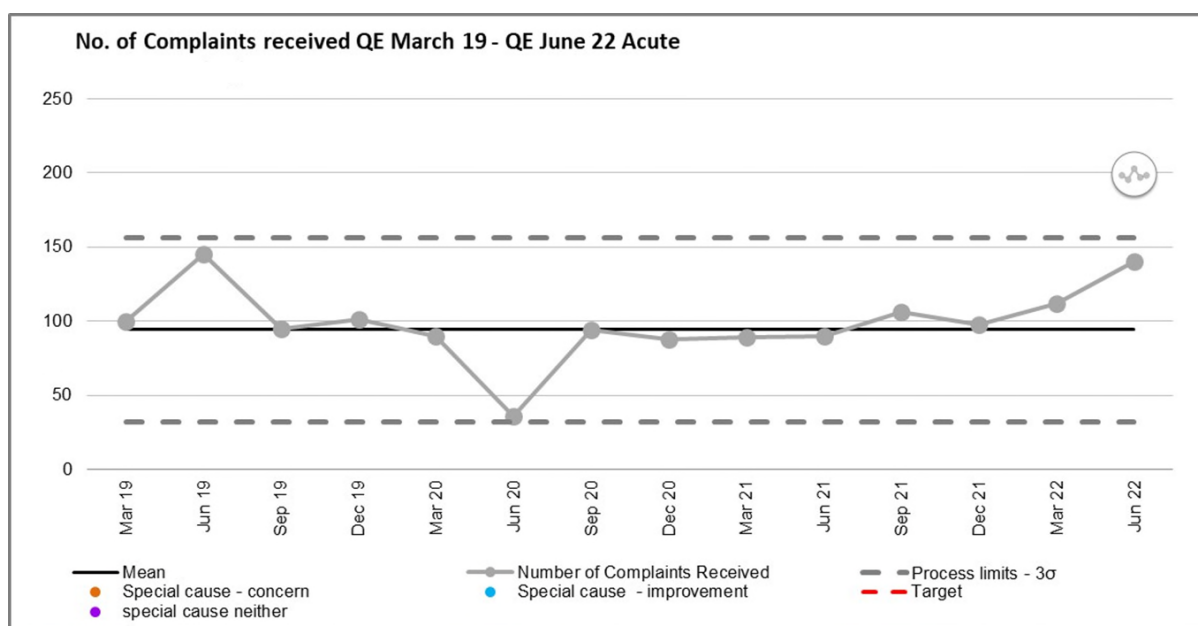
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The regional complaints procedure sets out standards in respect to acknowledgment and response times to formal complaints. Each complaint should be acknowledged within 2 working days and each complaint should be responded to within 20 working days.

No Operational Directorate responded to all complaints within 20 working days for this quarter, in some cases this is due to the complexity of the complaint, where issues fall across more than one Directorate or staff availability due to annual leave and/or service pressures. As noted below some of these complaints were not due for response until after the date of this report.

¹² The 20 Working Day response times and number of complaints received are created using P charts. The P chart displays an Upper control Limit (UCL/target) which correlates to the number of complaints received e.g. low number of complaints received, higher likelihood of achieving compliance, which would reach the upper control limit (100%).

Acute Directorate Complaints and Response Times

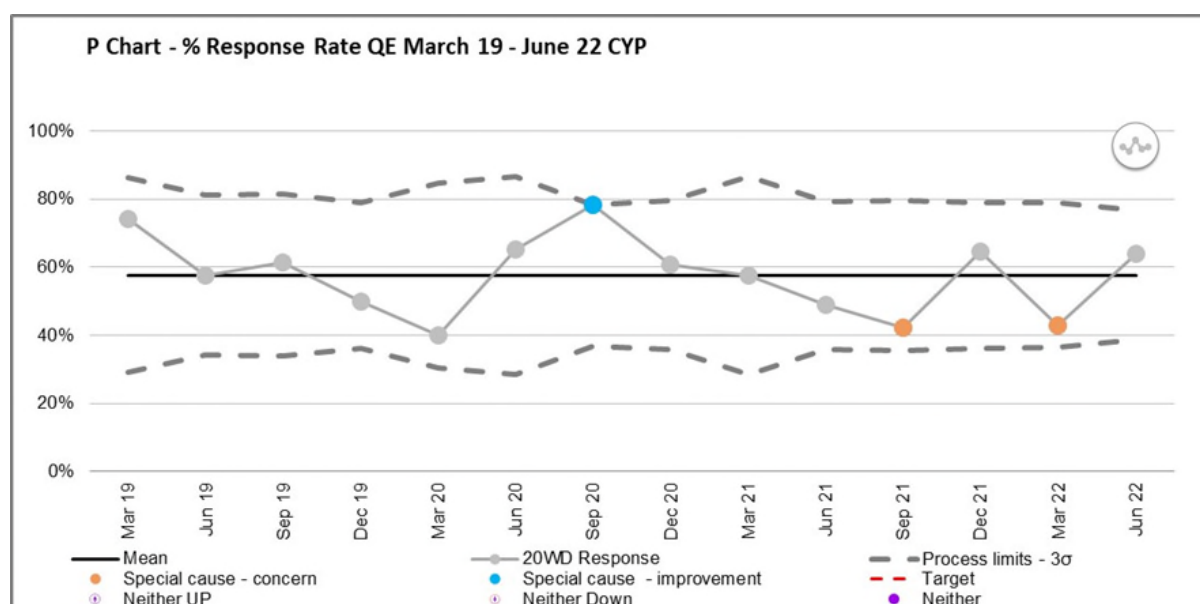
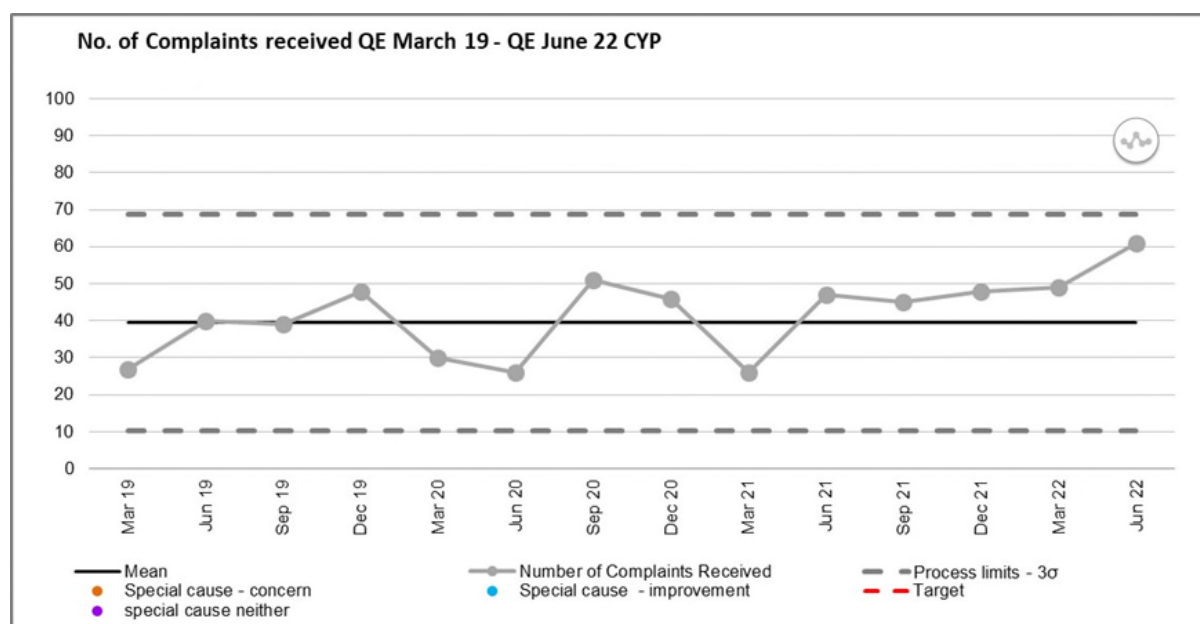


April 22 - 51 complaints received, 41% were responded to within 20 working days.

May 22 - 47 complaints received, 49% were responded to within 20 working days.

June 22 - 42 complaints received, 43% were responded to within 20 working days.

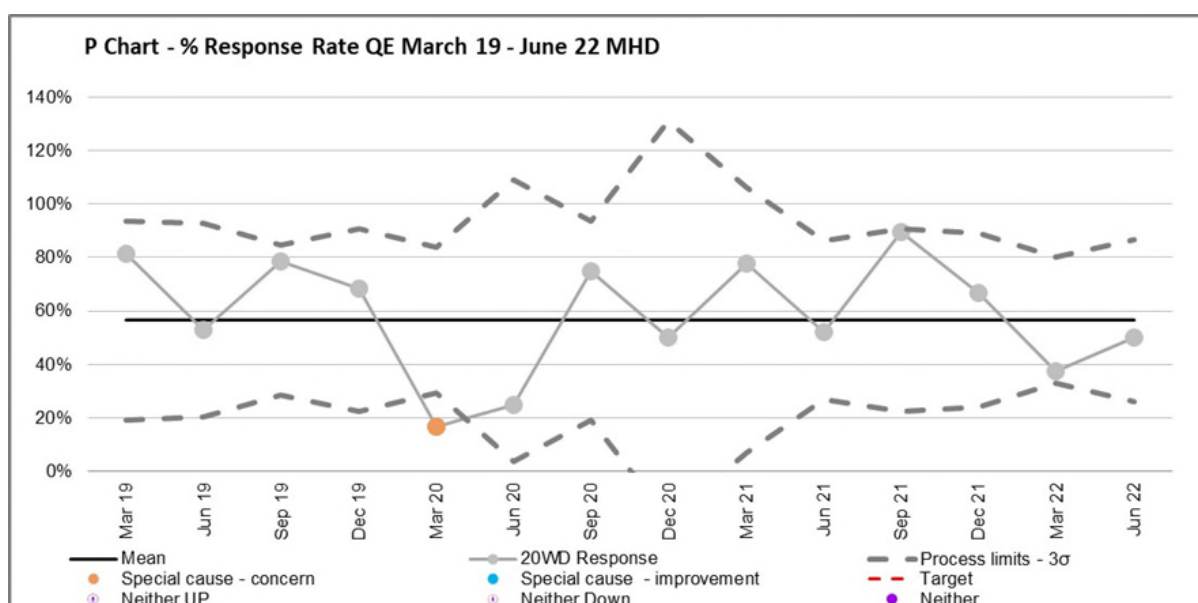
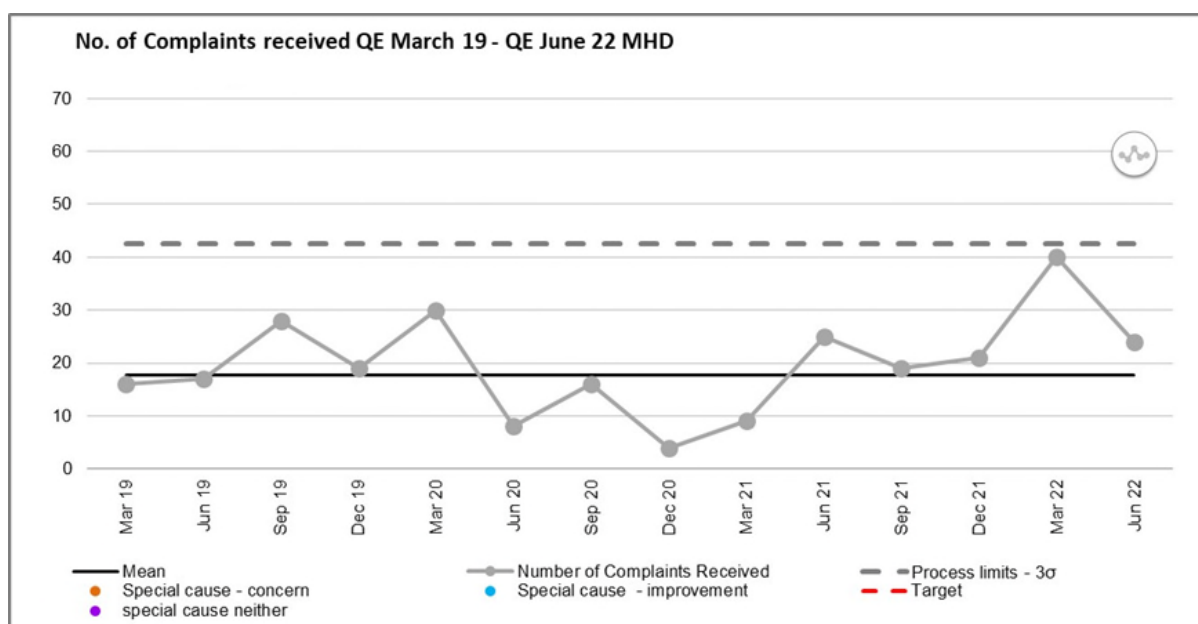
CYPs Complaints and Response Times



April 22 - 20 complaints received, 65% were responded to within 20 working days.

May 22 - 27 complaints received, 56% were responded to within 20 working days.

June 22 - 14 complaints received, 79% were responded to within 20 working days.

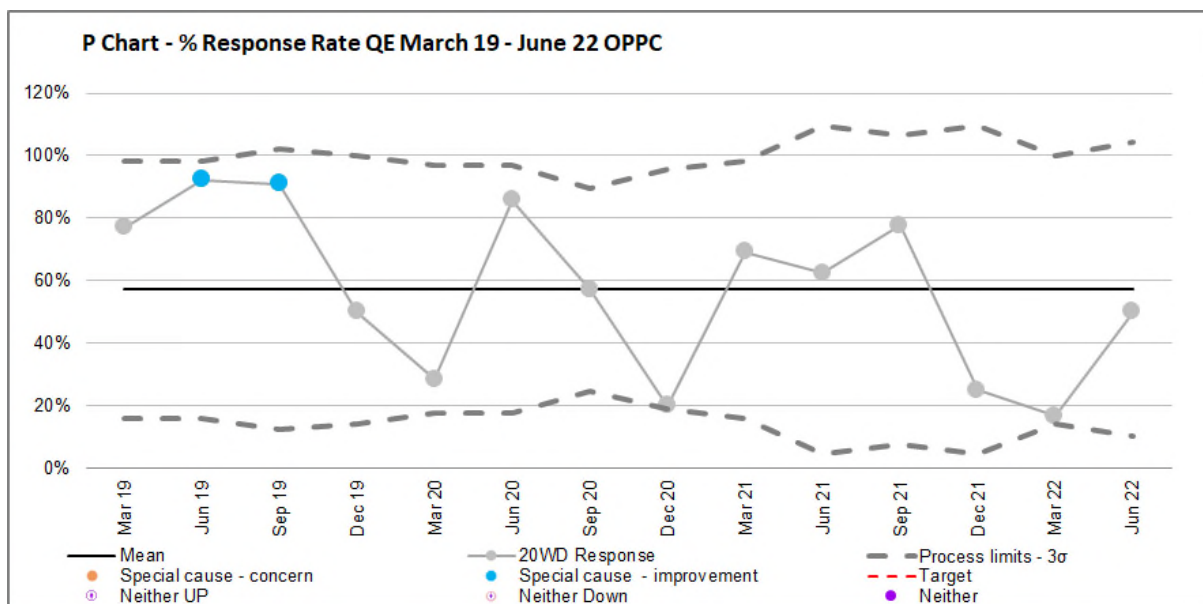
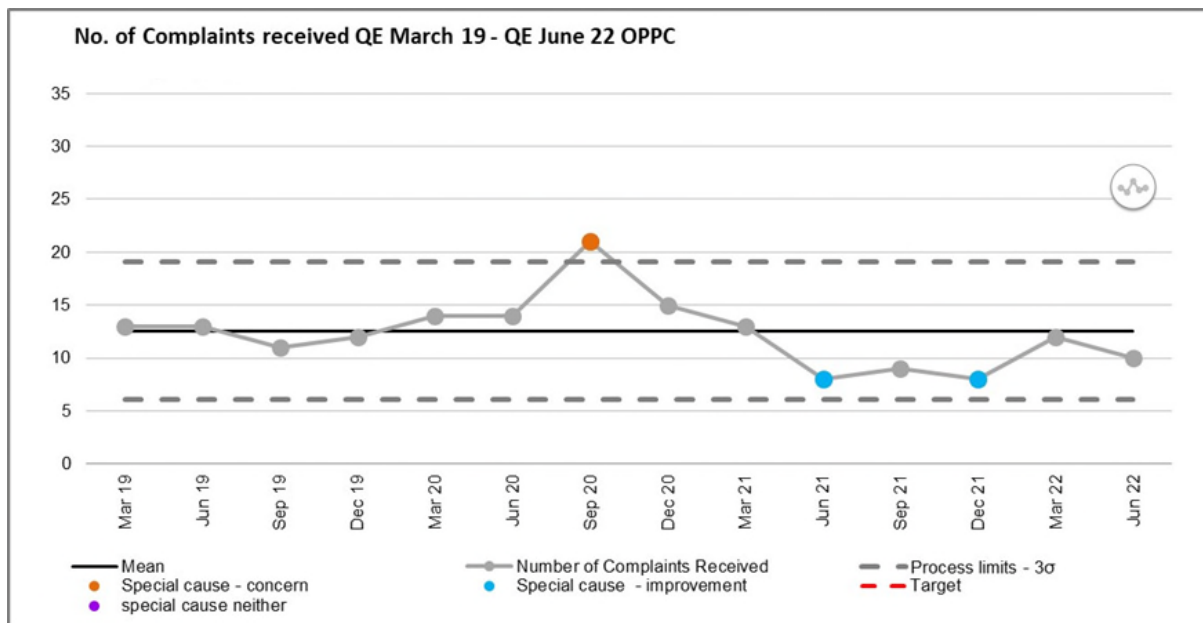
MHD Complaints and Response Times¹³

April 22 - 12 complaints received, 50% were responded to within 20 working days.

May 22 - 5 complaints received, 20% were responded to within 20 working days.

June 22 - 7 complaints received, 71% were responded to within 20 working days.

OPPC Complaints and Response Times



April 22 - 2 complaints received, 50% were responded to within 20 working days.

May 22 - 4 complaint received, 0% were responded to within 20 working days.

June 22 - 6 complaints received, 66% were responded to within 20 working days.

3.5 Nursing/Residential Homes and Supported Living Providers

The HSC Complaints Procedure stipulates that these providers must:

1. Manage complaints in line with best practice guidance and keep a full list of complaints and action taken, including learning from the outcome. A complaints register must be available for inspection by the Trust and those working on the Trust's behalf.
2. Submit a record of complaints to the Trust no later than 10 working days after the end of each Quarter for complaints closed in that period. This includes a Nil return if appropriate. The quarterly report should be sent electronically to the Trust.
3. Notify immediately the nominated Trust Corporate Governance Office any complaints of a serious nature, including those associated with alleged abuse, contraventions of employment legislation, accidents resulting in personal injury to staff or residents, or theft. Notification in writing must also be completed within one Working Day of the complaint being received.

3.6 Informal/Enquiries and Local Resolution

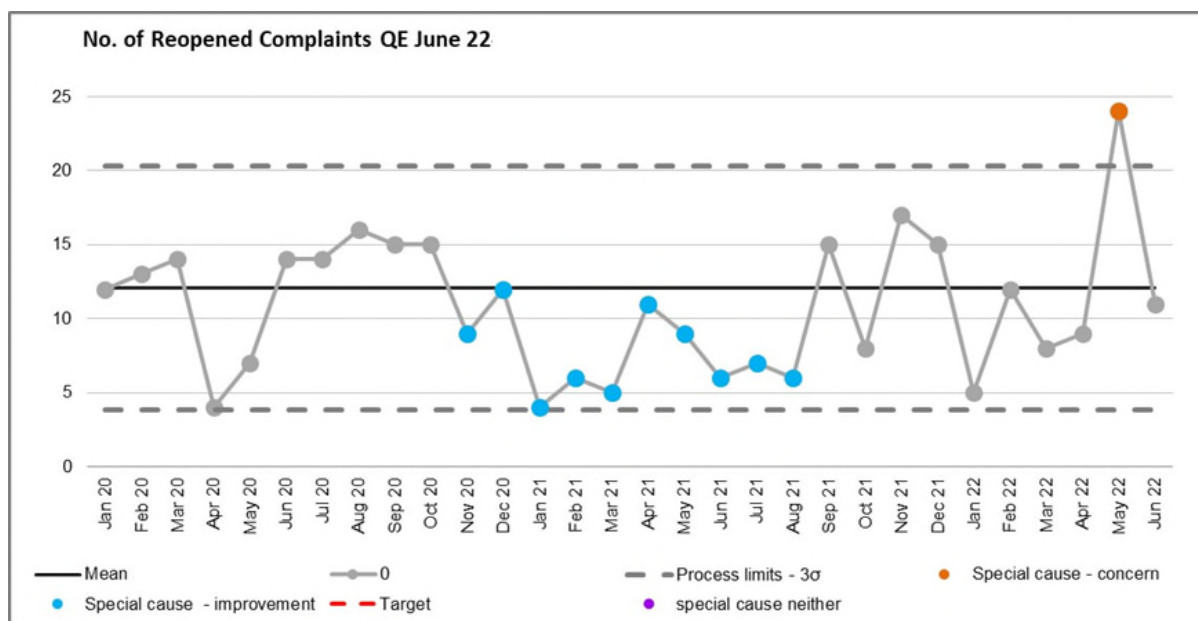
Directorates received a number of informal complaints and/or enquiries as detailed in Table 18.0 below.

Resolution Stage / Method									
	Apr - Jun 20	Jul-Sep 20	Oct - Dec 20	Jan - Mar 21	Apr - Jun 21	Jul - Sept	Oct - Dec 21	Jan - Mar 22	Apr - Jun 22
Enquiry	63	143	132	104	119	129	127	117	134
Informal HSC Complaint	35	30	47	46	61	50	66	66	89
Resolved at Point of Service Delivery	3	7	3	4	15	15	2	3	3
Redirected	10	4	7	4	2	3	3	11	12
COVID 19 Enquiry	61	12	26	28	5	17	3	11	1
Totals	182	211	219	186	220	214	201	208	239

3.7 Complaints – Re-opened

In this quarter, Apr – Jun 2022, 44 complaints were re-opened as the complainant remained unsatisfied with the initial investigation and outcome. The number of re-opened complaints this quarter has significantly increased compared to last quarter. In May '22, 24 complaints were re-opened breaching the normal variation, 18 of which fell within the Acute Directorate. On review, no common themes were identified as the reopened complaints contained varied subjects across a number of Divisions. The line graph, Figure 15 below, shows the number of re-opened complaints since January 2020.

Figure 15.0



3.8 Complaints - Response Audit

In previous quarters, 10% of all formal complaint responses had been audited. Following the outcome of a recent Internal Audit, a decision has been made to undertake an audit of 25% of all complaint responses issued for 3 quarter ends, and on an annual basis, for one quarter end period, an audit will be completed on 100% of all responses issued during that period.

As at 5th July there were 112 formal responses issued for complaints received from April to June 2022. A response audit was carried out on all 112 using the regionally agreed 'Checklist for Preparing Draft Responses to Complaints'. The checklist takes into consideration the Ombudsman's Principles of Good Complaint Handling¹⁴.

Audit results:

- All responses included a polite opening to the letter and thanks for raising the complaint.
- All responses reflected the Trust values, were very understandable and expressed regret where applicable.
- 42 responses were not responded to within 20 days.
- All of the responses addressed all issues identified within the complaint.
- Where applicable, responses advised the complainant of any changes/improvements that had taken place as a result of their complaint.

Internal Audit

Work on the recommendations from the BSO Internal Audit of the Trust's Management of Complaints process is progressing within associated timescales for completion. The Service User Feedback Policy and Procedures, which incorporates Complaints Management, has been

¹⁴ Question 13 has been excluded from the chart above as there is no way of detecting from reviewing the response whether the accuracy of the facts were verified.

revised and addresses 11 of the 17 recommendations made by Internal Audit. A Complaints Management Awareness training package has been drafted and will be disseminated to relevant staff for review and consultation. It is anticipated that the training will be finalised and launched as Mandatory Training for all staff during 'Safetember'. Contact has been made with an external provider in regards to the development and delivery of a training package for Complaints Investigators. A programme has been drafted for consideration. It is intended that staff who attend this training will then be involved in the development of an internal training package and participate in cascade training as required. One recommendation is regional and will be addressed at a regional Complaints meeting.

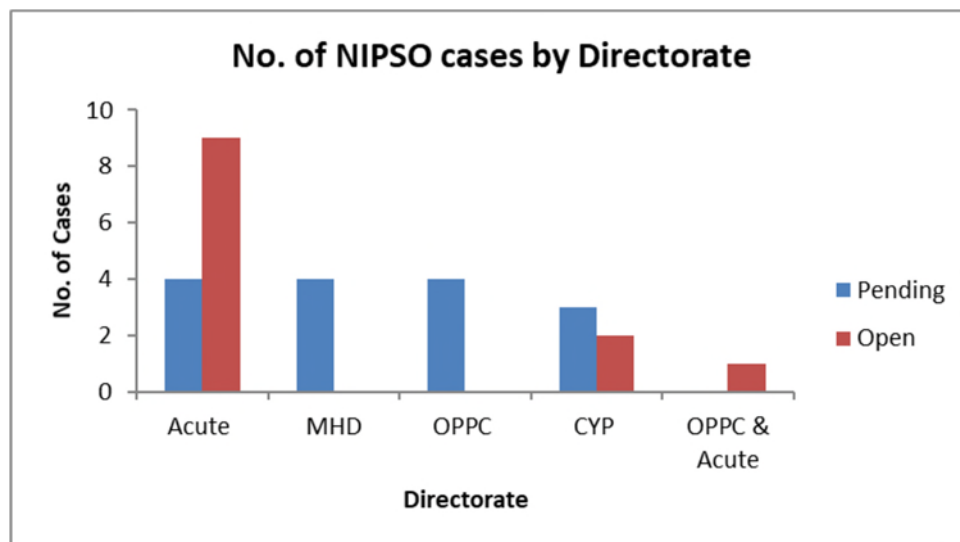
3.9 Ombudsman Cases

In the period April – June 2022, the SHSCT received 11 requests for information from the Ombudsman's Office, 2 of these cases are currently pending, the remaining 9 were closed at initial assessment.

At present, there are 12 open Ombudsman cases and 15 pending cases.

Of the 12 open cases, 1 draft report has been received, the recommendations will be shared on receipt of the final report with the relevant Directorate Governance team on receipt. A summary will also be shared here.

Figure 16.0 Breakdown of NIPSO cases across Directorates.



3.10 Health Care Complaint Analysis Tool

As an action from a previous Governance Committee meeting it was agreed that the HCAT tool would be used to analyse all formal complaints received into the Service User Feedback Team from the 1st June 2020. The report for complaints received April – June 2022 can be found at Appendix F.

4.0 Service User Compliments

Business Services Organisation (BSO) is the HSC organisation that hosts the compliments websites and servers, on which SHSCT compliment data is stored. BSO is now providing compliment information to HSCTs.

Compliments received into the Trust in this reporting period can be found in Table 19.0 below. Only written compliments are reported to the DOH (verbal compliments, confectionary etc. are not included) and only compliments from service users are included (compliments from staff are not included) in the figures.

There has been a 57% increase in compliments received since the previous quarter with a significant increase in compliments received through Care Opinion from 732 in Q4 of 2021/22 to 1467 in Q1 of 2022/23 and card which increased from 427 in Q4 of 2021/22 to 533 in Q1 of 2022/23. There has been a significant drop in compliments received via Social media, 119 in Q4 of 2021/22 to 2 in Q1 of 2022/23.

There has been a marked increase in compliments received this quarter relating to Quality of Treatment and Care, for Q4 last year there were 524 compared to 825 for Q1 in 2022/23 (an increase of 64%). There is also a marked increase in compliments received for Staff Attitude and Behaviour. In Q4 there were 425 compared to 723 for Q1, an increase of 59%. All other subject areas including Information and communication, Environment and other have also seen an increase compared to last quarter.

Table 19.0 – Compliments Received April – June 22

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	199	16	6	15	1	13	575	825
Staff Attitude & Behaviour	178	14	5	13	1	15	497	723
Information & Communication	82	6	1	7	0	8	90	194
Environment	73	1	0	0	0	1	305	380
Other	1	0	0	1	0	0	0	2
Total Compliments	533	37	12	36	2	37	1467	2124
Diff + or - previous Qtr.	+106	+5	+4	+5	-117	+34	+735	+772

Table 20.0 – Previous Quarter

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	162	9	2	11	25	1	314	524
Staff Attitude & Behaviour	148	14	2	13	39	1	208	425
Information & Communication	60	8	2	5	22	0	58	155
Environment	57	1	2	2	33	1	152	248
Other	0	0	0	0	0	0	0	0
Total Compliments	427	32	8	31	119	3	732	1352

Acute Clinical Governance and Social Care

MEETING WITH ACUTE DIRECTOR

Date: June 2022

AGENDA

1.0

SAI/ SEA reports

More than 26 weeks	Less than 26 weeks	Within Timescales	Level 3	Total
20	25	5	4	54

Personal information redacted by the USI



Ms Vivian McConvey, Chief Executive

2.0

Weekly report



Weekly Governance Report 20200609.do

3.0

Complaints



20220613 - Acute overview.xlsx

Division

17

SEC/ATICS

15

Medicine

18

USC

10

IWMH

2

CCS

3

FSS

Formal Complaints – 62 (41 outstanding)

	Red	Amber	Green	Total	Await approval from AD
SEC/ATICS	10	2	5	17	0
MED	13	2	0	15	4
ED	13	2	3	18	5
CCS	1	0	1	2	1
IWMH	2	2	3	10	3 meetings

	FSS	2	0	1	3	1
	Total	41	8	13	62	11
	Reopened Complaints– 31					
		Total	Out of total Await approval from AD	Meetings to be arranged		
	SEC/ATICS	12	1	0		
	MED	9	2 (one with OPPC)	0		
	ED	7	0	0		
	CCS	0	0	0		
	IWMH	4	0	3		
	FSS	2	0	0		
	Total	36	0	3		
4.0	Lab Letters - Difficult sourcing NOK will be progressed this week along with RR					
4.0	TOMCAT/ Cardiology  FW TOMCAT SAI .msg					
5.0	USI + Governance posts -					
6.0	Personal Information redacted by the USI Learning Letter					
7.0	Risk Registers - My background priority for over the next 2 weeks					
AOB						



Quality Care - for you, with you

Our ref: MOK/jc

9 June 2022

Chair

Eileen Mullan MBE

Chief Executive

Dr Maria O'Kane

By email only

Personal Information redacted by the USI

Ms Vivian McConvey
Chief Executive
Patient and Client Council
5th floor,
14-16 Great Victoria Street,
Belfast,
BT2 7BA

Dear Vivian

RE: SERIOUS ADVERSE INCIDENT REVIEW –

Personal Information redacted by the USI

As agreed I am writing to update you regarding the Southern Health and Social Care Trust's progress regarding the Serious Adverse Incident Review regarding [redacted]. I would like to reassure you and [redacted] family that the Trust is making every effort to progress this work in an open and transparent manner in order to achieve a satisfactory conclusion for [redacted] family.

As you are aware Ms Sharon Gallagher, Deputy Secretary, Strategic Planning and Performance Group wrote to my predecessor, Mr Shane Devlin on 7th February 2022 regarding the next steps in the Serious Adverse Incident Review. To further this work I met with Ms Gallagher to discuss the three requests set out in this correspondence that highlighted areas that will assist in re-instating the family's confidence in the Serious Adverse Incident process. For ease of reference I have listed each associated agreed action from the meeting below.

Competitive Tender for SAI Review

The Trust is continuing to progress an open competitive tender process with the aim of appointing an experienced, independent organisation to conduct the review. We expect the tender will be complete by August 2022.

Request to Nominate a Non-Executive Director to Oversee the Review

The Trust has considered this and to ensure there is no actual or perceived bias suggest that a lay representative should be nominated who would be willing to undertake this role in a fully independent capacity. I would welcome both your and the family's thoughts on a nomination and would be grateful if my office could be advised of who this may be and the contact details for same.

Nomination of Senior Clinician to Support the Family through the SAI Process

The Trust operates a Family Liaison team who are experienced in supporting patients and families through SAI and complaint processes. We believe this would be most appropriate to provide this service on behalf of the Trust for the family of Personal Information redacted by the USI. I will arrange a liaison officer to contact your office via Mr Gary Whitson to progress this engagement.

I trust you will share this update with the family and provide comments regarding the request for the nomination of a lay person.

Please do not hesitate to contact me if you have any further questions.

Yours sincerely

Personal Information redacted by the USI

DR MARIA O'KANE
CHIEF EXECUTIVE

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
AS51.22/23	Personal information redacted by the Usher Institute	FSS		Booking Centre	06/05/2022	20/05/2022	07/06/2022	135	Jane Scott	08/06/2022	10/06/2022	Natalie	Have louse devlin input just need Jane Scott 08/06/2022
AS58.22/23		FSS		Visiting	06/05/2022	20/05/2022	07/06/2022	135	Joanne McEvoy	08/06/2022	08/06/2022	Natalie	09.06.22 Sent to Anita Carroll for approval
AS55.22/23		FSS		ED CAH	13/05/2022	27/05/2022	14/06/2022	128	Sinead Corr, Joanne McEvoy	09/06/2022		Natalie	Investigation email sent

drafting date
days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
AS445.21/22	Personal information redacted by the USI	IMWH		EPPC	03/03/2022	18/03/2022	01/04/2022	meeting	Wendy Clarke, Judith Mitchell, Josie Matthews, Amie Nelson	21/04/2022 10/05/2022	28/03/2022	Natalie	Meeting booked for 14/06/22
AS449.21/22		IMWH		2 west	04/03/2022	21/03/2022	04/04/2022	meeting	Mary Dawson, Wendy Clarke, Rachel Bailie	21/04/2022	28/03/2022	Natalie	Going through SAI process - 10.06.22 Advised Caroline Keown complaint response still required
AS467.21/22		IMWH		Maternity Assessment Unit/Maternity Ward	08/03/2022	23/03/2022	06/04/2022	meeting	Emma Creagh, Emma Bailie, Joanne McGlade, Josie Rushe, Wendy Clarke, Meeta Kamath		28/03/2022/27/04/2022	Natalie	09.06.22 Meeting notes sent out to Wendy Clarke, Dr Loane and Sister McCann for approval
AS16.22/23		IMWH		DAU	14/04/2022	03/05/2022	17/05/2022	156	Emma Joe Bailey, Joanne McGlade, Wendly Clarke	18/05/2022, 06/06/2022	13/05/2022	Natalie	06/06/2022 - email sent to Caroline and Wendy to advise patient wants written response
AS40.22/23		IMWH		Delivery Suite	27/04/2022	12/05/2022	26/05/2022	147	Wendy Clarke, Mary Dawson			Natalie	Meeting date confirmed 28/06/2022
AS55.22/23		IMWH		Gynae	09/05/2022	23/05/202	08/06/2022	134	Wendy Clarke, Pamela Forde	08/06/2022	08/06/2022	Natalie	To Melanie for approval 10/06/2022
AS73.22/23		IMWH		Delivery Suite	18/05/2022	01/06/2022	17/06/2022	125	Mary Dawson, Wendy Clarke	09/06/2022		Natalie	Investigation email sent
AS89.22/23		IMWH		2 West/Maternity OPD	20/05/2022	07/06/2022	21/06/2022	121	Mary Dawson, Wendy Clarke, Edgar Boggs			Natalie	Investigation email sent
AS93.22/23		IMWH		Assessment Unit/ 2 West	25/05/2022	10/06/2022	24/06/2022	118	Mary Dawson, Wendy Clarke, Pamela Ford, Edgar Boggs			Natalie	Investigation email sent
AS96.22/23		IMWH		Maternity Ward	30/05/2022	15/06/2022	29/06/2022	113	Wendy Clarke, Samy Mutalab			Natalie	Investigation email sent
AS101.22/23		IMWH		Gynae OPD	01/06/2022	17/06/2022	01/07/2022	111	Dr Mutalab, Wendy Clarke			Natalie	Investigation email sent

drafting date
days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
AS433.21/22	Personal information redacted by the USI	MED		3 North	18/02/2022	04/03/2022	21/03/2022	213		26/04/2022 09/05/2022	18/03/2022, 24/05/2022	Chrisy	To be drafted 16.05/2022
AS463.21/22		MED		L4 Stroke Rehab	09/03/2022	24/03/2022	07/04/2022	196	Ursula Haughey Patricia Loughan/ Dr Gafer	26/04/2022 10/05/2022 19/05/2022 06/06/2022	28/03/2022, 25/05/2022	Chrisy	Reminder sent to L4 10/05/2022
AS469.21/22		MED		Stroke/rehab	21/03/2022	04/04/2022	20/04/2022	183	Ursula Haughey/ Patricia Loughan/Audrey Wilson Reid	27/04/2022 19/05/2022 06/06/2022	27/04/2022 10/05/2022 19/05/2022	chrisy	Reminder sent 27.04.2022
AS01.22/23		MED		1 North	04/04/2022	20/04/2022	05/05/2022	168	Dr Eltom, Anne McVey, Phillip Murphy, Ruth Weir	27/04/2022 19/05/2022 06/06/2022	28/04/2022, 25/05/2022	Chrisy	Investigation email sent
AS06.22/23		MED		1 South	05/04/2022	21/04/2022	06/05/2022	167	sent to manos epanomeritakis for input if possible, clair Quin oncology	28/04/2022 19/05/2022 06/06/2022	13/05/2022	Chrisy	Philip Nurphy has given response but have asked Clair Quin and Mano s if there is nayting further but if not come back in a week draft
AS11.22/23		MED		2 North/Patient flow	13.4.22	29/04/2022	16/05/2022	157	Victoria Burnett, Audrey Wilson Reid, Kay Carroll, Laura White, Paula McKay,	18/05/2022 07/06/2022	13/05/2022	Chrisy	Have Dr Convery and ED Consultant , need 2 North/ Patient Flow and ED Nursing
AS35.22/23		MED	MED	ED, 2 North, ICU	25/04/2022	10/05/2022	24/05/2022	149	Erskine Holmes	19/05/2022 08/06/2022	23/05/2022	Chrisy	ICU and ED drafted just need 2 north
AS36.22/23		MED		Dermatology	28/04/2022	13/05/2022	27/05/2022	146	Art O'Hagan, Dr Glover, Dr Boggs	19/05/2022 07/06/2022	23/05/2022	Chrisy	Investigation email sent 19.05.22 - Reminder email sent
AS39.22/23		MED		Ramone Isolation Ward 2	28/04/2022	12/05/2022	26/05/2022	147	Hannah Jameson, Patricia Loughan, Dr Elhaj	18/05/2022 07/06/2022	27/05/2022	Chrisy	Have bed management part just need all the rest.
AS78.22/23		MED		1 South	28/04/2022	13/05/2022	27/05/2022	146	Trudi Kelly, Louise Devlin, Philip Murphy, Shivram Bhat,	31/05/2022 07/06/2022	27/05/2022	Chrisy	Input needed from OPPC and the wards, HSW responded
A63.22/23		MED		1 North	05/05/2022	19/05/2022	06/06/2022	136	Need OPPC input	16/05/202208/06/2022	08/06/2022	Chrisy	Have HSW resposne need OPPC sent to OPPC 09/06/2022
AS52.22/23		MED		1 South	06/05/2022	20/05/2022	07/06/2022	135	Karen Kelly, Trudi Kelly, Louise Devlin,		10/06/2022	Chrisy	To Anne for approval 09/06/2022
AS64.22/23		MED		Cardiology	09/05/2022	23/05/2022	08/06/2022	134	Kay Carroll, Dr McClelland	09/06/2022	10/06/2022	Chrisy	To Anne from approval 10/06/2022
AS61.22/23		MED		FMW	11/05/2022	25/05/2022	10/06/2022	132	Abby McConnell, Laura McAuliffe, Kay Carroll	08/06/2022	10/06/2022	Chrisy	To Anne for approval 06/06/2022
AS68.22/23		MED		Stroke/rehab/1 North/ED CAH/ED DHH	16/05/2022	30/05/2022	16/06/2022	126	Ruth Weir, Audrey Wilson-Reid, Ursula Haughey, Patricia Loughan, Charlotte Anne Wells, Joanne McEvoy, Gerrard Sloan	09/06/2022		Chrisy	Email to Shelagh advising of process 07/06/2022
AS102.22/23		USC/MED		ED/2 South	06/06/2022	20/06/2022	04/07/2022	108	Paul Smyth, Rachel Greer, Stacey Leonard, Audrey Wilson-Reid, Patricia Loughan, Governance OPPC			Natalie	Investigation email sent
AS105.22/23		SEC/MED		ENT OPD/Dermatology OPD	07/06/2022	21/06/2022	05/07/2022	107	Jane Scott, Wendy Clayton, Dr Eedy, Audrey Wilson-Reid, Patricia Loughan			Chrisy	Investigation email sent

drafting date

days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
AS250.21/22	Personal information redacted by the USI	SEC		FMW	21/05/2021	04/06/2021	18/06/2021	489	Amie Nelson	13/09/2021 & 23/12/21	18/02/2022	Chrisy	Amie reminded 03/05/2022 - PCC requesting response. Escalated to Chris. Asked PCC if they wanted response as is - awaiting Amie 05/05/2022
AS399.21/22		SEC		Surgical	12/11/2021	24/11/2021	08/12/2021	316	Mr Hewitt, Amie Nelson	04/05/2022 06/06/2022	25/02/2022, 24/05/2022,	Chrisy	Awaiting response from Amie Nelson and Mr Hewitt. Escalated to Ronan, Chris, Amie and Mr Hewitt 04/05/2022
AS404.21/22		SEC	Ortho	Ortho OPD	31/01/2022	15/02/022	01/03/2022	233	Brigeen Kelly, Gary Rainey, Jonathan Bunn,	25/04/2022/05/05/2022	31/03/2022, 24/05/2022	Chrisy	For draftng
AS436.21/22		SEC		3 South	23/02/2022	09/03/2022	24/03/2022	210	Paula McKay Laura J White	26/04/2022/ 09/05/2022, 29/05/22 06/06/2022	25/03/2022, 24/05/2022	Natalie	Reminder again on 06/06/2022
AS14.22/23		SEC		SEC	14/04/2022	03/05/2022	17/05/2022	156	Jane Scott	18/05/2022 07/06/2022	23/05/2022	Chrisy	Investigation email sent
AS26.22/23		SEC		4 North	19/04/2022	04/05/2022	18/05/2022	155	Emma McCann, Tracey McGuigan, Amie Nelson	13/05/2022 19/05/2022 07/06/2022	13/05/2022	Chrisy	Per Tracey McGuigan - nursing notes awaited. Cannot respond until nursing notes are located 27/05/2022
AS41.22/3		SEC	MED	Female Medical	28/04/2022	12/05/2022	26/05/2022	147	Dr Gilpin	31/05/2022 07/06/2022	27/05/2022	Chrisy	Investigation email sent
AS42.22/23		SEC		Trauma	29/04/2022	16/05/2022	30/05/2022	143	Louise Currie, Brigeen Kelly (Amie Nelson) Veronica Roberts	07/06/2022	27/05/2022	Chrisy	Investigation email sent
AS62.22/23		SEC	Anaesthetics	1 West	04/05/2022	18/05/2022	01/06/2022	141	Helena Murray, Emma Jane Kearney	07/06/2022	31/05/2022	Chrisy	Elective ward response in just awaiting Anaesthetics 17.05.2022
AS53.22/23		SEC		3 South	04/05/2022	18/05/2022	01/06/2022	141	Laura White, Paula McKay, Wendy Clayton		31/05/2022	Chrisy	To Melanie for signing 10/06/2022
AS56.22/23		SEC		Scheduling	06/05/2022	20/05/2022	07/06/2022	135	Rachel Donnelly/ Bronach Tallon/ Jane Scott	08/06/2022	08/06/2022	Chrisy	Investigation email sent
AS81.22/23		SEC		General Surgery	18/05/2022	01/06/2022	17/06/2022	125	Colin Weir, Amie Nelson, Angela Higgins			Chrisy	Investigation email sent
AS90.22/23		SEC		Orthopaedic Surgery	20/05/2022	07/06/2022	21/06/2022	121	Brigeen Kelly, Wendy Clayton			Chrisy	To Melanie for approval 10/06/2022
AS91.22/23		SEC		Orthopaedic Clinic	23/05/2022	08/06/2022	22/06/2022	120	Brigeen Kelly, Wendy Clayton			Chrisy	Investigation email sent
AS94.22/23		SEC		4 South	26/05/2022	13/06/2022	27/06/2022	115	Gerarde McArdle, Emma McCann, Tracey McGuigan, Lisa Frazer, Paul Smyth			Chrisy	Investigation email sent
AS95.22/23		SEC		4 North	30/05/2022	15/06/2022	29/06/2022	113	Emma McCann, Tracey McGuigan, Amie Nelson, Anthony Glackin			Chrisy	Investigation email sent
AS104.22/23		SEC		Vascular Surgery	06/06/2022	20/06/2022	04/07/2022	108	Alastair Lewis, Amie Nelson			Chrisy	Investigation email sent
AS45.22/23		SEC		Trauma Ward	07/06/2022	21/06/2022	05/07/2022	107	Louise Currie, Brigeen Kelly, Trudy Reid, Grace Hamilton, Lisa Houlihan			Chrisy	Investigation email sent
AS105.22/23		SEC/MED		ENT OPD/Dermatology OPD	07/06/2022	21/06/2022	05/07/2022	107	Jane Scott, Wendy Clayton, Dr Eedy, Audrey Wilson-Reid, Patricia Loughan			Chrisy	Investigation email sent

drafting date
days for drafting

ACUTE GOVERNANCE CURRENT COMPLAINTS RECORD													
Ref	Record name	Div Lead	Input required	Loc (Exact)	Date Received	Investigation due	Reply due	DAYS OVER	Sent to....	Reminders Sent	Last Holding	Natalie or Chrisy	Comments
AS300.21/22	Personal Information redacted by the USI	USC		ED DHH	02/11/2021	16/11/2021	30/11/2021	324	Paul Smyth, Gareth Hampton, Pauline Fearon	08/06/2022	24/02/2022	Natalie	For investigation
AS308.21/22		USC		ED DHH	09/11/2021	23/11/2021	07/12/2021	317	CYP needed	22/02/2022, 03/05/2022, 23/05/22	25/02/2022, 03/05/2022, 24/05/2022	Natalie	03/05/22 Carly confirmed debrief for May's ACG Meeting for approval. Reminder sent to Joanne/Sinead for ED Reception response 03/05/2022 24.05.22 Debrief relisted for June
AS419.21/22		USC	SEC	AMU	15/02/2022	01/03/2022	15/03/2022	219		25/04/2022, 16/05/2022, 30/05/2022, 06/06/2022	16/03/2022, 16/05/2022	Chrisy	With all AD for approval
AS439.21/22		USC	MED	ED/2 SOUTH	01/03/2022	15/03/2022	30/03/2022	204	Gareth Hampton/ Paul Smyth, Mohamed Salah/ Stacey Leonard/ Patricia Loughan	26/04/2022, 25/05/2022, 06/06/2022	25/03/2022, 27/05/2022	Natalie	Investigation email sent. Sent for screening re missed fractures
AS446.21/22		USC	2 South/OT	ED/2South	03/03/2022	18/03/2022	01/04/2022	202	Stacey Leonard, Patricia Loughan, Charlotte Ann Wells,	26/04/2022, 10/05/2022, 19/05/22, 06/06/2022	28/03/2022, 25/05/2022	Natalie	OT, 2 South Stroke 19.05.22 Reminder email sent
AS480.21/22		USC		ED DHH	24/03/2022	07/04/2022	25/04/2022	178	Lisa Small, Rachel Greer, Paul Smyth, Gareth Hampton, Pauline Fearon, Mary Burke	27/04/2022, 25/05/2022	27/04/2022, 19/05/2022	Natalie	06.06.22. Mary for approval
AS483.21/22		USC		ED	29/03/2022	07/04/2022	25/04/2022	178		19/05/2022, 06/06/2022	27/04/2022, 25/05/2022	Natalie	05.05.22 Further comments added to complaint and sent to Paul Smyth and Mary Burke 19.05.22 Reminder email sent
AS13.22/23		USC		ED CAH	11/04/2022	27/04/2022	12/05/2022	161	Rachel Greer, Ashlene Kelly, Tracey McGuigan, Amie Nelson	19/05/2022	13/05/2022	Natalie	With Mary for approval 06/06/2022
AS43.22/23		USC		ED CAH	29/04/2022	16/05/2022	29/05/2022	144	Sharon Holmes and Roger Stewart	20/05/2022, 07/06/2022	27/05/2022	Natalie	20.05.22 - Draft received from ED and Porters - Awaiting AMU email sent to Sharon Holmes and Roger Stewart
AS47.22/23		USC		ED DHH	05/05/2022	19/05/2022	06/06/2022	136	Ursula Haughey, Patricia Loughan, Patricia McGrath, Abby McConnell, Kay Carroll	08/06/2022	10/06/2022	Natalie	Received ED part need Stroke Rehab/Bluestone/
AS57.22/23		USC		EDCAH	09/05/2022	23/05/2022	08/06/2022	134	Lisa Frazer/David Patton	08/06/2022	10/06/2022	Natalie	Input received from MHD
AS59.22/23		USC		ED CAH	10/05/2022	24/05/2022	09/06/2022	133	Gareth Hampton, Pauline Fearon, Paul Smyth	08/06/2022	10/06/2022	Natalie	10/06/2022 with Mary Burke
AS60.22/23		USC		ED CAH	11/05/2022	25/05/2022	10/06/2022	132	Lisa Frazer, Paul Smyth	08/06/2022	10/06/2022	Natalie	Investigation email sent
AS74.22/23		USC		ED CAH	16/05/2022	30/05/2022	15/06/2022	127	Lisa Frazer, Rachel Greer, Paul Smyth	09/06/2022		Natalie	Investigation email sent
AS86.22/23		USC		ED CAH	20/05/2022	07/06/2022	21/06/2022	121	Lisa Frazer, Rachel Greer, Paul Smyth, Ronan McKeown, Wendy Clayton	08/06/2022		Natalie	Investigation email sent
AS97.22/23		USC		ED CAH	31/05/2022	16/06/2022	30/06/2022	112	Lisa Frazer, Gareth Hampton, Elizabeth McVeigh, Julie Martin, Brenda Abraham, Paul Smyth			Natalie	09.06.22 With Mary for approval
AS100.22/23		USC		ED CAH	31/05/2022	16/06/2022	30/06/2022	112	Paul Smyth, Rachel Greer, Elizabeth McVeigh			Natalie	Investigation email sent
AS102.22/23		USC/MED		ED/2 South	06/06/2022	20/06/2022	04/07/2022	108	Paul Smyth, Rachel Greer, Stacey Leonard, Audrey Wilson-Reid, Patricia Loughan, Governance OPPC			Natalie	Investigation email sent

drafting date
days for drafting

REPORT SUMMARY SHEET

Quality care – for you, with you

Meeting: Date:	Senior Management Team 14 th June 2022
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Aisling Diamond, Interim Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information
<u>Overview:</u> Provide SMT with an Oversight of Weekly Activity in relation to Clinical & Social Care Governance	
•	

Summary of Weekly Governance Activity 24.05.2022 - 05.06.2022

	DIRECTORATE				
	ACUTE Number	MHLD Number	CYP Number	OPPC Number	TOTAL Number
New SAIs Notifications	1	0	0	0	1
SAI Reports submitted to HSCB	0	1	0	0	1
Ongoing SAIs*	53	31	2	13	99
High Risk Complaints	0	0	0	0	0
NIPSO Case Accepted for Investigation	0	0	0	0	0
NIPSO Draft/Final Reports Received	0	0	0	0	0
Early Alerts	0	0	1 update	1	1

*Below highlights the change in ongoing SAI figures from 99 last week to 99 this week:

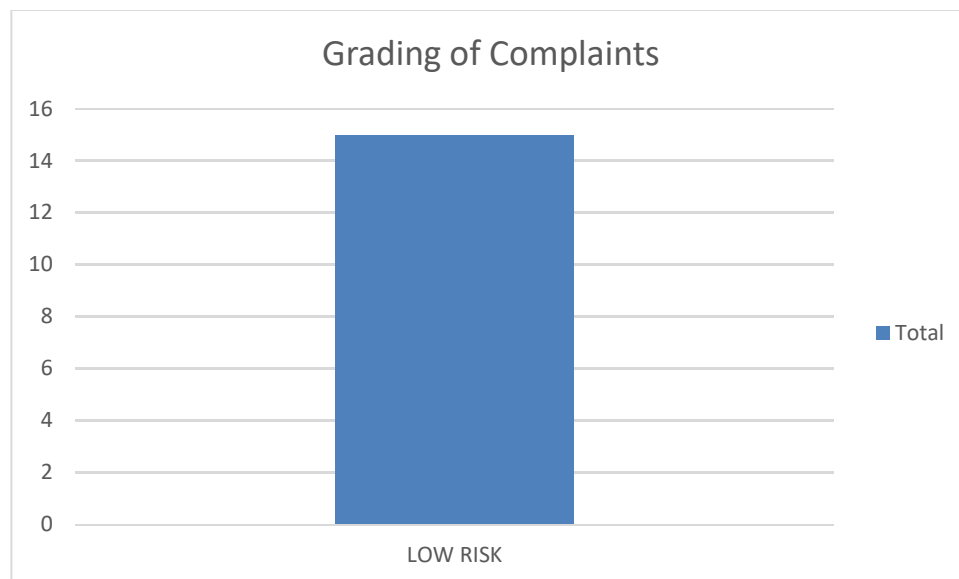
Ongoing SAIs reported last week –29/05/2022 99

Add New SAI notifications: Acute +1

Less SAI reports submitted: MHD -1

Ongoing SAIs reported week ended 05/06/2022 99

Grading of Formal Complaints Received 23.05.2022 - 05.06.2022



*Moderate Complaints –

- b/f from last week 15235 – Acute - Patient is not happy with care she received from CAH during her pregnancy and post c-section. Her daughter was born following emergency c-section and she was transferred to the ward with no sleep. In the early hours of the morning she was given her daughter to feed. She drifted off to sleep and her daughter rolled from her arms onto the floor. When a staff member came to help patient was handed another baby to hold. Patient's daughter suffered two fractures and a bleed to the brain.

Open Moderate Complaints

ID	Directorate	First received	Response due	Current Stage	Description (Policies)	Grade	Update from Directorate
15035	ACUTE	14/04/2022	12/05/2022	INVEST	Patient unhappy as she was told by consultant that she would receive procedure in 3 months' time. She waited a year and contacted hospital and was advised she was on waiting list and could be waiting a further 4 years. She contacted consultants secretary and her line manager and states that they were very unhelpful. She wants to know why she was told she would be seen within 3 months and why an urgent waiting list is 4 years long.	MODRIS	Waiting list – all moderate harm
15235	ACUTE	20/05/2022	17/06/2022	INVEST	Patient is not happy with care she received from CAH during her pregnancy and post c-section. Her daughter was born following emergency c section and she was transferred to the ward with no sleep. In the early hours of the morning she was given her daughter to feed. She drifted off to sleep and her daughter rolled from her arms onto the floor. When a staff member came to help patient was handed another baby to hold. Patient's daughter suffered two fractures and a bleed to the brain.	MODRIS	As discussed at last weeks meeting. Moderate as child suffered #s and bleed

Outstanding Complaints as at 5.6.2022

Directorate	20dys - 1 month	1 - 3 months	3 - 6 months	6 - 9 months	9 - 12months	12months	Total
Acute	13	27	3			1	44
CYP	3	8					11
MHD	2	6					8
OPPC		2	2				4
Total	18	43	5			1	67

ACUTE DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

1. Status of SAIs - Summary of the status of SAIs between 24.05.2022 - 05.06.2022

Any reports received after Friday will not be reflected in the numbers below until the following week

20	25	5	4	54

2. SAI Notifications (b/f from last week)

Incident ID	Incident Date	Incident Description
Personal information redacted by the USI	Personal information redacted by the USI	Alleged sterilization without consent
		Delay in the recognition of chorioamnionitis on CTG, baby admitted to neonatal unit and treated for sepsis.
		Elective C Section returned to theatre for small bowel obstruction = loop of small bowel herniation.

Incident ID	Incident Date	Incident Description
Personal information redacted by the USI		Omitted cardiac investigations referrals to the TOMCAT system; 1104 managed cardiac investigations outside of prescribed timeframe

3. SAI Reports

Final SAI Report sent to SPPG for Level 3 SAI.

4. Intertrust and Interface Incidents

Incident Date	Trust Origin	Description
Personal information redacted by the USI	BHSCT Ref: irrelevant information redacted	Patient was an inpatient in CAH requiring a Left nephrostomy tube insertion and repositioning of his Right nephrostomy tube. Was due to be completed in CAH however was cancelled as the suitable venous access cannula was not available. Patient had to be transferred to RVH. BHSCT advised that the procedure could and should have been performed in SHSCT, and we would need more of an understanding as to why this didn't happen as the patient was scheduled with their IR service and was in the department on Thursday but sent back to the ward. There was a risk of sepsis to the patient as infection markers were already elevated and continued to rise. SHSCT clinical team requested the

		procedure to be performed in BHSCT, which was accepted by Urology and IR, however the transfer took most of the day and the procedure was performed out of hours. Whilst the procedure had a positive outcome for the patient, this was a poor patient journey and placed increased pressure on the service in terms of conducting the procedure during the out of hours period. 19/05/2022- Awaiting response from Service 26/05/2022 – To be screened today. Emailed consultant involved for feedback, for rediscussion today at screening Response from consultant <i>“Patient had a blue cannula in place.</i> <i>I'm not prepared to do any interventional procedure unless a pink cannula is in place.</i> <i>This has been my practice for 15 years.</i> <i>If the patient has a major bleeding complication during or in the 6 hrs post procedure the patient would likely die.</i> <i>The ward are aware of this.</i> <i>Under no circumstance should a septic patient be managed anywhere in this trust with a blue cannula.</i> <i>If Belfast are promoting unsafe practice, while filing Datix against us, perhaps the ST reduce their IV commitments.</i> <i>I'm more than happy to do more cardiac work.”</i>
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5. Catastrophic Incidents b/f from last week

Irrelevant information - Acute – Trauma - Admitted with fall on **Personal information redacted by the USI**, resulted in left NOF fracture and left DHS. Probable Hospital Acquired Covid-19 Pneumonitis (**Personal information redacted by the USI**), on the background of End Stage COPD. Discharged from Trauma to Ramone for further Respiratory support and then to STH on **Personal information redacted by the USI**. died later on **Personal information redacted by the USI**. ? relate to original COVID. There are no concerns in regards to recent hip surgery and contributing death is the result of advanced frailty, cachexia and End Stage COPD.

COVID Death ? Hospital acquired

Irrelevant information – Acute – Theatres - Summary details taken from notes as staff gone off duty - night shift. Patient admitted from ED to Emergency Theatre @20:05 **Personal information redacted by the USI** for intubation and ventilation following suicide attempt patient self reported ingested weedkiller Praquat & Bleach & alcohol consumption. OGD, Flexible Bronchoscopy Direct laryngoscopy. ENT assessment. CT scan & consultation with Belfast- following advise & discussion insurmountable damage no surgical intervention, NOK informed. Family attended theatre for end of life. **Personal information redacted by the USI**.

Incident to be screened as catastrophic outcome but admitted to ED with irreversible injuries, no for SAI.

6. No Early Alerts

= update on TOMCAT early alert provided

7. No Never Events

8. Directors Oversight Groups

- General Surgery
- Obs and Gynae
- Urology – work is progressing
- Covid-19 SAI – Final report received. Being discussed at SMT
- New Oversight group (MHD/Acute) to be created to identify and action learning from the recent Coroners case involving a patient who absconded from the ward and completed suicide

9. SJR Process for the Review of COVID Deaths in a hospital setting

It was agreed that this would now be a standard agenda item, historical updates can be located in previous papers. Information regarding Outstanding v Completed reviews is being sought.

10. RQIA

11. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)

- Recommendation from SAI [redacted] – Dr Gormley asked for recommendation 1 to remain on this agenda.
 1. The Radiology Senior Team will provide administrative support for the Radiology General Enquiries Service to determine what additional support is needed to ensure effective communication for inpatient examinations that are rejected or changed through the justification process. In reviewing these processes, the Radiology Team will consider how ICT can be best utilised to ensure this process is effective.

26/05/2022 – Will be discussed at Screening 26/05/2022

Awaiting confirmation of word from Barry before sharing with Damian

The recommendations for SAI [redacted] identified the need for the Radiology Senior Team to provide administrative support for the Radiology General Enquiries Service. This was to improve the communications for inpatient examinations that are rejected or changed through the justification process.

The Radiology team have completed a review of their admin and clerical resources, also undertaking a review of what resources could be reallocated while implementing additional checks and balances. This will require additional resources (3 x band 4 positions). A new job description for these roles has been developed by the Radiology team and has been submitted to HR for AFC banding assessment.

The suggested amendments has been developed into a paper and shared with the Director for Acute Services as the suggested changes to strengthen the governance processes will require an increase in resources and therefore additional financial support.

This paper is currently with finance department however as currently within the trust we cannot appoint positions “at risk” the progression of this recommendation has reach a stalemate while we awaiting confirmation funding is approved for these positions.

Any support from the Medical Directors office to support and progress the approval of this funding would be greatly appreciate and facilitate earlier implementation of services to implement this recommendation fully.”

MENTAL HEALTH AND DISABILITY DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

12. Status of SAIs

Summary of the status of SAIs between 24.05.2022 - 05.06.2022

6	12	3	9	30

13. No SAI Notifications

14. SAI Reports – b/f from last week

Incident ID	Incident Description	Lessons Learned/Recommendations
irrelevant information	Death of service user in the Community.	No Recommendations

Incident ID	Incident Description	Lessons Learned/Recommendations
irrelevant information	Death of service user in the Community.	 Draft SAI Report irrelevant information.docx

15. No Catastrophic incidents

16. No Early Alerts

17. No Never Events

18. Directors Oversight Group

- Dorsy and Granville,
- Oversight group re absconding patient who completed suicide.

19. Public Inuiry – Muckamore - All Trusts have been directed to source and provide information under Schedules 1 and 2 to the Muckamore Abbey inquiry. MHD are the lead directorate for this extensive resource intensive exercise in SHSCT.

20. RQIA

21. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)

Dr O'Kane will share an email from DLS with Tony regarding the 3 day follow up procedure after discharge for Mental Health Service users. This intervention would potentially reduce the number of suicides.

26/05/2022- Tony has chased Dr O'Kane for an update.

CHILDREN AND YOUNG PEOPLE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

22. Status of SAIs

Summary of the status of SAIs between 24.05.2022 - 05.06.2022

Less than 26 weeks	Total
2	2

23. No SAI Notifications

24. No SAI Reports

25. No Catastrophic Incidents reported this period

26. Early Alerts

EA JAN 2022 14 UPDATE 1Update 30 May 2022

The PSNI have advised social work staff, by letter on Personal Information redacted by the USI, that the children's father (referred to above) appeared in Court on Personal Information redacted by the USI and pleaded not guilty to charges relating to harassment of staff, misuse of social media and breaching a restraining order. The children's father was found guilty, and sentenced to five months imprisonment.

27. No Never Events**28. RQIA****29. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)**

OLDER PEOPLE AND PRIMARY CARE SERVICES DIRECTORATE

Data provided by Corporate Office from the Datix Incident Management System to the Weekly Governance De-Brief (Thursday mornings – 8.30am – 9.30am)

30. Status of SAIs

Summary of the status of SAIs 24.05.2022 - 05.06.2022

More Than 26 weeks	Less than 26 weeks	Hold	Within Timescale	Total
6	1	1	5	13

31. No SAI Notifications

32. No SAI Reports

33. Catastrophic Incidents

34. Early Alert

2 x GP OOH

35. No Never Events

36. RQIA

37. Process for the Review of COVID Outbreaks/Deaths in Independent Sector

It was agreed that this would now be a standard agenda item, historical updates can be located in previous papers. Work is ongoing to establish numbers of deaths and outbreaks within Care Homes. Letter to be drafted to PHA, suggestions included this should be sent from Brian Beattie and Heather Trouton.

38. Issues escalated by Corporate or Directorate office at meeting (to include any updates from Directorate Governance meetings)

LITIGATION

B/F from last week

39. New Clinical negligence

No new clinical negligence claims: 23.05.2022 – 27.05.2022

40. Clinical Negligence Claims Listed for Hearing in June 2022

All claims listed for hearing in June have since been adjourned.

41. Vaginal Mesh Cases

The number of vaginal mesh claims open to the Trust remains at 13 (stage of the open claims are listed below). One further case has issued proceedings meaning the claim is now lodged with the Court.

Stage	Number of Mesh Cases
Letter of Claim	0
Discovery	1
Investigation	4
Proceedings Issued	8
Trial date Set	0

42. Urology Cases – no update since last week

Following an announcement by the Minister for Health a public inquiry is underway in relation to Trust Urology services. As a result, it is anticipated that there will be an increase in related litigation cases.

There are now a total of 17 open cases identified at present (stage of the claims are listed below).

Stage	Number of Urology Cases
Letter of Claim	1
Discovery	4
Investigation	6
Proceedings Issued	6
Trial date Set	0

43. Coroner's Inquiries and Inquests

Ref	Directorate	Division	Incident type	Incident date	Opened date	Description	Governance Process
Personal information redacted by the USI	ACUTE	MUC	Death of a patient	Personal information redacted by the USI	23/05/2022	The Coroner directed a Post Mortem in this case and the Pathologist's preliminary finding is: Stab Wound to Chest The Coroner requires statements from all the relevant medical personnel who treated the patient	None currently identified

- There are currently no Inquest Hearings scheduled to take place until October 2022
- The following preliminary Inquest Hearings are scheduled to take place in June 2022.

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal information redacted by the USI	ACUTE	MUC	Death of a Service User	Personal information redacted by the USI	10/07/2018	01/06/2022	Personal information redacted by the USI transferred to CAH ICU Coroner directed a post mortem in this case and the preliminary finding is (p) Pneumonia.	None Identified
Personal information redacted by the USI	OPPC	Older People		Personal information redacted by the USI	21/01/2019	01/06/2022	The deceased was a resident in a nursing home, who was admitted to hospital after a fall We currently await PIP status after PH on 1/6/22.	Falls proforma. Inc Ref No Personal information

Personal information redacted by the USI	ACUTE/MHD	MUC/MHS	Homicide	Personal Information redacted by the USI	05/07/2018	27/06/2022	This relates to the homicide of an elderly couple in their home by an individual known to mental health services Update from PH Inquest listed for 06/06/2022 postponed until 12/06/2023 Further PH 27/06/2022	Personal Information redacted by the USI
Personal information redacted by the USI	ACUTE	MUC	Death of a patient	Personal Information redacted by the USI	12/08/2019	27/06/2022	The Coroner directed a post mortem in this case and the preliminary finding is (p) Coronary Artery Atheroma The deceased had an OGD (Oesophago-gastro-duodenoscopy) (camera test) on [redacted] the deceased went missing off the ward. Despite the implementation of the absconding policy, family contact, a search of the ward and hospital site, the deceased was not found. Unfortunately, he was later discovered in a female toilet on the ward in which he was an in-patient. Currently await a Lessons Learned Statement	Personal Information redacted by the USI

Personal information redacted by the USI	ACUTE	SEC	Death of a patient	Personal information redacted by the USI	30/05/2018	12/04/2022	PM Cause of death - Multi organ failure, b) Multiple laparotomies, c) Perforated diverticular disease and small bowel obstruction	Personal information redacted by the USI
	MHD	MHS	Death of a service-user		14/12/2021	28/06/2022	Death of service user in the community – Personal information redacted by the USI Patient was known to MHD (PMHC and HTRC) within 12 months of death. The Coroner requested a statement from the Approved Social Worker, and a copy of the patient's mental health records	Personal information redacted by the USI
	ACUTE	MUC	Death of patient		11/05/2018	29/06/2022	PM Cause of death - infarct of left cerebral hemisphere due to thrombosis of left internal carotid and left middle cerebral arteries	None identified

44. Number of Subject Access Requests exceeding timeframe for completion

The Medico-Legal Team continues to be unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests and a lack of staffing to cope with the demand (which resulted in a significant back-log). The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. The HROD Risk Register demonstrates the significant back-log/significant time-delays that exist with ongoing Subject Access Requests.

A temporary Team Leader post has been in place within Medico-Legal effective from 18th October 2021, which has been integral to the reduction of figures over the past number of months. Work continues to be progressed to reduce those figures further.

The overall back-log at 90+ days has decreased this week to **80** (with 24 of the 90+ apps being signed out last week). Gaps currently exist within Litigation with regards sign-off of notes and records and is being kept under review, but the issue also remains about available resources outside of the Medico-Legal Team for review of records, consideration of redaction (where appropriate), task of redaction and consent to release as this also has a significant impact on the Trust's ability to comply with the legislation. A short-life working group chaired by Performance and Reform is reviewing the position in this regard.

There is currently a back-log of **80** requests that are in excess of 90 days across the following areas, and a large number of these are significantly over the required time-frame for response:-

Directorate	<u>Acute Services</u>	<u>C&YP</u>	<u>MH&D</u>	<u>OPPC</u>	<u>HROD</u>	<u>TOTAL</u>
Number of Outstanding Requests at 90+ days	63	8	9	0	0	80
New requests opened 23.05.2022:29.05.2022	61	2	5	0	0	68
Requests Closed 23.05.2022:29.05.2022	51	1	7	0	1	60 (24 90+)

LITIGATION 30/05/2022 – 05/06/2022

45. New Clinical negligence

No new clinical negligence claims: 30.05.2022 – 03.06.2022

46. Clinical Negligence Claims Listed for Hearing in June 2022

All claims listed for hearing in June have since been adjourned.

47. Vaginal Mesh Cases – no update since last week

The number of vaginal mesh claims open to the Trust remains at 13 (stage of the open claims are listed below).

Stage	Number of Mesh Cases
Letter of Claim	0
Discovery	1
Investigation	4
Proceedings Issued	8
Trial date Set	0

48. Urology Cases – no update since last week

Following an announcement by the Minister for Health a public inquiry is underway in relation to Trust Urology services. As a result, it is anticipated that there will be an increase in related litigation cases.

There are now a total of 17 open cases identified at present (stage of the claims are listed below).

Stage	Number of Urology Cases
Letter of Claim	1
Discovery	4

Investigation	6
Proceedings Issued	6
Trial date Set	0

49. Coroner's Inquiries and Inquests

- No New Coroner's Inquiries – 30.05.2022 – 03.06.2022
- There are currently no Inquest Hearings scheduled to take place until October 2022
- The following preliminary Inquest Hearings are scheduled to take place in June 2022.

Ref	Directorate	Division	Incident type	Incident date	Opened date	Hearing Date	Description	Governance Process
Personal information redacted by the USI	ACUTE	MUC	Death of a Service User	Personal information redacted by the USI	10/07/2018	01/06/2022	Personal information redacted by the USI transferred to CAH ICU Coroner directed a post mortem in this case and the preliminary finding is (p) Pneumonia. <u>Update</u> • The next of kin have instructed Solicitor's to represent them and an application for legal aid is being made • The Coroner's office have received the Prison Ombudsman's report and that will be released in due course • Next PH 15th September at 1.15pm	None Identified
Personal information redacted by the USI	OPPC	Older People		Personal information redacted by the USI	21/01/2019	01/06/2022	The deceased was a resident in a nursing home, who was admitted to hospital after a fall We currently await PIP status after PH on 1/6/22. <u>Update</u>	Personal information redacted by the USI

							It has been confirmed that the Trust are not a PIP	
Personal Information redacted by the USI	ACUTE/MHD	MUC/MHS	Homicide	Personal Information redacted by the USI	05/07/2018	27/06/2022	This relates to the homicide of an elderly couple in their home by an individual known to mental health services Further PH 27/06/2022	Personal Information redacted by the USI
ACUTE		MUC	Death of a patient	Personal Information redacted by the USI	12/08/2019	27/06/2022	The Coroner directed a post mortem in this case and the preliminary finding is (p) Coronary Artery Atheroma The deceased had an OGD (Oesophago-gastro-duodenoscopy) (camera test) on [REDACTED] the deceased went missing off the ward. Despite the implementation of the absconding policy, family contact, a search of the ward and hospital site, the deceased was not found. Unfortunately, he was later discovered in a female toilet on the ward in which he was an in-patient. Currently await a Lessons Learned Statement Will be completed later today, want to clarify specifics surrounding use of technology.	Personal Information redacted by the USI

Personal information redacted by the USI	ACUTE	SEC	Death of a patient	Personal Information redacted by the USI	30/05/2018	12/04/2022	PM Cause of death - Multi organ failure, b) Multiple laparotomies, c) Perforated diverticular disease and small bowel obstruction	Personal Information redacted by the USI
	MHD	MHS	Death of a service-user		14/12/2021	28/06/2022	Death of service user in the community – Personal information redacted by the USI. Patient was known to MHD (PMHC and HPCR) within 12 months of death. The Coroner requested a statement from the Approved Social Worker, and a copy of the patient's mental health records	Personal Information redacted by the USI
	ACUTE	MUC	Death of patient		11/05/2018	29/06/2022	PM Cause of death - infarct of left cerebral hemisphere due to thrombosis of left internal carotid and left middle cerebral arteries	None identified

50. Number of Subject Access Requests exceeding timeframe for completion

The Medico-Legal Team continues to be unable to comply with the General Data Protection Regulations (GDPR) 2018 in respect of responding to Subject Access Requests within the statutory time-frames. This had been due to the sheer volume of requests and a lack of staffing to cope with the demand (which resulted in a significant back-log). The Governance Committee have been advised of the ongoing back-log; it has been brought to the attention of the Trust's SIRO and placed on the HROD Risk Register. The HROD Risk Register demonstrates the significant back-log/significant time-delays that exist with ongoing Subject Access Requests.

A temporary Team Leader post has been in place within Medico-Legal effective from 18th October 2021, which has been integral to the reduction of figures over the past number of months. Work continues to be progressed to reduce those figures further.

The overall back-log at 90+ days has increased this week to **98** (with 15 of the 90+ apps being signed out last week). This is in part attributable to the 2 bank holidays impacting Gaps currently exist within Litigation with regards sign-off of notes and records and is being kept under review, but the issue also remains about available resources outside of the Medico-Legal Team for review of records, consideration of redaction (where appropriate), task of redaction and consent to release as this also has a significant impact on the Trust's ability to comply with the legislation. A short-life working group chaired by Performance and Reform is reviewing the position in this regard.

There is currently a back-log of **98** requests that are in excess of 90 days across the following areas, and a large number of these are significantly over the required time-frame for response:-

Directorate	<u>Acute Services</u>	<u>C&YP</u>	<u>MH&D</u>	<u>OPPC</u>	<u>TOTAL</u>
Number of Outstanding Requests at 90+ days	82	8	8	0	98
New requests opened 30.05.2022:03.06.2022	25	0	1	1	27
Requests Closed 30.05.2022:03.06.2022	26	1	4	0	31 (15 90+)

SARs Opened During May = 238

SARs Closed During May = 219

MEDICATION INCIDENTS

51. B/F 2 weeks due to annual leave. Governance teams to report any medication incidents.

SAFEGUARDING

Adult Safeguarding Activity 23.05.22 – 29.05.22	Trustwide	MHD	OPPC	Acute	CYP
1.0 No of new adult safeguarding referrals (APP1 sec 1)	36	16	10	10	0
2.0 No of new adult safeguarding referrals meeting threshold for	18	7	7	4	-

Adult Protection Gateway team (APP1 Sec 2)					
3.1 No of new referral assessed as Adult in Need of Protection by APGT (APP1 Sec 3)	8 1 Sexual 6 Neglect 1 Physical	1 1 Sexual	7 6 Neglect 1 physical	0	-
3.2 No of new referrals managed as adult at risk of harm (APP1 Sec 2/3)	10	5	3	2	-
3.3 No of new referrals with NFA under Adult Safeguarding (APP1 Sec 2/3)	5	1	0	4	-
Referrals by category of allegation					
▪ Physical	13	4	2	7	-
▪ Psychological	7	5	1	1	-
▪ Sexual	4	4	0	0	-
▪ Financial	5	2	1	2	-
▪ Neglect	6	0	6	0	-
▪ Institutional	1	1	0	0	-
▪ Exploitation	0	-	-	-	-

No of adult protection cases open on PARIS system * REF STATUS *	263	117	130	15	1
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*** 10 referrals are pending decision by delegated appointed persons in teams at section 2 of the APP1 referral (3 Acute, 6MHD & 1 OPPC)

*** 3 referral received by APGT are pending decisions being made at Section 3 of the APP1 referral regarding the outcome of the initial assessment (2 MHD & 1 OPPC)

Update:

Summary Position Table of high risk investigations previously reported on weekly governance report	
Ongoing Trust Investigation	36
Ongoing Joint Protocol with PSNI Investigation	22
PSNI Preparing file for PPS	1
Awaiting PPS decision	1
Pending Closure	5
Proceeding to hearing	0
Closed	0

Facilities with multiple ongoing Trust investigations:

Mother of Mercy Care Home (7 referrals)

St Macartan's Nursing Home Clogher (2 service users identified OPPC)

Top Class Dom Care Agency – 11 APP1 referrals; multiple whistleblowing concerns

Orchard House SL (3 LD referrals)

Iveagh House: 4 referrals relating to physical and psychological abuse allegations. 1 referral is being managed under Joint Protocol. (OPPC)

New Cases for escalation

1. Ashgrove care home:- 3 referrals relating to missed medication for 2 days. Previous concerns in April 22. NMC referral made due to the individual concerns
2. Referral re rough handling causing bruising and poor demeanour of staff member Memory service (Trust Home Care)
3. Referral re theft: (Trust home Care) 2nd incident involving same staff. OPPC
4. Orchard Lodge: 1 referral re unreported grade 4 pressure damage (Memory service) and
5. 2nd referral re person who fell from bed resulting in fracture L5 and L6 and head injury. Scoping exercise for wider investigation in Orchard Lodge found person had fallen over bedrails, which were not risk assessed or part of care plan. Unclear what was disclosed at ED
6. Carlingford Lodge: whistleblowing letter received 26/5/22 specific concern re 1 staff member

SAFEGUARDING 30/05/2022 – 05/06/2022

Adult Safeguarding Activity 30.05.22 – 05.06.22	Trustwide	MHD	OPPC	Acute	CYP
1.0 No of new adult safeguarding referrals (APP1 sec 1)	31	13	11	6	1
2.0 No of new adult safeguarding referrals meeting threshold for Adult Protection Gateway team (APP1 Sec 2)	15	4	7	3	1
3.1 No of new referral assessed as Adult in Need of Protection by APGT (APP1 Sec 3)	5 2 Physical 2 Financial	1 Sexual	4 2 Physical 2 Financial	0	0

	1 Sexual				
3.2 No of new referrals managed as adult at risk of harm (APP1 Sec 2/3)	9	5	4	0	0
3.3 No of new referrals with NFA under Adult Safeguarding (APP1 Sec 2/3)	9	4	0	4	1
Referrals by category of allegation					
▪ Physical	12	3	4	5	0
▪ Psychological	5	1	2	1	1
▪ Sexual	2	1	1	0	0
▪ Financial	2	0	2	0	0
▪ Neglect	5	3	2	0	0
▪ Institutional	1	1	0	0	0
▪ Exploitation	0	-	-	-	-
No of adult protection cases open on PARIS system * REF STATUS *	254	112	126	15	1

*** 5 referrals are pending decision by delegated appointed persons in teams at section 2 of the APP1 referral (3 MHD & 2 Acute)

*** 3 referral received by APGT are pending decisions being made at Section 3 of the APP1 referral regarding the outcome of the initial assessment (2 OPPC & 1 Acute)

Update:

Summary Position Table of high risk investigations previously reported on weekly governance report	
Ongoing Trust Investigation	38
Ongoing Joint Protocol with PSNI Investigation	21
PSNI Preparing file for PPS	1
Awaiting PPS decision	1
Pending Closure	5
Proceeding to hearing	0
Closed	0

Facilities with multiple ongoing Trust investigations:

Mother of Mercy Care Home (7 referrals)

St Macartan's Nursing Home Clogher (2 service users identified OPPC)

Top Class Dom Care Agency – 11 APP1 referrals; multiple whistleblowing concerns

Orchard House SL (3 LD referrals)

Iveagh House: 4 referrals relating to physical and psychological abuse allegations. 1 referral is being managed under Joint Protocol. (OPPC)

Orchard Lodge: 1 referral re unreported grade 4 pressure damage (Memory service) and 2nd referral re person who fell from bed resulting in fracture L5 and L6 and head injury. Scoping exercise for wider investigation in Orchard Lodge found person had fallen over bedrails, which were not risk assessed or part of care plan. Unclear what was disclosed at ED

Carlingford Lodge: whistleblowing letter received 26/5/22 specific concern re 1 staff member

Ashgrove care home: 3 referrals relating to missed medication for 2 days. Previous concerns in April 22. NMC referral made due to the individual concerns

New Case for escalation

Mahon Hall, PNH: Physical abuse referral re unexplained significant bruising (OPPC)

INFORMATION GOVERNANCE 23/05/2022 – 29/05/2022

52. Number of Subject Access Requests exceeding timeframe for completion.

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	27	2	5	17	-	-	1	-

These relate to Subject Access Requests that have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these service user notes etc. A group chaired by Siobhan Hanna is reviewing the current processes with a view to provide a paper to SMT by the end of May with some recommendations and options to improve compliance.

53. Data Breaches reported to the ICO

Directorate	ACUTE	OPPC	MH&D	CYPS	FINANCE	P&R	HROD	CX
Breaches	1	-	-	-	-	-	-	-

This data breach is in relation to a report which was shared inappropriately with another Trust.

Complaints received from the Information Commissioners Office.

There have been one complaint received from the Information Commissioner's Office in this period, this was in relation to the time taken to respond to a Subject Access request of emails exchanged between staff within Acute Services.

54. Freedom of Information Requests Exceeding Legislative Timeframes.

The Trust has 20 working days to provide a response to a request for information under the FOI Act. The Trust currently has one outstanding FOI requests.

ID	Subject	Date Received	Due Date	Days Overdue	Directorate
FOI/00001053	How many patient are urgently red-flagged by GP for suspected Gynae Cancer	26/04/2022	25/05/2022	2	Acute Services
FOI/00000965	Breakdown of all properties used and registered within the Trust Catchment as having asbestos	16/02/2022	16/03/2022	50	Finance Procurement and Estates

INFORMATION GOVERNANCE 30/05/2022 – 05/06/2022

Number of Subject Access Requests exceeding timeframe for completion.

Directorate	ACUTE	OPPC	MHD	CYPS	FINANCE	P&R	HROD	CX
Number of outstanding Requests	28	2	4	17	-	-	-	-

These relate to Subject Access Requests that have not been completed within the legislative timescale (legal timeframe 30 days or 90 days for complex requests). These delays are in relation to the demands on Services to carry out redactions of these service user notes etc. A group chaired by Siobhan Hanna is reviewing the current processes with a view to provide a paper to SMT by the end of May with some recommendations and options to improve compliance.

55. Data Breaches reported to the ICO

Directorate	ACUTE	OPPC	MH&D	CYPs	FINANCE	P&R	HROD	CX
Breaches	1	-	-	-	-	-	-	-

This data breach is in relation to a report which was shared inappropriately with another Trust.

Complaints received from the Information Commissioners Office.

There have been no complaints received from the Information Commissioner's Office in this period.

Freedom of Information Requests Exceeding Legislative Timeframes.

The Trust has 20 working days to provide a response to a request for information under the FOI Act. The Trust currently has three outstanding FOI requests.

ID	Subject	Date Received	Due Date	Days Overdue	Directorate
FOI/00001056	Information regarding Urological cancer	03/05/2022	01/06/2022	1	Acute Services
FOI/00001057	Information regarding Head and Neck cancer	03/05/2022	01/06/2022	1	Acute Services
FOI/00000965	Breakdown of all properties used and registered within the Trust Catchment as having asbestos	16/02/2022	16/03/2022	53	Finance Procurement and Estates

NEW STANDARDS AND GUIDELINES RECEIVED AND ASSURANCES DUE OR SUBMITTED

56. Responses Sent to External Agencies (23rd May to 5th June 2022)

Title of Correspondence	Reference	Guidance Type	Assurance response Date	Directorates applicability	Clinical Lead	Assurance Response
Medicines associated with dependence Withdrawal symptoms Adults	NG 215	NICE Equality Screening Questionnaire	03/06/2022	Acute, MHD, OPPC	To be discussed at DivAMD meeting scheduled for 17 June 2022 given scope of applicability within medical prescribers	 20220527_SHSCT Response - NICE Eq

57. Formal Assurance Responses that are due to be submitted to an external agency within the next 4 weeks [*up until 7th July 2022*]

Title of Correspondence	Reference	Guidance Type	Full Implementation / Response Date	Lead Directorate	Clinical Lead	Update Position
REISSUED Potential misuse and safe disposal of intravenous anaesthetic agents <i>2nd Line Assurance</i> <i>Replaces the letter issued on 22/09/2021 and recalled on 01/12/2021</i>	SQR 2021-044	Safety & Quality Learning Letter	29/06/2022	Medical	MDT Working Group chaired by Lyn Watt	For Implementation by the already established MDT cross directorate working group

2B Internal Assurances that are pending completion / review within the next 4 weeks **[*up until 7th July 2022*]**

Title of Correspondence	Reference	Guidance Type	Implementation / Review Date	Lead Directorate	Implementation / Clinical Lead
Use of Plastic Bags on Mental Health In-patient Wards	LL-SAI-2018-033 (MH)	Safety and Quality Learning Letter	30/06/2022	MHD	Mr Joe Walker
Re-Issued Delayed Diagnosis of Diabetic Ketoacidosis and Type 1 Diabetes in Children - Linked to previously issued letter SQR-SAI-2019-051	SQR/SL/2021/076 (AS/PHC)	Safety and Quality Reminder of Best Practice Guidance	30/06/2022	CYPS	Mrs Joan McMahon
Reissued Thrombolysis	SQR-SAI-2021-079 (AS)	Safety and Quality Reminder of Best Practice Guidance	30/06/2022	Acute / OPPC	Dr Michael McCormick Dr Patricia McCaffrey

58. Responses that are overdue for submission to External Agency

	Reference		Date S&G assurance was to be submitted	Directorate Applicability	Clinical Change Lead
<i>No responses are currently overdue</i>					

59. Regionally recalled circulars that the SHSCT are still awaiting re-issue / clarification

Title of Correspondence	Date of recall / escalation	Reference	Guidance Type	Clinical Change Lead
Assessment under the Mental Health Order NI 1986 <i>2nd Line Assurance Requirement</i>	03/05/2022	SQR SAI 2022-089	Safety & Quality Learning Letter	SPPG responded to the Trust's queries on 27/05/2022 but these did not fully address the issues raised. This was discussed at the monthly SHSCT / SPPG (DoH) Touchpoint meeting held on 30 May 2022 – SPPG to further review and clarify

60. Newly Issued S&G Circulars received by SHSCT (23rd May to 5th June 2022)

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation / Assurance Date	Action Required
Legal Advice Withdrawal of Life Sustaining Treatment for Pregnant Women who Lack Capacity to Consent	01/06/2022	HSS MD 27-2022	CMO Correspondence	n/a	n/a	For Action
REISSUED Potential misuse and safe disposal of intravenous anaesthetic agents <i>2nd Line Assurance</i> <i>Replaces the letter issued on 22/09/2021 and recalled on 01/12/2021</i>	01/06/2022	SQR 2021-044	Safety & Quality Learning Letter	n/a	29/06/2022	For Implementation by the already established MDT cross directorate working group
Regional Workshop SQR 2021-075 Risk of Serious Harm Death Choking on Foods <i>This is a follow up to the PHA letter issued on 08/03/2022</i>	01/06/2022	SQR 2021-075	PHA Correspondence	n/a	Ongoing as part of regional / SHSCT project plan	Ongoing Implementation Regional Workshop scheduled for 27 July 2022
CMO Letter UK Wide Supply Issue Smith Medical Epidural and Combined Epidural and Spinal Products	31/05/2022	n/a	CMO Correspondence	n/a	n/a	For Dissemination
Inadvertent oral administration of Potassium Permanganate	24/05/2022	HSC (SQSD) 16/22	nPSA	n/a	23/11/2022	For Implementation

UK Wide Joint Letter Release of doctors for the wider health system	24/05/2022	n/a	DoH Correspondence	n/a	n/a	For Dissemination
Regional Endorsement Shared Decision Making	23/05/2022	NG 197	NICE Clinical Guideline	23/08/2022	23/05/2023	For Implementation

Table 5B - From 23rd May to 5th June 2022 there were 4 circulars (either new or an update) received relating to COVID-19 guidance:

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Deadline Date for Implementation
COVID Therapeutic Alert nMABS Treatment of non hospitalised patients with COVID	01/06/2022	HSS MD 29-2022	CMO Correspondence	For Dissemination
COVID 19 Therapeutic Alert nMABS Treatment of Hospital Onset COVID 19	01/06/2022	HSS MD 28-2022	CMO Correspondence	For Dissemination
COVID 19 Guidance for infection risk deceased funerals Updated <i>WEF 27/05/2022 Replaces guidance issued on 18/02/2022 and CMO Letter issued on 23/05/2022</i>	26/05/2022	HE1/22/92754	CMO Correspondence	Updated guidance takes effect from 27 May 2022
COVID Spring Booster vaccine programme addendum <i>Previous guidance was issued on 25/03/2022</i>	24/05/2022	HSS MD 13-2022 (Addendum)	CMO Correspondence	The eligibility criteria has been extended by one month and therefore those who will turn 75 years old by 30 June 2022 (i.e. those born before 30 June 1947), can receive a spring booster dose

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Table 5C - From 23rd May to 5th June 2022 there was 0 new / updates relating to COVID-19 NICE Rapid Guidelines

Table 5D - From 23rd May to 5th June 2022 there 6 circulars relating to Monkey Pox

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Full Implementation Date / Assurance Requirements
Regional MonkeyPox Pathways for the Weekend and Bank Holiday Period	01/06/2022	n/a	PHA Correspondence	For Dissemination
NI HSC Monkeypox Secondary Care Patient Care Pathway Version 6 01.06.22	01/06/2022	n/a	PHA Correspondence	For Dissemination
PHA Letter Monkey Pox Preparedness - All Documents	31/05/2022	n/a	PHA Correspondence	For Dissemination
Monkeypox contact tracing guidance Classification of contacts advice Vaccination Follow up National Guidance Link: Monkeypox contact tracing guidance: classification of contacts and advice for vaccination and follow up (publishing.service.gov.uk)	30/05/2022	n/a	PHA Correspondence	For Dissemination

4 Nations Consensus Statement Monkeypox Control Principles for monkeypox control in the UK: 4 nations consensus statement - GOV.UK (www.gov.uk)	30/05/2022	n/a	CMO Correspondence	For Dissemination
Monkey Pox Interim Primary Care Pathway 27.05.2022	27/05/2022	n/a	PHA Correspondence	For Dissemination

61. New Update requests from SPPG (DoH) team (23rd May to 5th June 2022)

Title of Correspondence	Date of Request / Issue from External Agency	Reference	Guidance Type	Response Date	Clinical Change Lead
SPPG Further Assurance Request 2021-042 Potential risk of towel dispensers Ligature point <i>Cross reference to SQR letter received on 03/03/2021</i>	30/05/2022	SQR SAI 2021-042	Safety & Quality Learning Letter	Not specified	Ongoing Implementation by MDT Cross Directorate Policy Working group led by Dr Gormley – next meeting 16/06/2022
Update requests that are still pending following request by the SPPG (DoH)					
None outstanding					
SQA Compliance emails received closing off SQR assurance responses previously submitted by the SPPG (DoH)					
None received					

CLINICAL AUDITS AND REGIONAL PIVFAIT AUDITS

Topic

62. IV Fluids in children and Young People:

Week ending:

	Week ending 29/05/2022
CAH CYP	5/5 = 100% - fully compliant
DHH CYP	6/6 = 100% - fully compliant
ACUTE	1 new case identified this week: PIVFAIT =0, ATICS specific audit tool = 1

Clinical Audit

- Ongoing National Audit Participation

Date	Audit	Stage	Issues / Comments	This Weeks' Update
24/05/2022	NCEPOD – Crohn's Disease	Clinical Questionnaires	Quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent an abdominal surgical procedure NCEPOD – deadline 20/06/2022	5 cases selected. Questionnaires allocated for clinician review 06/05/2022 Reminder at surgical PSM – 17/05/2022 – None submitted to date
25/05/2022	NCEPOD - Community Acquired Pneumonia Study	Case Identification Stage	To identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia. Completion Deadline 17/06/2022	Approval at Acute Governance May 2022 mtg Information Request received - No presumed diagnostic ICD10 code on admission – FCE code on discharge only. Clarification from NCEPOD on discharge diagnosis – awaiting clinician approval

31/05/2022	NCEPOD: Transition from Child to Adult Services- Organisational NCEPOD - TRANSITION	Clinician Questionnaires Staff & Patient / Parent Experience Surveys	14 cases have been selected and casenote extracts for clinician review. Circulated via CYP Open to at least end of May 2022	MHD further review of cases selected for clinician identification Due 06/06/2022 Healthcare Professional Questionnaire – follow-up promotion	
19/05/2022	NCEPOD Newsletter	For Information		 NCEPOD Newsletter May 2022.pdf	
31/05/2022	NHS Benchmarking – Adult and Older person's Mental Health Submission 01/07/2022	Data collection	The objective of the data collection process is to assemble a dataset from providers that can be used in benchmarking mental health services in both inpatient and community settings – Services, Capacity, Workforce, Finance, Quality & Safety	Submission lead holding initial meetings with to review templates with corporate services providing data sets on service capacity & demand, workforce, HR and Governance	
25/05/2022	NHS Benchmarking – CYP Mental Health Services Submission 01/07/2022	Data Collection	The objective of the data collection process is to assemble a dataset from providers that can be used in benchmarking mental health services in both inpatient and community settings – Services, Capacity, Workforce, Finance, Quality & Safety	Submission lead identified by DivMD	
New national clinical audit reports published on the HQIP website					

Week Ending 05/06/2022

Topic	
IV Fluids in children and Young People:	
Week ending:	
	Week ending 05/06/2022
CAH CYP	1/1 = 100% compliant
DHH CYP	4/4 = 100% compliant
ACUTE	1 new case identified this week: PIVFAIT =0, ATICS specific audit tool = 1

Clinical Audit				
• Ongoing National Audit Participation				
Date	Audit	Stage	Issues / Comments	This Weeks' Update
06/06/2022	NCEPOD – Crohn's Disease	Clinical Questionnaires	Quality of care provided to patients aged 16 and over with a diagnosis of Crohn's disease who underwent an abdominal surgical procedure NCEPOD – deadline 20/06/2022	5 cases selected. Questionnaires allocated for clinician review 06/05/2022 Reminders re-issued – 06/06/2022 - none submitted to date
25/05/2022	NCEPOD - Community Acquired Pneumonia Study	Case Identification Stage	To identify and explore avoidable and modifiable factors in the care of adults presenting to hospital with a presumed diagnosis of community acquired pneumonia. Completion Deadline 17/06/2022	Approval at Acute Governance May 2022 mtg Information Request received - No presumed diagnostic ICD10 code on admission – FCE code on discharge only. Clarification from NCEPOD on discharge diagnosis – awaiting clinician approval
31/05/2022	NCEPOD: Transition from Child to Adult Services- Organisational NCEPOD - TRANSITION	Clinician Questionnaires Staff & Patient / Parent Experience Surveys	14 cases have been selected and casenote extracts for clinician review. Circulated via CYP Open to at least end of May 2022	MHD further review of cases selected for clinician identification Due 06/06/2022 Healthcare Professional Questionnaire – follow-up promotion

31/05/2022	NHS Benchmarking – Adult and Older person's Mental Health Submission Extension 15/07/2022	Data collection	The objective of the data collection process is to assemble a dataset from providers that can be used in benchmarking mental health services in both inpatient and community settings – Services, Capacity, Workforce, Finance, Quality & Safety	Submission lead holding initial meetings with to review templates with corporate services providing data sets on service capacity & demand, workforce, HR and Governance	
06/07/2022	NHS Benchmarking – CYP Mental Health Services Submission 08/07/2022	Data Collection	The objective of the data collection process is to assemble a dataset from providers that can be used in benchmarking mental health services in both inpatient and community settings – Services, Capacity, Workforce, Finance, Quality & Safety	Initial meeting to review dataset with submission lead – 06/07/2022	
New national clinical audit reports published on the HQIP website				Date Disseminated / Directorate	

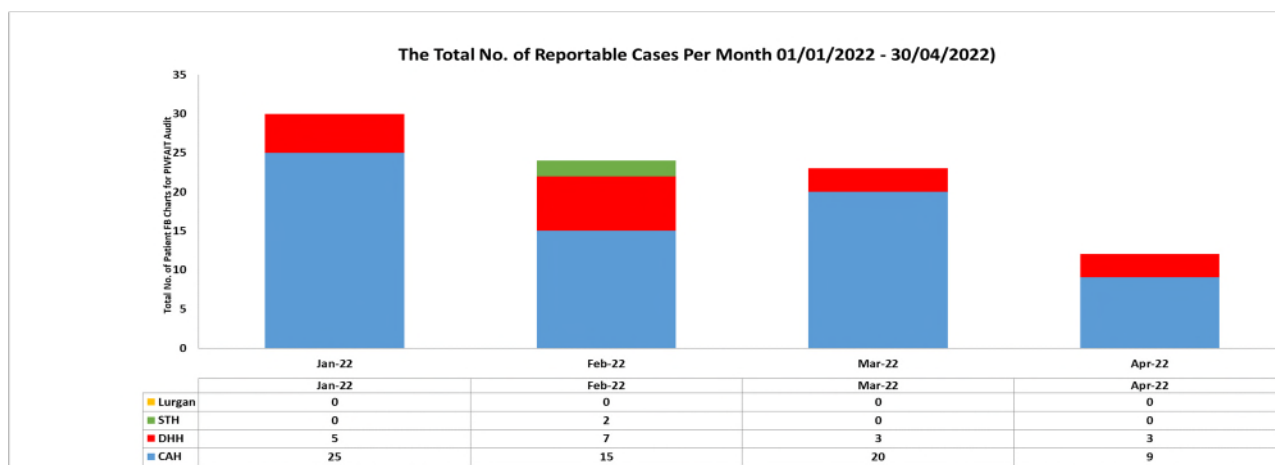
INFECTION PREVENTION CONTROL

63. COVID-19 update

Summary Position – 29/05/2022 @ 9.15am

	Current week	Previous week
No. met PHA notification definition (+ test - 28 days) since March 15 th 2020	666	666
Weekly Reportable COVID-19 deaths 23 rd – 29 th May 2022)	0	2

Four month overview - Reportable deaths 1st January 2022 – 30th April



64. Other Infection Prevention Control Data



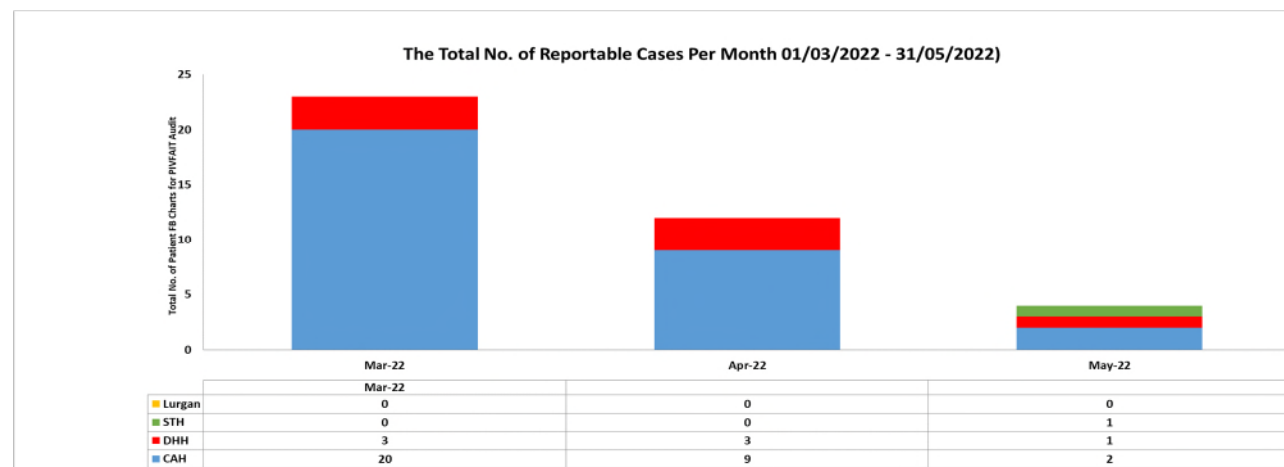
PfA 22-23 - May
2022.pdf

COVID-19 update

Summary Position – 05/06/2022 @ 9.15am

	Current week	Previous week
No. met PHA notification definition (+ test - 28 days) since March 15 th 2020	666	666
Weekly Reportable COVID-19 deaths 30 th May – 5 th June 2022)	0	0

Four month overview - Reportable deaths 1st March 2022 – 31st May 2022



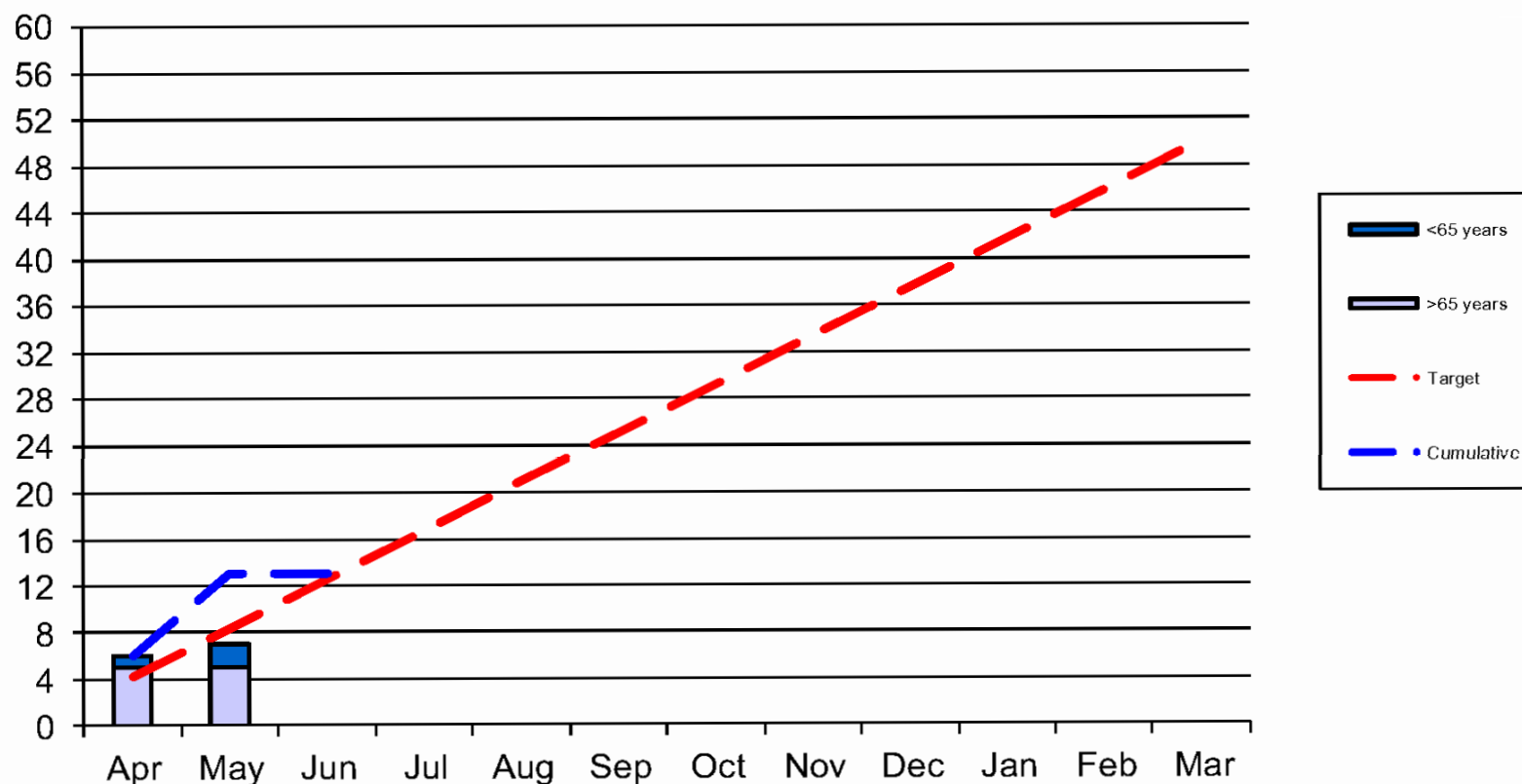
Priorities for Action Target 22/23

	TARGET 2022-23	No. of cases per month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Number of MRSA Cases 2022/23
MRSA Bacteraemia Preventable	5	0.42	2 (1)	2 (2)	0 (0)										4 (3)
Total (2021/22)	(5)	(0.42)	(0)	(0)	(0)	(2)	(0)	(0)	(0)	(0)	(0)	(1)	(1)	(1)	(5)
	TARGET 2022-23	No. of cases per month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Number of C.diff Cases 2022/23
C.diff	50	4.16	6	7	0										13
Total (2021/22)	(72)	(6.0)	(2)	(3)	(5)	(8)	(11)	(3)	(6)	(8)	(7)	(8)	(5)	(6)	(72)
		No. of cases per month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total Number of MSSA Cases 2022/23
MSSA Preventable			2 (1)	3 (3)	2 (0)										7 (4)
Total (2021/22)			(6)	(4)	(4)	(7)	(9)	(6)	(4)	(4)	(4)	(8)	(4)	(8)	(68)

Surveillance of MSSA bacteraemias continues – however currently there is no performance target associated with MSSA incidence.

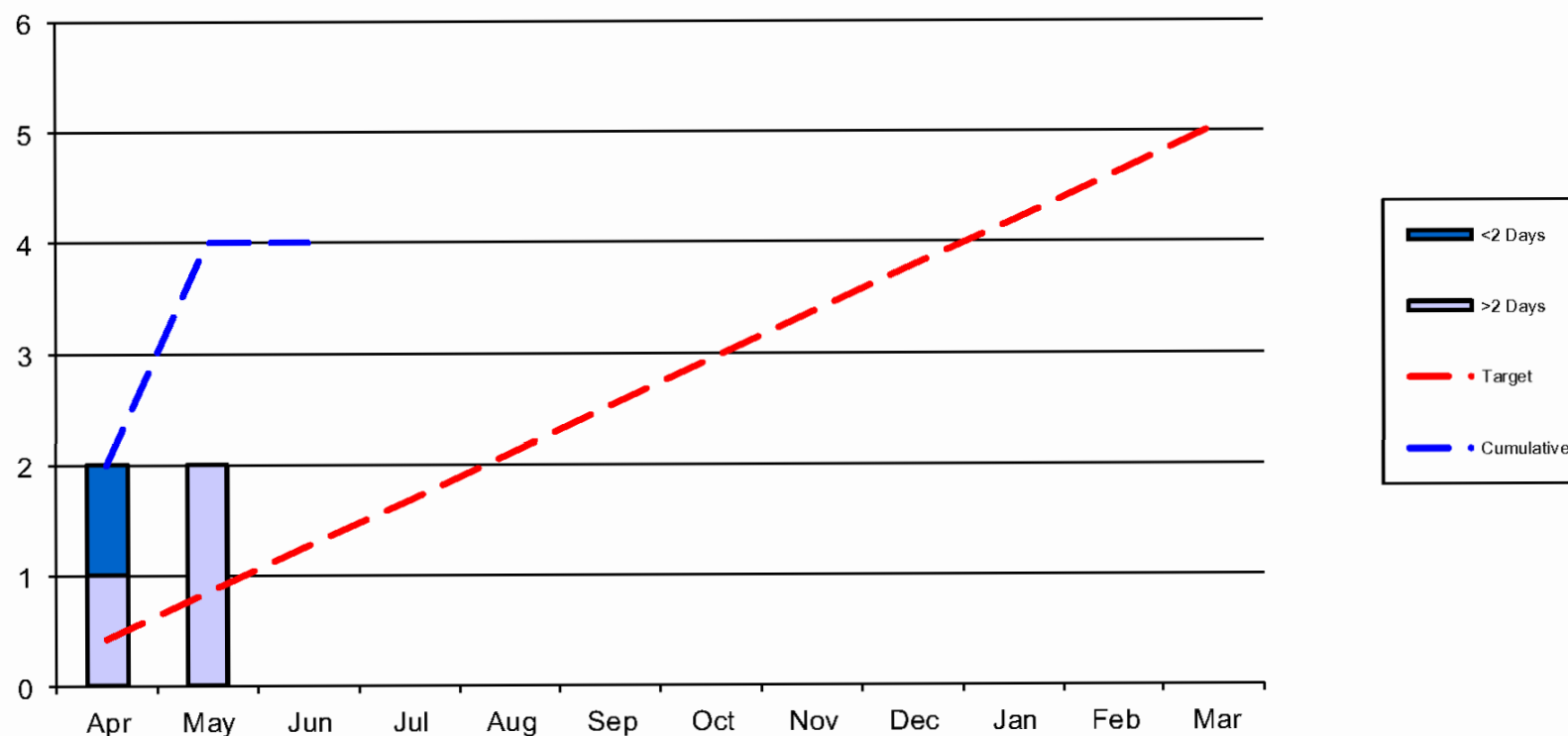
***C.difficile* Cumulative Total**

Apr 2022 – Mar 2023



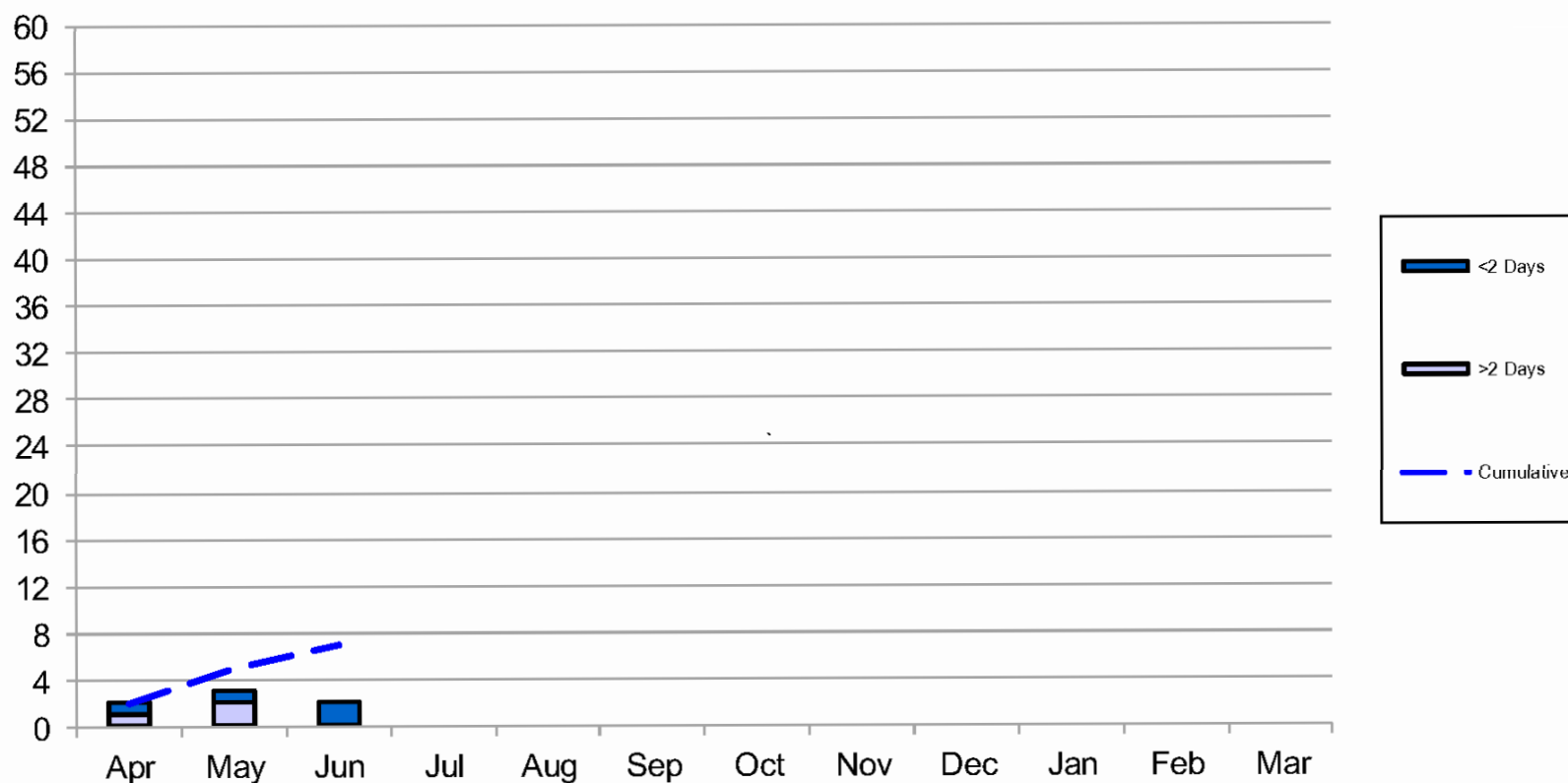
MRSA Bacteraemia Cumulative Total

Apr 2022 – Mar 2023



MSSA Cumulative Total

Apr 2022 – Mar 2023



INTERNAL AUDIT RECOMMENDATIONS

65. There was discussion around the need not to duplicate the work of the Trust's Internal Audit Forum, which already follows up the status of internal audit recommendations for the mid-year and year-end assurance process. **Suggestion to remove this section from weekly paper as quarterly reports on Internal Audit and RQIA recommendations are to be presented to SMT commencing July 2022 (for q/e June 2022). Caroline Doyle to confirm with Dr O'Kane.**

CONTRACT COMPLIANCE

66. The short life working group, reviewing the content of the Weekly Governance paper agreed there should be a section regarding Contract Compliance. Caroline Doyle to link with Dawn Livingstone.

FALLS AND PRESSURE ULCERS INCIDENTS

67. Falls. 23/05/2022 – 29/05/2022

	Insignificant	Minor	Total
1 South Medical	1	0	1
2 South Medical and Stroke	1	1	2
3 South	1	0	1
Bannvale SEC, Gilford	1	0	1
Brooklands Nursing Home Kilkeel	2	0	2
Carlingford PNH	1	0	1
Home of client	1	0	1
Linenbridge	1	0	1
Manor Day Centre, Lurgan	1	0	1
AMU	1	0	1
Stroke / Rehab	1	0	1
Sunnymead Residential Home	1	0	1
Trauma Ward	3	0	3
STH Ward 2, Assessment & Rehabilitation	1	0	1
Collegelands Nursing Home	0	1	1
Ward 3b	0	1	1
Delivery Suite, CAH	0	1	1
Female Medical	0	2	2

Female Surgical/Gynae	0	1	1
General Male Medical	0	1	1
Rosemount Care Home	0	1	1
Total	17	9	26

30/06/2022 – 05/06/2022

	Insignificant	Major	Minor	Total
1 South Medical	1	0	0	1
2 South Medical and Stroke	1	0	0	1
Emergency Department DHH	1	0	0	1
AMU	1	0	0	1
Rathfriland Manor Nursing Home	1	0	1	2
Sandringham Care Nursing Home	1	0	0	1
Aughnacloy House	0	1	0	1
2 North Respiratory	0	0	1	1
3 South	0	0	2	2
4 South	0	0	1	1
Ward 3b	0	0	1	1
Emergency Department CAH	0	0	1	1
Female Surgical/Gynae	0	0	1	1
Home of client	0	0	1	1
Roxborough House, Moy	0	0	2	2
Stroke / Rehab	0	0	1	1
Total	6	1	12	19

Major Fall – 161829 – OPPC – CHST – Aughnacloy- Fracture L Hip, Resident was found lying on her bedroom floor – Dementia Unit

Pressure Ulcers

68. Weekly Data. 23/05/2022 – 29/05/2022

	Insignificant	Minor	Total
Female Surgical/Gynae	1	1	2
Haematology	0	1	1
Brooklands Nursing Home Kilkeel	0	1	1
Emergency Department CAH	0	2	2
Female Medical	0	1	1
Trauma Ward	0	1	1
Ward 1, Stroke	0	1	1
Total	1	8	9

30/05/2022 – 05/06/2022

	Insignificant	Minor	Moderate	Total
Ramone Ward 3	1	0	0	1
4 North	0	1	0	1
4 South	0	1	0	1
Emergency Department CAH	0	1	0	1
Emergency Department DHH	0	1	0	1
Female Medical	0	1	1	2
Female Surgical/Gynae	0	2	0	2
2 South Medical and Stroke	0	0	1	1
Ward 2, Assessment and Rehabilitation	0	0	1	1
Total	1	7	3	11

Moderate – 161725 – OPPC – Care of Elderly Services

Moderate – 161828 – Acute – Acute Care of Elderly

Moderate – 162018 – Acute – General Medicine

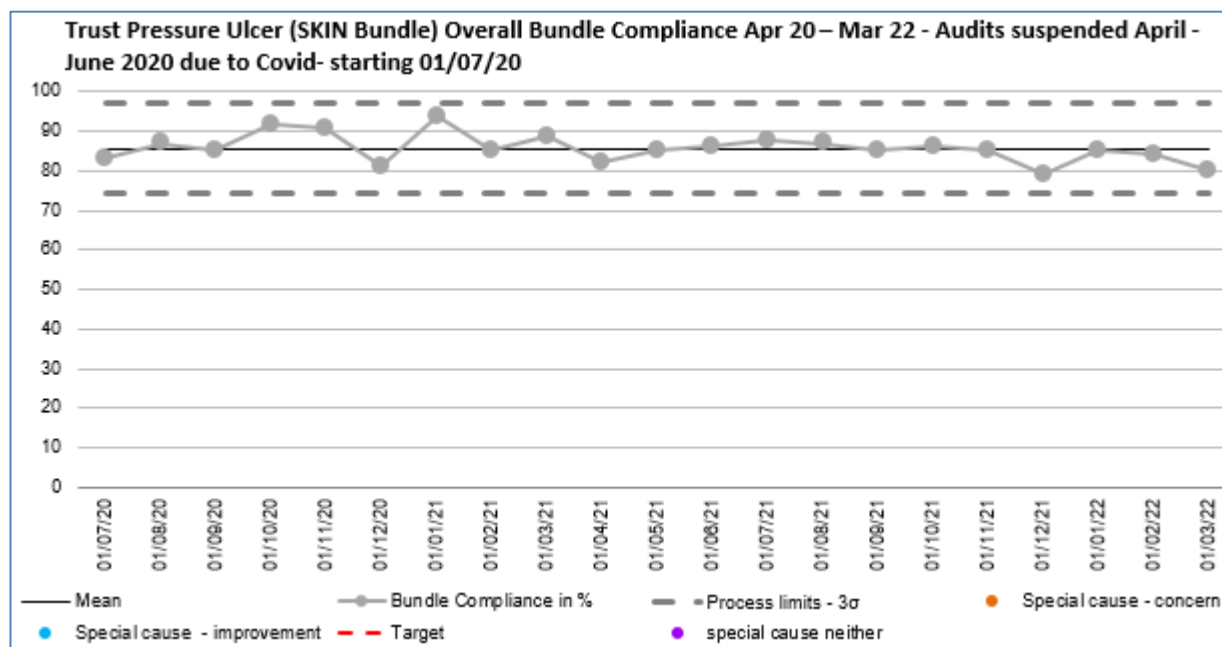
69. Total Number of Pressure Ulcers Monthly Data

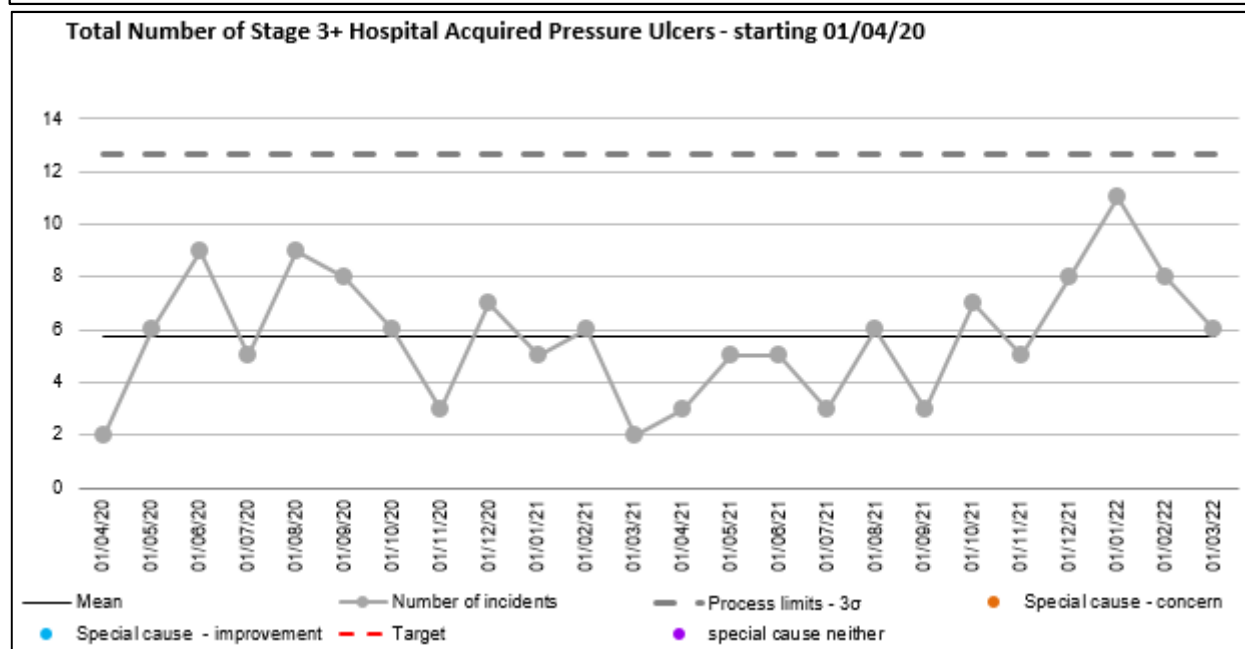
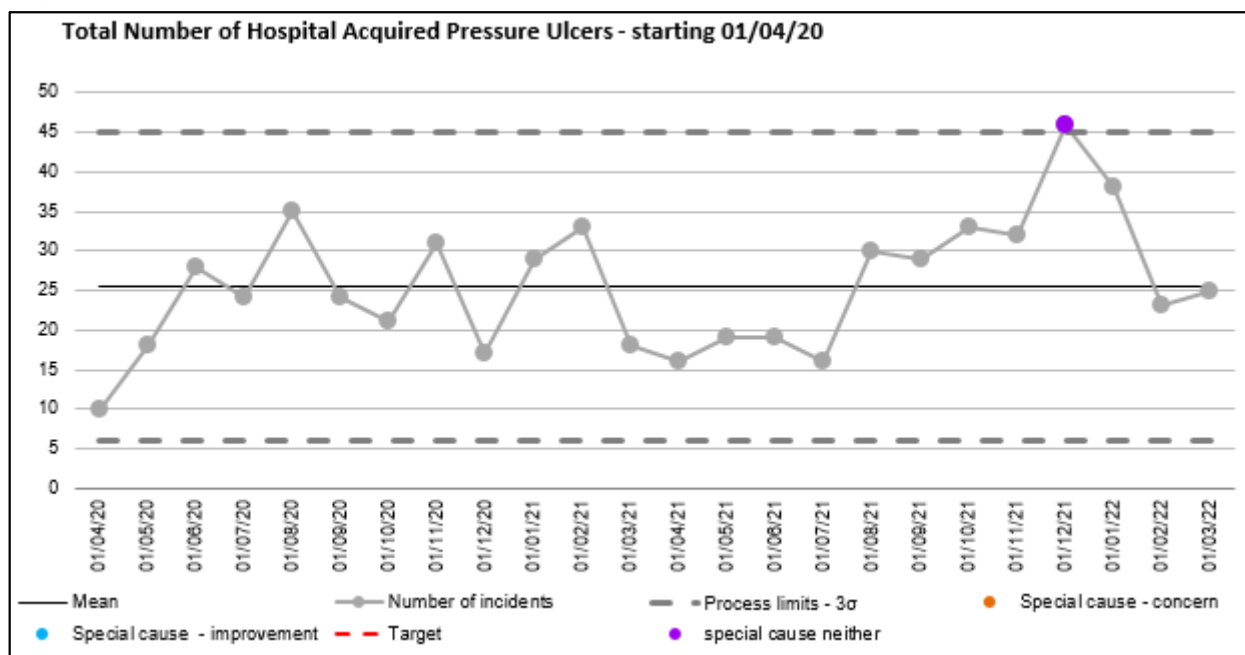
Corporate Clinical and Social Care Governance has created the 3 SPC charts for Hospital Acquired Pressure Ulcers below. The data has been provided by the Patient Safety Manager Colum Robinson.

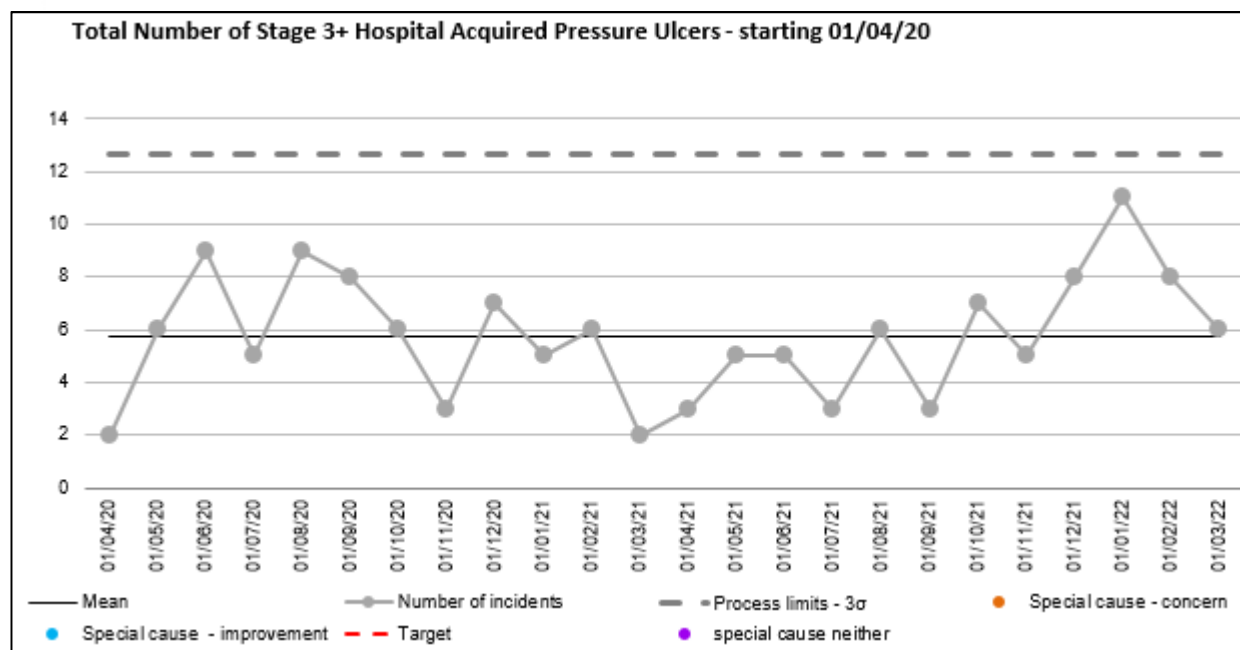
In addition to this data a Powerpoint presentation is delivered to the Safety and Quality Assurance Group every 12 weeks. This presentation will be shared with this group and includes narrative from the Post Incident Reviews (PIR) for avoidable Pressure Ulcers.

The UCL breach in December 2021 was mainly attributed to cases in ICU (n=12) and associated with patients who were COVID-19 positive.

Data from December 2021 – March 2022 is subject to change due to outstanding PIR (n=5).







70. APPROVAL STATUS OF DATIX INCIDENTS

* Some of these incidents relate to Urology. Due to the Public Inquiry there is likely to be an increase in the number of historical incidents dating back to 2018.

30/05/2022 – 05/06/2022

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	Total
Acute Services	1	0	0	0	1	0	1	0	24	75	645	1201	1948
Children and Young Peoples Services	0	0	0	0	0	0	0	0	0	0	0	86	86
Finance Procurement & Estates	0	0	0	0	0	0	0	0	0	0	2	7	9
Human Resources and Organisational Development	0	0	0	0	0	0	0	0	0	0	7	4	11
Mental Health and Disability	0	0	0	0	0	0	0	2	8	49	263	640	962
Nursing, Midwifery and AHP	0	0	0	0	0	0	0	0	0	0	1	9	10
Office of the Chair and Chief Executive	0	0	0	0	0	0	0	0	0	0	1	0	1
Office of the Medical Director	0	0	0	0	0	0	0	0	0	0	1	0	1
Older People and Primary Care	0	0	0	0	0	0	0	0	336	988	1850	867	4041
Performance and Reform	0	0	0	0	0	0	0	0	0	1	0	1	2
Total	1	0	0	0	1	0	1	2	368	1113	2770	2815	7071

AOB:

71. Sign Off

Chris Wamsley provided charts in relation to Sign Off data.



Sign Off Review
June 2022.docx

72. Waiting Lists and Waiting Times

Informatics produced this report on [Targets for Cancer patients](#). Chris Wamsley will explore this further with the OSLs.

Attendees:

Apologies: Jilly Redpath, Lisa Houlihan

Wamsley, Chris

From: OKane, Maria
Sent: 02 June 2022 10:44
To: chiefexecutiveoffice
Cc: Wamsley, Chris; McClements, Melanie
Subject: FW: TOMCAT SAI

Categories: Action

Please put this on smt for discussion on the 14th June.

Chris you may wish to present on this. This raises a few questions.

Many thanks Maria

From: Wamsley, Chris [Personal Information redacted by the USI]
Sent: 01 June 2022 17:40
To: OKane, Maria [Personal Information redacted by the USI]
Cc: McClements, Melanie [Personal Information redacted by the USI]
Subject: TOMCAT SAI

Hi Maria

Please see below for an update surrounding the TOMCAT – cardiac investigations system.
 An update to the early alert and SAI notification has been submitted today but wanted to provide greater detail for your oversight.

The SHSCT submitted an earlier alert regarding the 1383 referrals for Cardiac Investigations which were not logged into the Cardiac System (TOMCAT) on the 13th April 2022 and to coincide with the submission of an SAI notification we wished to provide an update surrounding this alert.

The 1383 referrals which were highlighted within the early alert have been added in chronological order to the TOMCAT system.
 The details of these missed referrals were not retained during the process of adding them to the TOMCAT system and therefore we currently are unable to identify the individual service users within the 1383 cohort.
 Unfortunately this places the Trust in the position where we are unable to communicate with the individual services user's to highlight their test was not added to the system at the time of referral but have been added in chronological order since.
 The Trust has linked with the informatics team and this information is unable to be retrieved as the tests were added in chronologic order to ensure they were allocated their appropriate location within the waiting list.

As these referrals were added to the system a record of the type of investigation was noted and a breakdown of this cohort is in the table below.

Test	Number to be put on Tomcat
Normal/Urgent/Managed Outpatient Echoes	278 urgent (longest waiter 10/9/2021) 449 managed (longest waiter 14/9/2021) 203 routine (longest waiter 3/11/2021)
DSE's	8 urgent (longest waiter 21/2/2022) 15 managed (longest waiter 6/12/2021) 19 routine (longest waiter 5/2/2022)
TOE's	1 routine (longest waiter 16/2/2022)
24 Hour Heart Monitors	47 urgent (longest waiter 2/2/2022)

	19 managed (longest waiter 8/11/2021) 135 routine (longest waiter 20/12/2021)
48 Hour Heart Monitors	10 urgent (longest waiter 21/2/2022) 3 managed (longest waiter 7/2/2022) 11 routine (longest waiter 20/1/2022)
72 Hour Heart Monitors	2 urgent (longest waiter 25/2/2022) 3 managed (longest waiter 20/9/2021) 5 routine (longest waiter 11/2/2022)
12 Lead ECG's	21 urgent (longest waiter 2/2/2022) 5 managed (longest waiter 2/12/2021) 27 routine (longest waiter 31/1/2022)
Pacing	54 (longest waiter 23/2/2022)
Treadmills	9 urgent (longest waiter 23/2/2022) 3 managed (longest waiter 9/2/2022) 11 routine (longest waiter 16/2/2022)
Blood Pressure Monitors	11 urgent (longest waiter 4/2/2022) 4 managed (longest waiter 6/12/2021) 25 routine (longest waiter 20/1/2022)
Exercise Echoes	2 urgent (longest waiter 9/2/2022) 3 routine (longest waiter 24/1/2022)

A review of the process of adding referrals for Cardiac investigations onto TOMCAT was undertaken.

This review identified there were inadequate balance checks to ensure all referrals received to the referral inbox had been added to the TOMCAT system.

There is now appropriate balances checks added to this process which ensure all referrals now received into the Cardiac Investigations inbox are added to the TOMCAT system.

There was a change of the Cardiac Investigation referral process in April 2021 with the introduction of a single generic email address.

As we have identified inadequate checks and balances within the process the Trust are undertaking a review audit of the Cardiac Investigations referrals from April 2021 to April 2022.

The new balance checks were implemented during the month of April and therefore we are assured from May 2022 all referral have been added to the system.

This audit will take an extended time period and staffing resource as each individual referral may contain multiple Cardiac Investigations requests and therefore a manual review of each referral sent is necessary.

For April 2021, 1059 email referrals were audited, identifying 9 which were not added to TOMCAT. The audit for May 2021 is ongoing but no missed referrals have been identified currently. All missed referrals are added to the TOMCAT system chronologically when identified.

On review of the referral process a further risk was identified surrounding the allocation of Cardiac Investigations. Currently there is insufficient internal capacity within the SHSCT to complete Transthoracic Echocardiograms (TTE) and we increase our provision through support from the SEHSCT.

Cardiac Investigations are subdivided into 3 categories; urgent, managed and routine.

The Trust had a long waiting time for urgent TTEs and therefore priority was given to allocating investigation slots to urgent requests, rather than managed and routine requests.

Managed referrals are Cardiac Investigations which are urgent investigations however they have a specified timeframe in which they need to be completed.

As priority was placed on urgent TTE referrals, managed and routine investigations were delayed as a consequence. This has led to a backlog of 1104 managed Cardiac Investigations which have not been completed within the specified timeframe.

The identified service users within this cohort are at risk as the monitoring or assessment for their cardiac condition has not been completed within the correct timeframes as prescribed during their clinical assessments.

The identified risks associated with Cardiac Investigations are in the process of being added to the Risk Register within Acute Services.

A key high risk group, pericardial effusions, have all been prioritised and booked for their TTE (9 service users). The provision of slots within the Trust and the SEHSCT will be a combination of the current urgent TTEs and managed TTEs which are outside there specified timeframe. It will take time to address this backlog of managed requests, approximately 3 months. As a consequence of this the waiting times for TTEs will increase.

The Trust current reporting system for outstanding Cardiac Investigations does not capture the time sensitive detail surrounding managed referrals.

The operational teams have been working with informatics to develop a report which will capture the time sensitive detail rather than the provision of a static figure for managed referrals.

This work has been progressing prior to the identification of this backlog and once this report is operational it will identify managed tests outside of their timeframe so actions can be implemented to prevent a similar backlog occurring in the future.

The SAI notification will involve both incidents highlighted above within the scope of the investigation; 1383 missed referrals and the backlog of 1104 managed referrals outside of the allocated timeframe.

The delay in submitting the SAI was secondary to identifying accurate detail to place within the notification and this will be submitted alongside this early alert update.

Many thanks
Chris

Chris Wamsley
Acute Clinical Governance Coordinator
Governance Office
Room 53
The Rowans
Craigavon Area Hospital

Personal Information redacted by the USI



ACUTE SERVICES STANDARDS & GUIDELINES FORUM

Date: 18th October 2022

Time: 330pm

Venue: Personal information redacted by the USI

AGENDA

1.0	In attendance: Apologies:	
2.0	Approval of last meeting notes (06/09/2022 meeting) Review of action log from previous meeting	 20220927 Acute SG Meeting Notes.docx  Action Report.docx
3.0	Standards & Guidelines Service Activity Reports: - Standards and Guidelines Activity Report - HSCB Outstanding Assurance Report	 20220915_SG Forum_SG Activity r  HSCB Outstanding Assurance Report S
4.0	Newly Issued Standards & Guidelines (issued to) Review & determine applicability to Acute Services (Table 1) Nomination of Change Lead Risk review & Prioritisation	See Table 1 of agenda See Table 2 of

Received from Chris Wamsley on 25/10/22. Annotated by the Urology Services Inquiry.

8.0	For Sharing and Information NICE Newsletter Learning Matters	 NICE News for Health and Social C  PHA Learning Matters (Special Ed
9.0	Standing Item Monthly report diabetes awareness training ATICS  ATICS Graph.docx CCS  CCS Graph.docx IMWH  IMWH Graph.docx Medicine  Medicine Graph.docx SEC  SEC Graph.docx Unscheduled Care  Unscheduled Care Graph.docx	 Diabetes Awareness Training
10.0	For Discussion: NICE NG 127 Updated Suspected Neurological Conditions Recognition and Referral NICE CG 150 Headaches in over 12's: diagnosis and management NICE NG 99 Brain Tumours(Primary) and Brain Metastases in Adults NICE NG 192 Caesarean birth (updates and replaces CG132) NICE NG 133 Hypertension in pregnancy: diagnosis and management (updates and replaces CG107). NICE CG 118 Colonoscopy Surveillance	

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11.0	Any Other Business:	
12.0	Date of Next Meeting Tuesday 1st November 2022 at 330pm link to follow	

Acute S&G Forum –18th October 2022 Acute S&G Forum

Table 1 – Newly Issued S&G received from Corporate Governance Team: (S&G issued from 26/09/2022 to 14/10/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments
05/10/2022	NG 222	Depression in Adults Treatment Management <i>Updates and replaces CG 90 issued on 14/09/2010 and ESQ circular issued on 29/06/2022</i>	NICE Clinical Guideline	05/10/2023 Full implementation date (3mth assurance date 05/01/2023)	For Review and Implementation within timescales Leah Ann Shanks – Implementation Lead (MHD)
03/10/2022	n/a	NICE COVID Rapid Guidance Quarterly HSC Communication July to Sept 2022	CMO Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 07/10/2022
30/09/2022*	n/a	DOH Letter Pause Asymptomatic Testing Adult Day Care Centre Staff	DOH Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 07/10/2022
30/09/2022*	n/a	DoH Letter Pause Asymptomatic Testing Supported Living Facility Staff	DOH Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 07/10/2022
29/09/2022	NG 220	Multiple sclerosis in adults Management <i>Guideline replaces NICE CG 186 that was regionally endorsed on 28/11/2014 and ESQ that was issued on 22/06/2022</i>	NICE Clinical Guideline	29/09/2023 Full implementation date (3 month assurance 29/12/2022)	Dr J Campbell is confirmed as Clinical Change Lead

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29/09/2022	n/a	PHA Learning Matters Special Edition Medication Edition 23	SPPG Correspondence	n/a	For Dissemination
28/09/2022	n/a	COVID-19 AND OR Influenza Vaccination Service for frontline HSCW From Local Community Pharmacies	DoH Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 30/09/2022
27/09/2022	HSC-F 32-2022	Charges For Blood and Blood Derivatives Supplied To Non-Health Service Hospitals	DoH Correspondence	n/a	For Dissemination – these charges will be applied for the supply of any blood or derivatives on or after 1 st October 2022 and will be subject to review each financial year.
26/09/2022	n/a	Prescribing Supply Arrangements Specialist Medicines NI Update to Red Amber List August 2022	SPPG Correspondence	n/a	For Dissemination
26/09/2022	n/a	Withdrawal COVID Guidance for Direct Payments	DoH Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 30/09/2022
26/09/2022	n/a	UKHSA Monkeypox Project Board Updated Green Book chapter JCVI Statement on vaccine prioritisation	UKHSA Correspondence	n/a	For Dissemination / Action as appropriate Disseminated by Trudy Reid 30/09/2022

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14/10/2022	NG 224	NICE NG 224 UTIs in the Under 16s Assessment Management <i>Updates and replaces ESQ issued on 28/07/2022 and guidance CG 54 last updated on 31/10/2018</i>	NICE Clinical Guideline	14/10/2023	For Implementation Dr Grier the Implementation Lead (CYPS)
14/10/2022	TA 770	Pembrolizumab with Carboplatin paclitaxel Untreated Metastatic Squamous NSC Lung Cancer	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 768	Upadacitinib Active Psoriatic Arthritis Inadequate response DMARDs	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 767	Ponesimod Relapsing–remitting Multiple Sclerosis	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 761	Osimertinib Adjuvant treatment EGFR mutation positive NSC Lung Cancer	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 760	Selpercatinib RET fusion-positive advanced NSC -	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 758	Solriamfetol Excessive daytime sleepiness Narcolepsy	NICE Technology Appraisal	14/07/2023	For Review / Implementation

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14/10/2022	TA 753	Cenobamate Focal onset seizures in Epilepsy	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 751	Dupilumab Severe Asthma with Type 2 inflammation	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 748	Mexiletine for treating the symptoms of myotonia in non-dystrophic myotonic disorders	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 747	Nintedanib for treating progressive fibrosing interstitial lung diseases	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 744	Upadacitinib for treating moderate rheumatoid arthritis	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 743	Crizanlizumab for preventing sickle cell crises in sickle cell disease	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 739	Atezolizumab for untreated PD-L1-positive advanced urothelial cancer	NICE Technology Appraisal	14/07/2023	For Review / Implementation

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14/10/2022	TA 738	Berotralstat for preventing recurrent attacks of hereditary angioedema	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 704	Trastuzumab deruxtecan <i>Treating HER2-positive unresectable or metastatic breast cancer after 2 or more anti-HER2 therapies</i>	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 677	Autologous anti-CD19-transduced CD3 cells	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 659	Galcanezumab for preventing migraine	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 658	Isatuximab with pomalidomide and dexamethasone	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 644	Entrectinib for treating NTRK fusion-positive solid tumours	NICE Technology Appraisal	14/07/2023	For Review / Implementation
14/10/2022	TA 630	Larotrectinib for treating NTRK fusion-positive solid tumours	NICE Technology Appraisal	14/07/2023	For Review / Implementation

Acute S&G Forum –18th October 2022 Acute S&G Forum

14/10/2022	TA 619	Palbociclib with fulvestrant for treating hormone receptor-positive	NICE Technology Appraisal	14/07/2023	For Review / Implementation
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**Received by corporate S&G team outside of the reporting period for last week*

Acute S&G Forum –18th October 2022 Acute S&G Forum

Table 2 – Updates received for NICE Clinical Guidelines/Technology Appraisals/Public Health issued from (S&G issued from 26/09/2022 to 14/10/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments
04/10/2022	HSS MD 46 2022	ADDENDUM Guidance Revised Arrangements Certification Registration of Deaths Stillbirths Cremation Process	CMO Correspondence	n/a	For Dissemination The only change in the letter is confirmation that there continues to be <u>no requirement</u> for completion of Cremation Form C Disseminated by Trudy Reid 07/10/2022
29/09/2022	HSS MD 47 2022	UPDATE Advice for Primary COVID 19 Vaccination of Children turning 5 years of age <i>Update to HSS MD 09/2022 issued by CMO on 25/02/2022</i>	CMO Correspondence	n/a	For Dissemination Disseminated by Trudy Reid 30/09/2022
29/09/2022	HSS MD 48 2022	MONKEYPOX VACCINATION <i>Further update on guidance issued by CMO on 27/07/2022 (HSS MD 35/2022)</i>	CMO Correspondence	n/a	For Dissemination / Action as appropriate Disseminated by Trudy Reid 30/09/2022

Acute S&G Forum –18th October 2022 Acute S&G Forum**Table 3** - Circulars issued from Corporate Governance Team with no applicability to Acute Services from (S&G issued from 26/09/2022 to 14/10/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments
14/10/2022	TA 766	Pembrolizumab Adjuvant treatment Completely Resected Stage 3 Melanoma	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT
14/10/2022	TA 746	Nivolumab for adjuvant treatment	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT
14/10/2022	TA 742	Selpercatinib for treating advanced thyroid cancer with RET alterations	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT
14/10/2022	TA 693	Olaparib plus bevacizumab for maintenance treatment <i>Advanced ovarian, fallopian tube or primary peritoneal cancer</i>	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT

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14/10/2022	TA 673	Niraparib for maintenance treatment <i>Treatment of advanced ovarian, fallopian tube and peritoneal cancer after response to first-line platinum-based chemotherapy</i>	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT
14/10/2022	TA 645	Avelumab with axitinib for untreated advanced renal cell carcinoma	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT
14/10/2022	TA 620	Olaparib for maintenance treatment	NICE Technology Appraisal	14/07/2023	Not Applicable to SHSCT

ACUTE SERVICES STANDARDS & GUIDELINES FORUM

Date: 27th September 2022

Time: 130pm

Venue: [Redacted]

Irrelevant Information Redacted by the USI

MEETING NOTES

1.0	In attendance: Trudy Reid, Denise Newell, Fiona Stevenson, Ann McCorry, Chris Warr, Chris Wamsley, Ronan Carroll, Mary Burke Apologies: Cathrine Reid	
2.0	Approval of last meeting notes (06/09/2022 meeting) Everyone to review and contact Chris Warr if there is a concern. Otherwise approved. Review of action log from previous meeting Action Log to be carried over to next meeting for Action	
3.0	Standards & Guidelines Service Activity Reports: - Standards and Guidelines Activity Report June, July and August 2022 Presented for information - HSCB Outstanding Assurance Report Presented for information	
4.0	Newly Issued Standards & Guidelines (issued to) Review & determine applicability to Acute Services (Table 1) Nomination of Change Lead Risk review & Prioritisation	See Table 1 of agenda See Table 2 of

	Updates to NICE Guidance received (<i>Table 2</i>) Circulars issued from Corporate Governance Team with no applicability to Acute Services (<i>Table 3</i>) Table 1 Chris has shared that both HSC/F/31 2022 and NG 225 have both been disseminated on 23/09/2022 EAM approval of spike vacs, Trudy shared 11th Sept Ciroxate – working on an alternate, Ann linking with procurement HSCT non British child – CYP widely distributed - Child taken by patients out of the country, password not issued, child can travel on an identity card. - Someone abducted, children can travel on an identity card. Emergency policy governance changes - Rep for panel, new Med Director and Simon Gibson, they are emergency planning leads. - Any training from emergency planning training – will request off Simon Gibson – Trudy to follow up Firearm holder. - MH assessment need addition questions for firearms, MH are the leads but will link to AMU and ED department - Tony black is the lead, Acute rep will be needed. World patient safety day - Rescheduled for tomorrow Monkey pox hospitalisation – disseminated 23rd Sept Fall newsletter will be shared by Chris Warr post meeting Death cert – go back to partially arrangement pre Covid - Seen and treated within 28 days to complete. Health correspondence - Pre op/ OP setting, we now must supply with their LFTs - Trudy disseminated 2nd table – all in hand. COT, Obesity – Gerard Rocks has funding – link with for training Vaccination programme - sent by Trudy Colorectal Cancer update remove recommendations and follow GI guidelines 3rd table – nothing new.	agenda See Table 3 of agenda
5.0	For Acute S&G Forum Approval: Section E Proformas NICE Guidance:	

	NICE NG 10 Violence and Aggression - Approved in May - Returned from MH, 24/25 recommendations applicable and compliant - Size of the room, no plans to increase capacity of room currently. - 5 years deadline on this one. Trudy amend to 10 years as we are using a 10 year plan site wide redevelopment works for infrastructure. Approved Safety Quality Learning Letter: HSC (SQSD) 6/22 Serious Hazards of Transfusion Alert (SHOT): Preventing transfusion delays in bleeding and critically anaemic patients - Replied to SPPG in June and they have returned Question regard 5 - Critical SAI or death following transfusion, SOP has updated and approved.	
6.0	Approved responses that have been sent to the HSCB – For Information Assurance Responses issued to HSCB:	
7.0	Closed at HSCB but Remain Open within SHSCT	
8.0	For Sharing and Information NICE Newsletter <i>For information</i>	

	Learning Matters-	
9.0	Standing Item Monthly report diabetes awareness training-will be presented at next meeting	
10.0	For Discussion: NICE NG 157 joint replacement- 3 questions on for Ronan, Dr McKeown opinion they do better processes than NICE guidelines. Now added to the response but need Ronan to discuss with all surgeons.	
11.0	Positive Assurance Report- Sent as separate email due to size Highlight 2 x Charlotte NG 202 – Sleep Apnoea = E Performa needed, baseline completed NG 203 – Chronic Kidney Disease – progressing 2 for Caroline NG 192 – Caesarean Birth – need a reply NG 133 – HTN in pregnancy – E profoma and baseline need 17 TAs currently working on 16 for Cancer with Clair Quinn	
12.0	Any Other Business: Caroline Beattie CLEAR guidelines clarifications. Overview by Mary of the standards	
13.0	Date of Next Meeting Tuesday 18th October 2022 at 330pm link to follow	

Acute S&G Forum – 20th September 2022 Acute S&G Forum

Table 1 – Newly Issued S&G received from Corporate Governance Team: (S&G issued from 05/09/2022 to 23/09/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments
01/09/2022*	HSC/F/31 2022	HM Treasury Minutes PAC Q1 2022-23	DoH Correspondence	n/a	For Dissemination *07/09/2022 – DoF approved issue following receipt by CEO on 01/09/2022, Disseminated 23/09/2022
07/09/2022	NG 225	Self-Harm Assessment Management Preventing Recurrence <i>Updates and replaces CG 16 and CG 133 that were both endorsed by DoH on 18/07/2012</i>	NICE Equality Screening Questionnaire	18/10/2022	For nomination of CCL, review of guidance and completion of s75 form
08/09/2022	HSS MD 43 2022	EMA Approval Comirnaty Spikevax Bivalent Original OMICRON BA.1 COVID-19 Vaccines	CMO Correspondence	n/a	For Dissemination and Action as appropriate- disseminated by Trudy Reid 11/09/2022
07/09/2022	n/a	GSK UK Limited Seroxat 20mg 10ml oral suspension Global Product Discontinuation	Pharmaceutical Company - GSK UK	n/a	For Review and Appropriate Action SHSCT Pharmacy Service has confirmed that 3 have been used over the last year and MI are MI are currently checking alternatives to ensure there is stock of other liquid preparations
Received from Chris Walmsley on 25/10/22 Annotated by the Urology Services Inquiry			5		

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14/09/2022	SQR 2022 091	Abduction of a Non British Irish Child in Care of HSCT <i>1st Line Assurance</i>	SQR Learning & Quality Letter	n/a	Disseminate the SQR letter to all relevant staff and discuss at relevant governance / team meetings, Disseminated 23/09/2022
14/09/2022	HSS MD 44 2022	Emergency Planning Policy Governance Reporting Changes	CMO Correspondence	30/09/2022	Trust requirement to forward details of nominees for NI HEPF membership to emergencyplanningbranch@hhealth-ni.gov.uk by 30th September 2022 Please note that for the 2021/22 year all annual reports should be forwarded to sppgemergencyplanning@hscni.net by 31 October 2022
22/09/2022	SQR 2022 092	Risk Assessment Service User Licenced Firearm Holder <i>3rd Line Assurance</i>	SQR Learning & Quality Letter	14/12/2022	For Implementation disseminated 28/09/2022
22/09/2022	HSS MD 37 2022	World Patient Safety Day Rescheduled for 28 September 2022	CMO Correspondence	n/a	For Dissemination- disseminated 28/09/2022

Acute S&G Forum –27th September 2022 Acute S&G Forum

21/09/2022	HSS MD 45/2022	Tecovirimat Treatment for Patients hospitalised due to Monkeypox	CMO Correspondence	n/a	For Dissemination / Action as appropriate- disseminated by Trudy Reid 23/09/2022
23/09/2022	n/a	Regional Learning from Falls Newsletter - September 2022 edition	SPPG Correspondence	n/a	For Dissemination disseminated 28/09/2022

Acute S&G Forum – 20th September 2022 Acute S&G Forum

Table 2 – Updates received for NICE Clinical Guidelines/Technology Appraisals/Public Health issued from (S&G issued from 05/09/2022 to 23/09/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments
08/09/2022	CG 189	NICE Clinical Guideline NG 189 Obesity Identification Assessment Management <i>Supersedes original guidance that was endorsed by DoH on 14/01/2015</i>	NICE Clinical Guideline Update	08/12/2022	For review / Implementation following update to recs 1.2.14 and 1.4.2
06/07/2022	HSS MD 41 2022	RE-ISSUED HSS MD 41 2022 Seasonal Influenza Vaccination Programme 2022-23 <i>Supersedes circular issued on 01/09/2022</i>	CMO Correspondence	n/a	<u>For Reissue</u> – amendment made to para 16, page 4- disseminated by Trudy Reid 11/09/2022
05/09/2022	n/a	Update Request RQIA Review Prevent choking incidents NI Progress Reporting <i>Original RQIA Review Report was issued on 19/05/2022</i>	SPPG Correspondence	23/09/2022	Change Leads have a meeting planned for 15/09/2022 to complete regional assurance template. This will be sent out to key stakeholders for comment / approval prior to submission to the SPPG

Acute S&G Forum –27th September 2022 Acute S&G Forum

14/09/2022	HSS MD 37 2022	ADDENDUM HSS MD 37 2022 WORLD PATIENT SAFETY DAY - 17 September 2022 EVENTS POSTPONED <i>Supersedes Circular issued on 16/08/2022</i>	CMO Correspondence	n/a	For Dissemination to advise staff of postponement – event to be rescheduled Disseminated 23/09/2022
20/09/2022	CG 118	Colorectal cancer prevention Colonoscopic surveillance in adults <i>Supersedes original guidance endorsed by DOH on 29/07/2013</i>	NICE Clinical Guideline Update	20/12/2022	NICE have replaced recommendations 1.1.6 to 1.1.13 on colonoscopy for adults with adenomas with a link to the British Society of Gastroenterology's guidelines on post-polypectomy and post-colorectal cancer resection surveillance

Acute S&G Forum –27th September 2022 Acute S&G Forum

Table 3 - Circulars issued from Corporate Governance Team with no applicability to Acute Services from (S&G issued from 05/09/2022 to 23/09/2022)

Date of Issue from External Agency	Reference	Title of Circular	Guidance Type	External Assurance Requirement Date	Comments

Quality Care - for you, with you

Meeting Date- 18th October 2022

Agenda Item	Actions Required	Actionee	Update for next S&G Meeting 18/10/2022
2.0 Previous Meeting Notes/Matters Arising			
From meeting 21/06/2022 Actions Template Interruption of oxygen- Training of Nursing staff	The proposed amalgamation of the oxygen training into the Medicines Management Training to be discussed at the next Senior Nurse Governance meeting.	Needs further discussion. Mary Burke and Caroline Keown	 O2 CEC training.xlsx  NRLS-1124-RRR-Oxygen-safety-2009.09.1
From meeting 19/07/2022	Trust Oxygen Champion to be followed up with Dr Philip Murphy	Chris Warr	Email sent 06/07/2022, 09/08/2022 and 08/09/2022 
From meeting 02/08/2022	To be discussed at meeting 16/08/2022		Actions from Acute S&G 05 07 2022.msg D/W Dr Gormley who will discuss with Dr Murphy



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Agenda Item	Actions Required	Actionee	Update for next S&G Meeting 18/10/2022
			Email sent 07/07/2022  Trust Oxygen Champion.msg Email received from Dr Murphy 22/09/2022- will d/w registrar previously D/W respiratory
From meeting 02/08/2022 4.0 table 1 NICE CG 191 Reinstatement_Pneumonia in Adults Last update received on 17/09/2019	Chris to forward to Charlotte for nomination of new CCL- previous CCL retired Personal information redacted by the USI	Chris Warr	Email sent 03/08/2022, 18/08/2022 and 02/09/2022, 17/10/2022

Quality Care - for you, with you

Agenda Item	Actions Required	Actionee	Update for next S&G Meeting 18/10/2022
From meeting 02/08/2022 11.0 Resuscitation committee	To gain the group consensus for the nomination of representatives to sit on the reformed Trust Resuscitation Committee	Chris Warr Charlotte to Chair committee	Email sent 03/08/2022 with Terms of Reference and previous group membership  Actions from Acute Standards and Guid  Terms of Reference.docx
02/08/2022 12.0 Never Event Memo re medical air flow meters	Chris to complete and share with Directors for approval	Chris Wamsley	Update given meeting held 06/09/2022

Title	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G	Date Responded to External Agency	Applicable to Trust? (YES / NO)	Change Lead(s)	Lead Directorate	Directorates applicability	Trust Corporate Compliance Rating	Trust Corporate Risk Rating
DoH Letter_Addendum_HSC TC8-1-2022_Pay Circular <i>Supercedes circular issued on 04/05/2022</i>	26/08/2022	HSC (TC8) 1/2022	DoH Correspondence	n/a	n/a		Yes	For Dissemination			For Dissemination	Not Applicable
Regional Falls Assistive Technology guidelines_August 2022 - All Documents	19/08/2022	n/a	PHA Correspondence	n/a	n/a		Yes				For Dissemination	Not Applicable
Type 1 Diabetes in Adults <i>Last Update: 30/06/2022</i>	17/08/2022	NG 17	NICE Clinical Guideline Update	n/a	17/11/2022		Yes	Dr Una Bradley	Acute	Acute, OPPC	Non Compliant	Low
Mental Wellbeing at Work	17/08/2022	NG 212	NICE Equality Screening Questionnaire	n/a	27/09/2022		Yes				Under Review	Under Review
WORLD PATIENT SAFETY DAY_17th September 2022	16/08/2022	HSS MD 37/2022	CMO Correspondence	n/a	n/a		Yes	For Dissemination			For Dissemination	Not Applicable
NI Formulary_Skin Chapter Review	11/08/2022	n/a	DoH Correspondence	n/a	08/09/2022	08/09/2022	Yes	Anita Heron	Acute	Acute	Compliant	Low
PHA Letter_For action_Update on Polio	12/08/2022	n/a	PHA Correspondence	n/a	n/a		Yes				For Dissemination	Not Applicable
Update to NICE COVID 19 Rapid Guideline_Systemic Anticancer Treatment <i>Replaces previous update issued on 12/02/2021</i>	11/08/2022	NG 161	NICE COVID 19 Rapid Guideline Update	n/a	11/11/2022		Yes				N/A	
Lung Cancer_Diagnosis_Management <i>Guidance was previously endorsed by DOH on 23/05/2019</i>	11/08/2022	NG 122	NICE Clinical Guideline Update	n/a	11/11/2022		Yes	Dr Rory Covery	Acute	Acute	Non Compliant	Low
Gout Diagnosis and Management	05/08/2022	NG 219	NICE Clinical Guideline	05/11/2022	05/08/2023		Yes	Dr Stewart	Acute	Acute, OPPC	Under Review	Under Review
Shortage of Alteplase_Tenecteplase Injections.	04/08/2022	HSS MD 36 2022	CMO Correspondence	n/a	11/08/2022		Yes		Acute	Acute	Non Compliant	Low
UKHSA investigation_Contamination of Bioprosthetic Heart Valves_Mycobacterium Chelonae	03/08/2022	n/a	PHA Correspondence	n/a	n/a		Yes				Under Review	Under Review
New guidance_Known safety issues_Dialysis_Continuous renal replacement therapy	27/07/2022	PL 2022-047	DoH Correspondence	n/a	n/a		Yes	Neal Morgan	Acute	Acute	Compliant	Low
Melanoma Assessment and Management <i>Guidance endorsed by DoH on 15/09/2015</i>	27/07/2022	NG 14	CE Clinical Guideline Upd	n/a	27/10/2022		Yes	Dr A O'Hagan	Acute	Acute	Non Compliant	Low
Topiramate Topamax_Start of Safety Review <i>This review has been initiated by the MHRA as a result of an observational study reporting an increased risk of neurodevelopmental disabilities in children whose mothers took topiramate during pregnancy</i>	25/07/2022	HSS MD 34 2022	CMO Correspondence	n/a	n/a		Yes	For Dissemination	For Dissemination	Acute, CYPS, MHD, OPPC	For Dissemination	Not Applicable
Managing COVID-19 <i>This update replaces the update issued on 16/06/2022 by DoH</i>	25/07/2022	NG 191	NICE COVID-19 Rapid Guideline Update	n/a	n/a		Yes		Acute	Acute, OPPC	Under Review	Under Review
Vitamin D <i>This update replaces the previous guidance endorsed by DoH on 17/12/2020</i>	25/07/2022	NG 187	NICE COVID-19 Rapid Guideline Update	n/a	n/a		Yes	For Dissemination	For Dissemination	Acute, CYPS, OPPC	Under Review	Under Review
Haematopoietic Stem Cell transplantation <i>This update replaces the previous update issued by the DoH on 22/07/2021</i>	25/07/2022	NG 164	NICE COVID-19 Rapid Guideline Update	n/a	n/a	n/a	Yes	Dr Chris McCauley	Acute	Acute	N/A	
Update to Red Amber List Prescribing and Supply Arrangements for Specialist Medicines NI	20/07/2022	n/a	DoH Correspondence	n/a	n/a		Yes	For Dissemination	For Dissemination	OPPC	For Dissemination	Not Applicable
Regional Ophthalmology and Optometry Thematic Analysis	18/07/2022	n/a	DoH Correspondence	n/a	19/08/2022	19/08/2022	Yes	Chris Wamsley	Acute	Acute	Compliant	Low
REISSUE_Inadvertent oral administration_Potassium Permanganate <i>Previously issued on 24/05/2022 - This circular has been reissued to ensure the onward transmission to all relevant organisations addressed. There is otherwise no change to the content of this reissued circular</i>	11/07/2022	HSC SQSD 16-2022	Patient Safety Alert	n/a	23/11/2022		Yes	Lyn Watt	Acute	Acute, OPPC	Non Compliant	Low
HSC SQSD 20-2022_Contamination of Hygiene Products_Pseudomonas Aeruginosa - 3rd Line Assurance <i>Previous PHA email received on 27/06/2022 and circulated in the weekly papers issued on 01/07/2022</i>	08/07/2022	HSC SQSD 20-2022	Patient Safety Alert	n/a	29/07/2022	29/07/2022	Yes	Caroline Beattie	For Dissemination	Acute, CYPS, MHD, OPPC	Compliant	Low
Reinstatement_Pneumonia in Adults <i>Last update received on 17/09/2019</i>	08/07/2022	CG 191	NICE Clinical Guideline	n/a	n/a		Yes		Acute	Acute, OPPC	Under Review	Under Review
NICE Covid-19 Rapid Guidance_Quarterly HSC Communication April to June 2022	04/07/2022	n/a	NICE Correspondence	n/a	n/a		Yes	For Dissemination	For Dissemination	Acute, CYPS, MHD, OPPC	For Dissemination	Not Applicable
NICE Interventional Procedures Guidance_May-June 2022	04/07/2022	n/a	NICE Interventional Procedures	n/a	n/a		Yes	For Dissemination	For Dissemination	Acute, CYPS, MHD, OPPC	For Dissemination	Not Applicable
Type 2 Diabetes in Adults <i>Last Update 31/03/2022</i>	30/06/2022	NG 28	NICE Clinical Guideline Update	n/a	30/09/2022		Yes	Dr Una Bradley	Acute	Acute, OPPC	Non Compliant	Low
Vaccine-induced immune thrombocytopenia and thrombosis <i>Updates guideline endorsement on 29/07/2022</i>	23/06/2022	NG 200	NICE COVID-19 Rapid Guideline Update	n/a	n/a		Yes	Dr Mark Bridgham	Acute	Acute, OPPC	Compliant	Low
Learning Matters Newsletter_21st Edition_2022	22/06/2022	n/a	DoH Correspondence	n/a	n/a		Yes	For Dissemination	For Dissemination	Acute, OPPC	For Dissemination	Not Applicable
Multiple sclerosis in adults <i>Guideline replaced NICE CG 186 that was regionally endorsd on 28/11/2014</i>	22/06/2022	NG 220	NICE Equality Screening Questionnaire	n/a	02/08/2022	22/07/2022	Yes	Dr Jamie Campbell	Acute	Acute	Compliant	Low
Preterm Labour and Birth <i>Updates previous version issued on 12/08/2019</i>	10/06/2022	NG 25	NICE Clinical Guideline Update	na	10/09/2022		Yes	Mr Sim, Dr McKeown	Acute	Acute	Non Compliant	Low
Legal Advice_Withdrawal of Life Sustaining Treatment for Pregnant Women who Lack Capacity to Consent	01/06/2022	HSS MD 27-2022	CMO Correspondence	n/a	n/a		Yes	Disseminated 22/06/2022	For Dissemination	Acute	For Dissemination	Not Applicable
REISSUED Potential misuse and safe disposal of intravenous anaesthetic agents_2nd Line Assurance <i>Replaces the letter issued on 22/09/2021 and recalled on 01/12/2021</i>	01/06/2022	SQR 2021-044	Safety & Quality Learning Letter	n/a	29/06/2022	21/06/2022	Yes	SHSCT MDT Working Group led by Lyn Watt	Acute	Acute, CYPS, MHD	Non Compliant	Low

Standards and Guidelines Activity Report - Presented at Standards Guidelines Governance Officers Forum - 15/09/2022 **WIT-63525**

Title of Correspondence	Infection Risk	Date of Issue from External Agency	Reference	Guidance Type	Applicable to Trust	Corporate position
Removal of Temporary COVID Polices	COVID 19	25/08/2022	HSC Gen 3 2022	DoH Guidance	Yes	Circulated from Standards & Guidelines email box via papers for Review 02/09/2022 - due to annual leave there was no service cover for 26/08/2022
20220819 Covid-19 Testing and Isolation guidance Symptoms of respiratory infection General Population - All Documents	COVID 19	19/08/2022	By Internal Email	DoH Guidance	Yes	Circulated from Standards & Guidelines email box via papers for Review 19/08/2022
Testing to support a planned admission to hospital including admission Planned Elective Procedure	COVID 19	05/08/2022	n/a	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 05/08/2022
CNO Update Care Home Visiting Pathway	COVID 19	28/06/2022	n/a	CNO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 01/07/2022
COVID 19 Spring Booster Vaccination Programme	COVID 19	10/06/2022	HSS MD 31-2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 10/06/2022
COVID Therapeutic Alert nMABS Treatment of non hospitalised patients with COVID	COVID 19	01/06/2022	HSS MD 29-2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 06/06/2022 - delayed issued due to Jubilee Bank Holiday
COVID 19 Therapeutic Alert nMABS Treatment of Hospital Onset COVID 19	COVID 19	01/06/2022	HSS MD 28-2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 06/06/2022 - delayed issued due to Jubilee Bank Holiday

Title of Correspondence	Infection Risk	Date of Issue from External Agency	Reference	Guidance Type	Applicable to Trust? (YES / NO)	Corporate position	Date of Circulation by Trudy Reid
Regional laboratory testing advice RVL form for Monkeypox	MonkeyPox	18/08/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 19/08/2022	22/08/2022
Monkeypox Vaccination	MonkeyPox	27/07/2022	HSS MD 35 2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 29/07/2022	31/07/2022
Updates on Monkeypox Guidance - Waste Management and Secondary Patient Care Pathway	MonkeyPox	07/07/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 22/07/2022 - due to annual leave there were no papers issued on 08/07/2022 or 15/07/2022	08/07/2022
Flow Chart - Air Transfer of Monkeypox Patients	MonkeyPox	27/06/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 01/07/2022	27/06/2022
Updated Regional Guidance documents Monkeypox	MonkeyPox	16/06/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 17/06/2022	16/06/2022
MONKEYPOX VACCINATION	MonkeyPox	15/06/2022	HSS MD 32 2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 17/06/2022	16/06/2022
MonkeyPox Notifiable Disease in Northern Ireland	MonkeyPox	08/06/2022	HSS MD 30 2022	CMO Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 10/06/2022	08/06/2022
Regional MonkeyPox Pathways for the Weekend and Bank Holiday Period	MonkeyPox	01/06/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 06/06/2022 - delayed issued due to Jubilee Bank Holiday	01/06/2022
NI HSC Monkeypox Secondary Care Patient Care Pathway Version 6 01.06.22	MonkeyPox	01/06/2022	n/a	PHA Correspondence	Yes	Circulated from Standards & Guidelines email box via papers for Review 06/06/2022 - delayed issued due to Jubilee Bank Holiday	01/06/2022

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Full Implementation Date for S&G	Applicable to SHSCT (Y/N)	Date that Director of Pharmacy confirmed applicability	Further information
Limited Supplies Varivax Varilrix Injection Until mid October 2022	19/08/2022	HSS MD 38 2022	CMO Correspondence	n/a	n/a	08/09/2022	07/09/2022 Email sent to Ann McCorry seeking applicability status 08/09/2022 - Ann McCorry has confirmed that Procurement have advised Usage low and will be managed with RPhPS (regional procurement). Currently 11 in stock which could last a month or 3 months

Formal Assurance Responses that are due to be submitted to an external agency **[*up until 31 October 2022]**

Title of Correspondence	Reference	Guidance Type	Full Implementation Date for S&G	Lead Directorate	Clinical Lead
Update Request RQIA Review Prevent choking incidents NI Progress Reporting <i>(Cross reference to previous correspondence issued on 10/06/2022 and 19/05/2022)</i>	n/a	SPPG Correspondence	23/09/2022	Executive Directorate of Nursing, Midwifery & AHPs	SHSCT Dysphagia Steering Group
Mental Wellbeing at Work	NG 212	NICE Equality Screening Questionnaire	27/09/2022	HR	TBC
Level 3 SAI Independent Review Quarterly Monitoring Arrangements Need to Audit CLEAR Standards	S10617	PHA Correspondence	30/09/2022	MHD	Jan McGall working with Acute Colleagues
NOT RECOMMENDED Pralsetinib RET fusion-positive advanced NSC lung cancer	TA 812	NICE Technology Appraisal	01/10/2022	Acute	Clair Quin
NOT RECOMMENDED Ibrutinib Waldenstroms Macroglobulinaemia	TA 795	NICE Technology Appraisal	01/10/2022	Acute	Dr Allister Foy
NOT RECOMMENDED Solriamfetol Excessive daytime sleepiness Obstructive Sleep Apnoea	TA 777	NICE Technology Appraisal	01/10/2022	Acute	Dr Liam Polley
NOT RECOMMENDED Pitolisant hydrochloride Excessive daytime sleepiness Obstructive Sleep Apnoea	TA 776	NICE Technology Appraisal	01/10/2022	Acute	Dr Liam Polley
NOT RECOMMENDED Abiraterone Newly diagnosed high-risk hormone-sensitive metastatic prostate cancer	TA 721	NICE Technology Appraisal	01/10/2022	Acute	Clair Quin

Internal Assurances that are overdue / pending completion / review **[*up until 31 October 2022*]**

<u>Title of Correspondence</u>	Reference	Guidance Type	Implementation / Review Date	Lead Directorate	Implementation / Clinical Lead
REISSUED Potential misuse and safe disposal of intravenous anaesthetic agents 2nd Line Assurance <i>Replaces the letter issued on 22/09/2021 and recalled on 01/12/2021</i>	SQR 2021-044	Safety & Quality Learning Letter	30/09/2022	Pharmacy working with relevant clinical specialities (primarily ATICS)	Lyn Watt
Safe management of the intoxicated, violent and aggressive patient in the Emergency Department <i>2nd Line Assurance</i>	SQR-SAI-2021-088	Safety and Quality Reminder of Best Practice Guidance	30/09/2022	Acute Services	Dr Michael Perry
In Hospital Care out of Hospital Cardiac Arrest	n/a	NCEPOD Report	30/09/2022	Acute Services	Dr J McCormick, Dr C Clarke, Dr A Gray, Kay Carroll, Cardiac Resuscitation Team

Submissions to External Agency (11 June to 11th September 2022)

Title of Correspondence	Reference	Guidance Type	Assurance response Date for S&G	Directorates applicability	Clinical Lead	Assurance Response
UTI Infection in the Under 16s	NG 224	NICE Equality Screening Questionnaire	07/09/2022	CYPS	Dr David Greer	 20220908_SHSCT s75 response_NICE ↑
NI Formulary Skin Chapter Review	n/a	DoH Correspondence	08/09/2022	Acute	Anita Heron nominated as SHSCT Representative at Regional Review meeting scheduled for 22/09/2022	 SHSCT Representative NI F
HSCB NICE Positive Assurance - April 2022 - All Documents	n/a	SPPG Correspondence	31/08/2022	Acute, CYPS, MHD, OPPC	Caroline Beattie	 20220831_SHSCT_FINAL_APPROVED_NIC
Regional Ophthalmology and Optometry Thematic Analysis	n/a	DoH Correspondence	19/08/2022	Acute	Chris Wamsley working with clinical leads	 20220819_SHSCT Response - Ophthal
Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation	HSC (SQSD) 17/20	nPSA	18/08/2022	Acute, CYPS, MHD	Dr Laure Martin	 20220818_SHSCT_Updated Action Plan
Tobacco Preventing Uptake Promoting Quitting Treating Dependence	NG 209	NICE Equality Screening Questionnaire	18/08/2022	Acute, MHD, OPPC	Lynne Smart	 20220818_SHSCT s75 response_NICE ↑

Preventing Transfusion Delays Bleeding Critically Anaemic Patients	HSC SQSD 06/22	nPSA	18/08/2022	Acute	Dr Mark Bridgham	 20220818_SHSCT_Updated Approved 3r
Looked After Children and Young People	NG 205	NICE Equality Screening Questionnaire	10/08/2022	CYPS	Jill McGivern RISE NI Coordinator	 20220808_SHSCT Response_ NICE Gui
Social emotional and mental wellbeing Primary Secondary Education	NG 223	NICE Equality Screening Questionnaire	16/08/2022	CYPS	Stella Kelly Head of 14 +	 20220808_SHSCT Response_ NICE Gui
Depression in Adults <i>Updates and replaces CG 90</i>	NG 222	NICE Equality Screening Questionnaire	09/08/2022	MHD	Leah Ann Shanks	 20220802_SHSCT_s7 5 Equality Questioni
Level 3 SAI Independent Review S10617 Quarterly Monitoring Arrangements	PL 2022-047	PHA Correspondence	22/07/2022	MHD (Lead), Acute	Mrs Jan McGall	 20220729_SHSCT FINAL_APPROVED_S
HSC SQSD 20-2022 Contamination of Hygiene Products Pseudomonas Aeruginosa - 3rd Line Assurance <i>Previous PHA email received on 27/06/2022 and circulated in the weekly papers issued on 01/07/2022</i>	HSC SQSD 20-2022	Patient Safety Alert	29/07/2022	All Operational Directorates	Alert shared to raise awareness of risk	 20220729_FINAL_SHSCT 3rd Line Assurati

Behaviour change Digital and mobile health interventions <i>(Public Health Guideline)</i>	NG 186	NICE Equality Screening Questionnaire	02/08/2022	OPPC Informatics	Lynne Smart Mark Toal Helene McKee	 20220729_SHSCT_s7 5 Equality Questionnaire
Multiple sclerosis in adults <i>Guideline replaced NICE CG 186 that was regionally endorsed on 28/11/2014</i>	NG 220	NICE Equality Screening Questionnaire	22/07/2022	Acute	Dr Jamie Campbell	 NICE Equality Screening Questionnaire
Update request - Risk of serious harm or death from choking on foods <i>3rd Line Assurance</i>	SQR 2021-075	Safety & Quality Learning Letter	06/07/2022	Acute, CYPS, MHD, OPPC	SHSCT Dysphagia Steering Group	 20220613_Updated_SHSCT CYPS Action  20220706_Updated_Appealed_SHSCT A
SPPG Request Adverse Incident data Choking on food; Maternity <i>16/06/2022 - confirmation from the SPPG of a regionally agreed list of search words to support IA report</i>	n/a	SPPG Correspondence	08/07/2022	Acute, CYPS, MHD, OPPC	SHSCT Dysphagia Steering Group	Adverse Incident Data report for Choking submitted to SPPG on 07/07/2022 by Corporate Governance Team
Preventing Transfusion Delays Bleeding Critically Anaemic Patients	HSC SQSD 06-2022	Patient Safety Alert	15/07/2022	Acute	Dr Mark Bridgham	 20220705_Approved SHSCT_3rd Line As

Gout Diagnosis and Management	NG 219	NICE Equality Screening Questionnaire	05/07/2022	Acute	Dr Stewart	 20220705_SHSCT_A pproved S75 Equalit
Eliminating the risk of inadvertent connection to medical air via a flowmeter	HSC SQSD 8/21	nPSA	06/07/2022	Acute	Trust Medial Gas Committee	 20220705_Approve d_SHSCT Action Plar
Management of Small Bowel Obstruction with Additional Pathology - All Documents	SQR SAI 2020/071	Safety & Quality Learning Letter	06/07/2022	Acute	Mr Gilpin	 20220623_SHSCT_A proved Assurance R
Use of Plastic Bags on Mental Health In-Patient Wards - All Documents	SQR 2018/033	Safety & Quality Learning Letter	20 th July 2022	MHD	Joe Walker	 20220701_Updated SHSCT Action Plan -  20220701_SHSCT_BI uestone Informatior
Revised Response Timeframe Assessment under the Mental Health Order <i>2nd Line Assurance Supersedes Circular issued on 07/04/2022</i>	SQR 2022 / 089	Safety & Quality Learning Letter	01/07/2022	MHD	Kathy Lavery	 20220701_SHSCT_2 nd Line Assurance -
REISSUED Potential misuse and safe disposal of intravenous anaesthetic agents <i>2nd Line Assurance</i>	SQR 2021- 044	Safety & Quality Learning Letter	29/06/2022	Medical	MDT Working Group chaired by Lyn Watt	 20220621_SHSCT_2 nd Line Assurance_E

<u>Replaces the letter issued on 22/09/2021 and recalled on 01/12/2021</u>						
<u>SPPG Further Assurance Request 2021-042 Potential risk of towel dispensers Ligature point</u> <u>Cross reference to SQR letter received on 03/03/2021</u>	SQR SAI 2021-042	Safety & Quality Learning Letter	Not specified	Acute, CYPS, MHD, OPPC	Ongoing Implementation by MDT Cross Directorate Policy Working group led by Dr Gormley – next meeting 16/06/2022	 <u>20220609_SHSCT_U pdated_Approved A</u>

SECTION E -

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

Clinical Guideline Number	NG 10
Title	Violence and aggression: short-term management in mental health, health and community settings
Date of Review	September 2022 (Previous E proforma submitted 20/03/2017)
Clinical Lead	Louise Hall – Lead for Acute Mental Health Adrian Corrigan – Lead for Community Mental Health Mary Burke – Head of ED Services
Description of major barrier/s to implementation	Following completion of the baseline assessment tool recommendation 1.5.8 is indicated as an external barrier. It states "Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that: • <i>is close to or part of the main emergency department receiving area</i> • <i>is made available for mental health assessments as a priority</i> • <i>can comfortably seat 6 people</i> • <i>is fitted with an emergency call system, an outward opening door and a window for observation</i> • <i>contains soft furnishings and is well ventilated</i> • <i>contains no potential weapons.</i> Staff and senior management within ED have been undertaking work to resolve the inability to comply with this recommendation. Whilst a cubicle is provided for staff to undertake a mental health assessment/interview with patients the following control measures are not in place. There is no dedicated area available within CAH Emergency Department but staff members try to use cubicle 5 in minors CAH. Within DHH Emergency Department staff use whatever cubicle is available. Despite the lack of dedicated space for this specified purpose, staff members working in both departments do ensure that the environment where the interview/assessment takes place is conducive to a safe and caring environment. Staff who are undertaking the assessment with the patient are able to call for

	help since with ED staff are in proximity and an emergency bell is available. The areas do not have soft furnishings and do not accommodate 6 people The room that is used in CAH only has a patient trolley in it so items that could be used as a weapon are negligible
Indicate any specific requirements to address the major barrier/s to implementation	Unfortunately without a major redevelopment investment the Trust will not be able to provide an interview room that meets the specification of recommendation 1.5.8
Description of any immediate patient safety concerns if clinical guideline is not implemented within 12 month timescale	If a patient becomes agitated and presents as violent and aggressive there is the potential for both patient and staff harm
No. of recommendations applicable to SHSCT <i>(If a number are deemed N/A, please state)</i>	Three baseline assessments have been completed for the following Mental Health & Learning Disability services: • Home Treatment – 23 applicable recommendations • Liaison service – 15 applicable recommendations • Bluestone Unit – 8 applicable recommendations
No. of applicable recommendations currently implemented (e.g. 99/100)	• Home Treatment – 21 recommendations implemented (91%) • Liaison service – 13 recommendations implemented (87%) • Bluestone Unit – all 8 recommendations implemented (100%)
Additional resources required to ensure implementation	There is need for a major redevelopment investment for both Emergency Departments to provide a dedicated room that meets the requirements outlined in recommendation 1.5.8 The Trust can confirm that it has an Emergency Department sub group established as part of the CAH Redevelopment Project. This group are currently looking at initial plans for a new Emergency Department in CAH. This new facility has been agreed as the main priority for Phase 1 of the redevelopment of the CAH. At this time we are working to a 5-7 year timescale for this work. The new facility will be based on the Estates schedule for an ED which will include the appropriate facility for management of violent / aggressive patients in ED.

	The Trust is currently looking at an interim expansion to CAH ED but this will be aimed at additional majors / ambulance triage space. There would not be enough space to provide a facility for the above until we have the new facility.		
Suggested revised compliance date if outstanding issues are addressed	30/09/2032-10yrs		
ACUTE SERVICES APPROVAL			
Date presented to Acute SMT Governance Forum	27/09/2022		
Assistant Director/s signature:	Mrs Mary Burke	Date	27/09/2022
Director signature:	Personal information redacted by the USI	Date	07.10.2022
Date Submitted to Corporate Governance team for onward submission to HSCB	07/10/2022		

Regional endorsement: 20/07/2015

Number of recommendations applicable to the organisation	23
Number of recommendations met	22
Percentage of recommendations met	96%
Version control 26/09/2022	

Approved at Acute S&G and by CCL 27/09/2022
Approved by MHD Sept 2022

WIT-63538

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
1.1 Principles for managing violence and aggression										
Improving service user experience										
Use this guideline in conjunction with NICE's guideline on service user experience in adult mental health and: • work in partnership with service users and their carers • adopt approaches to care that respect service users' independence, choice and human rights • increase social inclusion by decreasing exclusionary practices, such as the use of seclusion and the Mental Health Act 1983.	1.1.1	No	Yes	ACUTE We currently work in partnership with service users and carers Home treatment by its nature is less restrictive and seeks to increase social inclusion HTCR We currently work in partnership with service users and carers Home treatment by its nature is less restrictive and seeks to increase social inclusion	Yes					
Ensure that the safety and dignity of service users and the safety of staff are priorities when anticipating or managing violence and aggression.	1.1.2	No	Yes	HTCR We complete full risk assessment and safety planning at each assessment and continue to review and update throughout treatment We comply with how working arrangements to ensure the health and safety of staff and service users	Yes	HTCR When assessing in ED dept we try to use an appropriate room which promotes privacy and dignity of service users. Awaiting allocation of suitable room in ED for mental health assessments				
Use of restrictive interventions must be undertaken in a manner that complies with the Human Rights Act 1998 and the relevant rights in the European Convention on Human Rights.	1.1.3	No	No	n/a						
Unless a service user is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the Mental Capacity Act 2005, health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty.	1.1.4	No	No	n/a						
Staff training										
In any setting in which restrictive interventions could be used, health and social care provider organisations should train staff to understand and apply the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983.	1.1.5	No	No	n/a						
Involving service users in decision-making										
Involve service users in all decisions about their care and treatment, and develop care and risk management plans jointly with them. If a service user is unable or unwilling to participate, offer them the opportunity to review and revise the plans as soon as they are able or willing and, if they agree, involve their carers.	1.1.6	No	Yes	We work collaboratively with service users and carers to support treatment at home. Service users in HTT are fully involved with all decision making about their care	Yes					
Check whether service users have made advance decisions or advance statements about the use of restrictive interventions, and whether a decision maker has been appointed for them, as soon as possible (for example, during admission to an inpatient psychiatric unit) and take this information into account when making decisions about care.	1.1.7	No	No	n/a						
If a service user has not made any advance decisions or statements about the use of restrictive interventions, encourage them to do so as soon as possible (for example, during admission to an inpatient psychiatric unit). Ensure that service users understand the main side effect profiles of the medications recommended in this guideline for rapid tranquillisation (see recommendation 1.4.3.37) so that they can make an informed choice.	1.1.8	No	No	n/a						
Ensure that service users understand that during any restrictive intervention their human rights will be respected and the least restrictive intervention will be used to enable them to exercise their rights (for example, their right to follow religious or cultural practices during restrictive interventions) as much as possible. Identify and reduce any barriers to a service user exercising their rights and, if this is not possible, record the reasons in their notes.	1.1.9	No	No	n/a						
Ensure that carers are involved in decision-making whenever possible; if the service user agrees, and that carers are involved in decision making for all service users who lack mental capacity, in accordance with the Mental Capacity Act 2005.	1.1.10	No	No	n/a						
Preventing violations of service users' rights										
Evaluate, together with the service user, whether adjustments to services are needed to ensure that their rights and those of their carers (including rights related to protected characteristics as defined by the Equality Act 2010) are respected, and make any adjustments that are needed. Adjustments might include providing a particular type of support, modifying the way services are delivered or the approach to interaction with the service user, or making changes to facilities. Record this in the service user's care plan.	1.1.11	No	Yes	We complete collaborative care plans and seek to provide an alternative to other more restrictive practices	Yes					
Health and social care provider organisations should train staff in cultural awareness and in the organisation's duties under the Equality Act 2010.	1.1.12	No	Yes	Staff can access online training for BME and cultural awareness	Yes					
Working with the police										
Health and social care provider organisations should work with the police, and local service user groups if possible, to develop policies for joint working and locally agreed operating protocols that cover: • when and how police enter health or social care settings (including psychiatric and forensic inpatients, emergency departments, general health inpatients, GP surgeries, social care and community settings and 136 place of safety suites) • when and how health and social care professionals enter police cells • transferring service users between settings. Review the operating protocols regularly to ensure compliance with the policies and update the policies in light of operational experience.	1.1.13	No	Yes	Home Treatment adhere to Trust Joint Agency working and there is an agreement that the police will attend if there is a breach of the peace.	Yes					
1.2 Anticipating and reducing the risk of violence and aggression										
Reducing the use of restrictive interventions										
Staff training										

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
Health and social care provider organisations should train staff who work in services in which restrictive interventions may be used in psychosocial methods to avoid or minimise restrictive interventions. The training should enable staff to develop: • a person-centred, values-based approach to care, in which personal relationships, continuity of care and a positive approach to promoting health underpin the therapeutic relationship • an understanding of the relationship between mental health problems and the risk of violence and aggression • skills to assess why behaviour is likely to become violent or aggressive, including personal, constitutional, mental, physical, environmental, social, communicational, functional and behavioural factors • skills, methods and techniques to reduce or avert imminent violence and diffuse aggression when it arises (for example, verbal de-escalation) • skills, methods and techniques to undertake restrictive interventions safely when these are required • skills to undertake an immediate post-incident debrief (see recommendations 1.4.5(a)-(4.6)) • skills to undertake a formal external post-incident review in collaboration with experienced service users who are not currently using the service (see recommendations 1.4.6(2)-(4.6)). Restrictive intervention reduction programme	1.2.1	Yes	Yes	All staff are trained in MAPA level 3, which includes de-escalation skills. Debrief occurs after incidents within the team.	Yes					
Health and social care provider organisations should ensure that all services that use restrictive interventions have a restrictive intervention reduction programme (see recommendation 1.2.3) to reduce the incidence of violence and aggression and the use of restrictive interventions.	1.2.2	No	Yes	All staff in Home Treatment are suitably trained in MAPA and adhere to MOVIA policy. Staff will carry out assessments in home in community or where historical risks appear high. When assessing in ED security staff in Acute hospital may be utilised and informed of risk. Risks are alerted on the PARIS system	Yes	We need to develop skills to undertake formal external post-incident review in collaboration with experienced service users who are currently using the service.				
Restrictive intervention reduction programmes should: • ensure effective service leadership • address environmental factors likely to increase or decrease the need for restrictive interventions (see recommendation 1.2.7) • involve and empower service users and their carers • include leisure activities that are personally meaningful and physical exercise for service users • use clear and simple care pathways • use de-escalation • use crisis and risk management plans and strategies to reduce the need for restrictive interventions • include post-incident debrief and review (see recommendations 1.4.5(a)-(4.6)) • explore the current and potential use of technology in reporting, monitoring and improving the use of restrictive interventions • have routine outcome monitoring, including quality of life and service user experience • be based on outcome measures (safety, effectiveness and service user experience) to support quality improvement programmes • include regular staff training in line with recommendation 1.2.1. Health and social care provider organisations should collect, analyse and synthesise all data about violent events and the use of restrictive interventions, and involve service users in the process. The information should: • be shared with the teams and services involved • be shared with the trust board or equivalent organisational governing body • be linked to the standards set in safeguarding procedures.	1.2.3	No	No							
Health and social care provider organisations should develop a service user experience monitoring unit, or equivalent service user group, led by service users and including staff, to report and analyse data on violence and aggression and the use of restrictive interventions.	1.2.4	No	No	n/a						
Health and social care provider organisations should publish board reports on their public websites that include data about incidents of violence and aggression and use of restrictive interventions within each team, ward and service, and include reasons for the similarities and differences between services.	1.2.5	No	No	n/a						
A framework for anticipating and reducing violence and aggression in inpatient psychiatric wards	1.2.6	No	No	n/a						
Use the following framework to anticipate violence and aggression in inpatient psychiatric wards, exploring each domain to identify ways to reduce violence and aggression and the use of restrictive interventions. • Ensure that the staff work as a therapeutic team by using a positive and encouraging approach, maintaining staff emotional regulation and self management (see recommendation 1.3.16) and encouraging good leadership. • Ensure that service users are offered appropriate psychological therapies, physical activities, leisure pursuits such as film clubs and reading or writing groups, and support for communication difficulties. • Recognise possible teasing, bullying, unwanted physical or sexual contact, or miscommunication between service users. • Recognise how each service user's mental health problem might affect their behaviour (for example, their diagnosis, severity of illness, current symptoms and past history of violence or aggression). • Anticipate the impact of the regulatory process on each service user, for example, being formally detained, having leave refused, having a failed detention appeal or being in a very restricted environment such as a low-, medium- or high secure hospital. • Improve or optimise the physical environment (for example, use unlocked doors whenever possible, enhance the decor, simplify the ward layout and ensure easy access to outside spaces and privacy). • Anticipate that restricting a service user's liberty and freedom of movement (for example, not allowing service users to leave the building) can be a trigger for violence and aggression. • Anticipate and manage any personal factors occurring outside the hospital (for example, family disputes or financial difficulties) that may affect a service user's behaviour.	1.2.7	Yes								
Assessing and managing the risk of violence and aggression										

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
When assessing and managing the risk of violence and aggression use a multidisciplinary approach that reflects the care setting.	1.2.8	No	No	n/a						
Before assessing the risk of violence or aggression: - Take into account previous violent or aggressive episodes because these are associated with an increased risk of future violence and aggression. - Do not make negative assumptions based on culture, religion or ethnicity. - Recognise that unfamiliar cultural practices and customs could be misinterpreted as being aggressive. - Ensure that the risk assessment will be objective and take into account the degree to which the perceived risk can be verified.	1.2.9	No	No	n/a						
Carry out the risk assessment with the service user and, if they agree, their carer. If this risks that the service user could become violent or aggressive, set out approaches that address: - service user-related domains in the framework (see recommendation 1.2.7) - contexts in which violence and aggression tend to occur - usual manifestations and factors likely to be associated with the development of violence and aggression - primary prevention strategies that focus on improving quality of life and meeting the service user's needs - symptoms or feelings that may lead to violence and aggression, such as anxiety, agitation, disappointment, jealousy and anger; and secondary prevention strategies focusing on these symptoms or feelings - de-escalation techniques that have worked effectively in the past - restrictive interventions that have worked effectively in the past, when they are most likely to be necessary and how potential harm or discomfort can be minimised.	1.2.10	No	No							
Consider using an actuarial prediction instrument such as the S-V-C (Briefed Violence Checklist) or the OASIS IV (Dynamic Appraisal of Situational Aggression – Inpatient Version), rather than unstructured clinical judgement alone, to monitor and reduce incidents of violence and aggression and to help develop a risk management plan in <u>inpatient psychiatric settings</u> .	1.2.11	No	No							
Consider offering service users with a history of violence or aggression psychological help to develop greater self control and techniques for <u>self soothing</u> .	1.2.12	No	No							
Regularly review risk assessments and risk management plans, addressing the service user and environmental domains listed in recommendation 1.2.7 and following recommendations 1.2.9 and 1.2.10. The regularity of the review should depend on the assessment of the level of risk. Base the care plan on accurate and thorough risk assessments.	1.2.13	No	No							
If service users are transferring to another agency or care setting, or being discharged, share the content of the risk assessment with staff in the relevant agencies or care settings, and with carers.	1.2.14	No	Yes	All information including a detailed risk assessment is forwarded to the relevant agencies. Information is documented on PARQs and risk screening tools are updated.	Yes					
<u>An individualised pharmacological strategy, to reduce the risk of violence and aggression</u> A multidisciplinary team that includes a psychiatrist and a specialist pharmacist should develop and document an individualised pharmacological strategy for using routine and p.r.n. medication to calm, relax, tranquillise or sedate service users who are at risk of violence and aggression as soon as possible after admission to an <u>inpatient psychiatric unit</u> .	1.2.15	No	No							
The multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used. The review should be recorded and include: - clarification of target symptoms - the likely timescale for response to medication - the total daily dose of medication, prescribed and administered, including p.r.n. medication - the number of and reason for any missed doses - therapeutic response - the emergence of unwanted effects. If rapid tranquillisation is being used, a senior doctor should review all medication at least once a day.	1.2.16	No	No							
1.3 Preventing violence and aggression										
Searching										
<u>Developing a policy on searching</u>										
Health and social care provider organisations should have an operational policy on the searching of service users, their belongings and the environment in which they are accommodated, and the searching of carers and visitors. The policy should address: - the reasons for carrying out a search, ensuring that the decision to search is proportionate to the risks - the searching of service users detained under the Mental Health Act 1983 who lack mental capacity - the rationale for repeated searching of service users, carers or visitors, for example those who misuse drugs or alcohol - the legal grounds for, and the methods used when, undertaking a search without consent, including when the person physically resists searching - which staff members are allowed to undertake searching and in which contexts - who and what can be searched, including persons, clothing, possessions and environments - the storage, return and disposal of drugs or alcohol - how to manage any firearms or other weapons carried by service users, including when to call the police - links to other related policies such as those on drugs and alcohol, and on police liaison.	1.3.1	No	No							
Develop and share a clear and easily understandable summary of the policy on searching, for use across the organisation for all service users, carers or visitors who may be searched.	1.3.2	No	No							
<u>Carrying out searches</u>										

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
Health and social care provider organisations should ensure that searches are undertaken by 2 members of staff, at least 1 of whom should be the same sex as the person being searched. When a decision has been made to undertake a search: + provide the person who is to be searched with the summary of the organisation's policy on searching + seek consent to undertake the search + explain what is being done and why throughout the search + ensure the person's dignity and privacy are respected during the search + record what was searched, why and how it was searched, and the disposal of any items found.	1.3.3	No	No							
If a service user refuses to be searched, carry out a multidisciplinary review of the need to perform a search using physical force and explore any consequences in advance. Use physical force only as a last resort.	1.3.4	No	No							
If consent for a search has not been given, a multidisciplinary review has been conducted and physical force has been used, conduct an immediate post incident debrief (see recommendations 1.4.5D–1.4.5I) and a formal external post incident review (see recommendations 1.4.6D–1.4.6I) with the service user that includes a visit from an advocacy service or hospital manager.	1.3.5	No	No							
If a service user is carrying a weapon, ask them to place it in a neutral location rather than handing it over.	1.3.6	No	No							
If a service user who is at risk of becoming violent or aggressive is in a room or area where there are objects that could be used as weapons, remove the objects or relocate the service user.	1.3.7	No	No							
Audit the exercise of powers of search and report the outcomes to the trust board or equivalent governing body at least twice a year.	1.3.8	No	No							
Using p.r.n. medication										
When prescribing p.r.n. medication as part of a strategy to de escalate or prevent situations that may lead to violence and aggression + do not prescribe p.r.n. medication routinely or automatically on admission + tailor p.r.n. medication to individual need and include discussion with the service user if possible + ensure there is clarity about the rationale and circumstances in which p.r.n. medication may be used and that these are included in the care plan + ensure that the maximum daily dose is specified and does not inadvertently exceed the maximum daily dose stated in the British national formulary (BNF) when combined with the person's standard dose or their dose for rapid tranquillisation + only exceed the BNF maximum daily dose (including p.r.n. dose, the standard dose and dose for rapid tranquillisation) if this is planned to achieve an agreed therapeutic goal, documented, and carried out under the direction of a senior doctor + ensure that the interval between p.r.n. doses is specified. The multidisciplinary team should review p.r.n. medication at least once a week and, if p.r.n. medication is to be continued, the rationale for its continuation should be included in the review. If p.r.n. medication has not been used since the last review, consider stopping it.	1.3.10	Yes	No							
	1.3.11	No	No							
De-escalation Staff training										
Health and social care provider organisations should give staff training in de-escalation that enables them to: + recognise the early signs of agitation, irritation, anger and aggression + understand the likely causes of aggression or violence, both generally and for each service user + use techniques for distraction and calming, and ways to encourage relaxation + recognise the importance of personal space + respond to a service user's anger in an appropriate, measured and reasonable way and avoid provocation.	1.3.12	Yes	Yes	Staff are trained in MAPA level 0	Yes					
General principles										
Establish a close working relationship with service users at the earliest opportunity and sensitively monitor changes in their mood or composure that may lead to aggression or violence.	1.3.13	Yes	No							
Separate agitated service users from others (using quiet areas of the ward, bedrooms, comfort rooms, gardens or other available spaces) to aid de escalation, ensuring that staff do not become isolated.	1.3.14	No	No							
Use a wide range of verbal and non-verbal skills and interactional techniques to avoid or manage known 'flashpoint' situations (such as refusing a service user's request, asking them to stop doing something they wish to do or asking that they do something they don't wish to do) without provoking aggression.	1.3.15	No	No							
Encourage service users to recognise their own triggers and early warning signs of violence and aggression and other vulnerabilities, and to discuss and negotiate their wishes should they become agitated. Include this information in care plans and advance statements and give a copy to the service user.	1.3.16	No	No							
Communicate respect for and empathy with the service user at all stages of de escalation.	1.3.17	No	No							
De-escalation techniques										
If a service user becomes agitated or angry, 1 staff member should take the primary role in communicating with them. That staff member should assess the situation for safety, seek clarification with the service user and negotiate to resolve the situation in a non confrontational manner.	1.3.18	No	No							
Use emotional regulation and self-management techniques to control verbal and non-verbal expressions of anxiety or frustration (for example, body posture and eye contact) when carrying out de escalation.	1.3.19	No	No							

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Use a designated area or room to reduce emotional arousal or agitation and support the service user to become calm. In services where seclusion is practised, do not routinely use the seclusion room for this purpose because the service user may perceive this as threatening.	1.3.20	No	No							
1.4 Using restrictive interventions in inpatient psychiatric settings										
Staff training										
Health and social care provider organisations should train staff working in inpatient psychiatric settings to undertake restrictive interventions, and understand the risks involved in their use, including the side effect profiles of the medication recommended for rapid tranquillisation in this guideline, and to communicate these risks to service users.	1.4.1	No	No							
Staffing and equipment										
Health and social care provider organisations should: - define staff:patient ratios for each inpatient psychiatric ward and the numbers of staff required to undertake restrictive interventions - ensure that restrictive interventions are used only if there are sufficient numbers of trained staff available - ensure the safety of staff during the use of restrictive interventions, including techniques to avoid injury from needles during rapid tranquillisation.	1.4.2	No	No							
Health and social care provider organisations should ensure that resuscitation equipment is immediately available if restrictive interventions might be used and: - include an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, suction and first line resuscitation medications - maintain equipment and check it every week.	1.4.3	No	No							
Staff trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency, if restrictive interventions might be used.	1.4.4	No	No							
Using restrictive interventions										
Use a restrictive intervention only if de-escalation and other preventive strategies, including p.r.n. medication, have failed and there is potential for harm to the service user or other people if no action is taken. Continue to attempt de-escalation throughout a restrictive intervention.	1.4.5	No	No							
Do not use restrictive interventions to punish, inflict pain, suffering or humiliation, or establish dominance.	1.4.6	Yes	No							
Ensure that the techniques and methods used to restrict a service user: - are proportionate to the risk and potential seriousness of harm - are the least restrictive option to meet the need - are used for no longer than necessary - take account of the service user's preferences, if known and it is possible to do so - take account of the service user's physical health, degree of frailty and developmental age.	1.4.7	No	No							
Observation										
General principles										
Staff should be aware of the location of all service users for whom they are responsible, but not all service users need to be kept within sight.	1.4.8	No	No							
At least once during each shift a nurse should set aside dedicated time to assess the mental state of, and engage positively with, the service user. As part of the assessment, the nurse should evaluate the impact of the service user's mental state on the risk of violence and aggression, and record any risk in the notes.	1.4.9	No	No							
Developing a policy on observation										
Health and social care provider organisations should have a policy on observation and positive engagement that includes: - definitions of levels of observation in line with recommendation 1.4.11 - who can instigate, increase, decrease and review observation - when an observer should be male or female - how often reviews should take place - how service users' experience of observation will be taken into account - how to ensure that observation is underpinned by continuous attempts to engage therapeutically - the levels of observation necessary during the use of other restrictive interventions (for example, seclusion) - the need for multidisciplinary review when observation continues for 1 week or more.	1.4.10	No	No							
Levels of observation Staff in inpatient psychiatric wards (including general adult wards, older adult wards, psychiatric intensive care units and forensic wards) should use the following definitions for levels of observation, unless a locally agreed policy states otherwise. - Low-level intermittent observation: the baseline level of observation in a specified psychiatric setting. The frequency of observation is once every 30-60 minutes. - High-level intermittent observation: usually used if a service user is at risk of becoming violent or aggressive but does not represent an immediate risk. The frequency of observation is once every 15-30 minutes. - Continuous observation: usually used when a service user presents an immediate threat and needs to be kept within eyesight or at arm's length of a designated one to one nurse, with immediate access to other members of staff if needed. - Multiprofessional continuous observation: usually used when a service user is at the highest risk of harming themselves or others and needs to be kept within eyesight of 2 or 3 staff members and at arm's length of at least 1 staff member.	1.4.11	No	No							
Using observation										
Use observation only after positive engagement with the service user has failed to dissipate the risk of violence and aggression.	1.4.12	No	No							
Recognise that service users sometimes find observation provocative, and that it can lead to feelings of isolation and dehumanisation.	1.4.13	No	No							

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
Use the least intrusive level of observation necessary, balancing the service user's safety, dignity and privacy with the need to maintain the safety of those around them.	1.4.14	No	No							
Give the service user information about why they are under observation, the aims of observation, how long it is likely to last and what needs to be achieved for it to be stopped. If the service user agrees, ask their care about the aims and level of observation.	1.4.15	No	No							
Record decisions about observation levels in the service user's notes and clearly specify the reasons for the observation.	1.4.16	No	No							
When deciding on levels of observation take into account: • the service user's current mental state • any prescribed and non-prescribed medications and their effects • the current assessment of risk • the views of the service user, as far as possible.	1.4.17	No	No							
Record clearly the names and titles of the staff responsible for carrying out a review of observation levels (see recommendation 1.4.11) and when the review should take place.	1.4.18	No	No							
Staff undertaking observation should: • take an active role in engaging positively with the service user • be appropriately briefed about the service user's history, background, specific risk factors and particular needs • be familiar with the ward, the ward policy for emergency procedures and potential risks in the environment • be approachable, listen to the service user and be able to convey to the service user that they are valued.	1.4.19	No	No							
Ensure that an individual staff member does not undertake a continuous period of observation above the general level for longer than 2 hours. If observation is needed for longer than 2 hours, ensure the staff member has regular breaks.	1.4.20	No	No							
When handing over to another staff member during a period of observation, include the service user in any discussions during the handover if possible.	1.4.21	No	No							
Tell the service user's psychiatrist or on-call doctor as soon as possible if observation above the general level is carried out (see recommendation 1.4.11).	1.4.22	No	No							
Manual restraint										
Health and social care provider organisations should ensure that manual restraint is undertaken by staff who work closely together as a team, understand each other's roles and have a clearly defined lead.	1.4.23	No	No							
When using manual restraint, avoid taking the service user to the floor, but if this becomes necessary: • use the supine (face up) position if possible or • if the prone (face down) position is necessary, use it for as short a time as possible.	1.4.24	No	No							
Do not use manual restraint in a way that interferes with the service user's airway, breathing or circulation, for example by applying pressure to the rib cage, neck or abdomen, or obstructing the mouth or nose.	1.4.25	No	No							
Do not use manual restraint in a way that interferes with the service user's ability to communicate, for example by obstructing the eyes, ears or mouth.	1.4.26	No	No							
Undertake manual restraint with extra care if the service user is physically unwell, disabled, pregnant or obese.	1.4.27	No	No							
Aim to preserve the service user's dignity and safety as far as possible during manual restraint.	1.4.28	No	No							
Do not routinely use manual restraint for more than 10 minutes.	1.4.29	No	No							
Consider rapid tranquillisation or sedation as alternatives to prolonged manual restraint (longer than 10 minutes).	1.4.30	No	No							
Ensure that the level of force applied during manual restraint is justifiable, appropriate, reasonable, proportionate to the situation and applied for the shortest time possible.	1.4.31	No	No							
One staff member should lead throughout the use of manual restraint. This person should ensure that other staff members are: • able to protect and support the service user's head and neck, if needed • able to check that the service user's airway and breathing are not compromised • able to monitor vital signs • supported throughout the process.	1.4.32	No	No							
Monitor the service user's physical and psychological health for as long as clinically necessary after using manual restraint.	1.4.33	No	No							
Mechanical restraint										
Health and social care provider organisations should ensure that mechanical restraint in adults is used only in high secure settings (except when transferring service users between medium- and high secure settings as in recommendation 1.4.36) and its use is reported to the trust board.	1.4.34	No	No							
Use mechanical restraint only as a last resort and for the purpose of: • managing extreme violence directed at other people or • limiting self-harm or behaviour of extremely high frequency or density.	1.4.35	No	No							
Consider mechanical restraint, such as handcuffs, when transferring service users who are at high risk of violence and aggression between medium- and high secure settings. In this context, restraint should be clearly defined as part of overall risk management.	1.4.36	No	No							
Rapid tranquillisation										
Use either intramuscular lorazepam on its own or intramuscular haloperidol combined with intramuscular promethazine for rapid tranquillisation in adults. When deciding which medication to use, take into account: • the service user's preferences or advance statements and decisions • pre-existing physical health problems or pregnancy • possible intoxication • previous response to these medications, including adverse effects • potential for interactions with other medications • the total daily doses of medications prescribed and administered.	1.4.37	No	No							

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
If there is insufficient information to guide the choice of medication for rapid tranquillisation, or the service user has not taken antipsychotic medication before, use intramuscular lorazepam.	1.4.38	No	No							
If there is evidence of cardiovascular disease, including a prolonged QT interval, or no electrocardiogram has been carried out, avoid intramuscular haloperidol combined with intramuscular promethazine and use intramuscular lorazepam instead.	1.4.39	Yes	No							
If there is a partial response to intramuscular lorazepam, consider a further dose.	1.4.40	No	No							
If there is no response to intramuscular lorazepam, consider intramuscular haloperidol combined with intramuscular promethazine.	1.4.41	No	No							
If there is a partial response to intramuscular haloperidol combined with intramuscular promethazine, consider a further dose.	1.4.42	No	No							
If there is no response to intramuscular haloperidol combined with intramuscular promethazine, consider intramuscular lorazepam if this hasn't been used already during this episode. If intramuscular lorazepam has already been used, arrange an urgent team meeting to carry out a review and seek a second option if needed.	1.4.43	No	No							
When prescribing medication for use in rapid tranquillisation, write the initial prescription as a single dose, and do not repeat it until the effect of the initial dose has been reviewed.	1.4.44	No	No							
After rapid tranquillisation, monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. Monitor every 15 minutes if the BNF maximum dose has been exceeded or the service user: • appears to be asleep or sedated • has taken illicit drugs or alcohol • has a pre-existing physical health problem • has experienced any harm as a result of any restrictive intervention.	1.4.45	No	No							
Seclusion Use and seclusion in adults only if the service user is detained in accordance with the Mental Health Act 1983. If a service user not detained under the Mental Health Act 1983 is secluded in an emergency, arrange a mental health assessment under the Mental Health Act 1983 immediately.	1.4.46	No	No							
Services that use seclusion should have a designated seclusion room that: • allows staff to clearly observe and communicate with the service user • is well insulated and ventilated, with temperature controls outside the room • has access to toilet and washing facilities • has furniture, windows and doors that can withstand damage.	1.4.47	No	No							
Carrying out seclusion Record the use of seclusion in accordance with the Mental Health Act 1983 Code of Practice.	1.4.48	No	No							
Ensure that seclusion lasts for the shortest time possible. Review the need for seclusion at least every 2 hours and tell the service user that these reviews will take place.	1.4.49	No	No							
Set out an observation schedule for service users in seclusion. Allocate a suitably trained member of staff to carry out the observation, which should be within oversight as a minimum.	1.4.50	No	No							
Ensure that a service user in seclusion keeps their clothing and, if they wish, any personal items, including those of personal, religious or cultural significance, unless doing so compromises their safety or the safety of others.	1.4.51	No	No							
Rapid tranquillisation during seclusion If rapid tranquillisation is needed while a service user is secluded, undertake with caution following recommendations 1.4.37-1.4.45 and: • be aware of and prepared to address any complications associated with rapid tranquillisation • ensure the service user is observed within eyesight by a trained staff member • undertake a risk assessment and consider ending the seclusion when rapid tranquillisation has taken effect.	1.4.52	No	No							
Post-incident debrief and formal review Health and social care provider organisations should ensure that wards have sufficient staff with a mix of skills and severity levels that enable them to: • conduct an immediate post-incident debrief (see recommendations 1.4.50-1.4.61) • monitor and respond to ongoing risks, and contribute to formal external post incident reviews (see recommendations 1.4.62-1.4.63). The trust board or equivalent governing body should ensure that it receives regular reports from each ward about violent incidents, the use of restrictive interventions, service users' experience of those interventions and the learning gained.	1.4.53	No	No							
Immediate post-incident debrief After using a restrictive intervention, and when the risks of harm have been contained, conduct an immediate post incident debrief, including a nurse and a doctor, to identify and address physical harm to service users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses.	1.4.54	No	No							
Use the framework outlined in recommendation 1.2.7 to determine the factors that contributed to an incident that led to a restrictive intervention, identify any factors that can be addressed quickly to reduce the likelihood of a further incident and amend risk and care plans accordingly.	1.4.56	No	No							
Advise the service user experience monitoring unit, or equivalent service user group, to start a formal external post incident review.	1.4.57	No	No							
Ensure that the service user involved has the opportunity to discuss the incident in a supportive environment with a member of staff or an advocate or carer. Offer the service user the opportunity to write their perspective of the event in the notes.	1.4.58	No	No							

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
Ensure that any other service users who may have seen or heard the incident are given the opportunity to discuss it so that they can understand what has happened.	1.4.59	No	No							
Ensure that all staff involved in the incident have the opportunity to discuss their experience with staff who were not involved.	1.4.60	No	No							
Discuss the incident with service users, witnesses and staff involved only after they have recovered their composure and aim to: • acknowledge the emotional responses to the incident and assess whether there is a need for emotional support for any trauma experienced • promote relaxation and feelings of safety • support a return to normal patterns of activity • ensure that everyone involved in the service user's care, including their carers, has been informed of the event, if the service user agrees. Ensure that the necessary documentation has been completed.	1.4.61	No	No							
Formal external post-incident review										
The service user experience monitoring unit or equivalent service user group should undertake a formal external post incident review as soon as possible and no later than 72 hours after the incident. The unit or group should ensure that the formal external post incident review: • is led by a service user and includes staff from outside the ward where the incident took place, all of whom are trained to undertake investigations that aim to help staff learn and improve rather than assign blame • uses the information recorded in the immediate post incident debrief and the service user's notes relating to the incident • includes interviews with staff, the service user involved and any witnesses if further information is needed • uses the framework in recommendation 1.2.7 to: - evaluate the physical and emotional impact on everyone involved, including witnesses - help service users and staff to identify what led to the incident and what could have been done differently - determine whether alternatives, including less restrictive interventions, were discussed - determine whether service barriers or constraints make it difficult to avoid the same course of actions in future - recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education and training, if appropriate - avoid a similar incident happening in future, if possible. The service user experience monitoring unit or equivalent service user group should give a report to the ward that is based on the formal external post incident review.	1.4.62	Yes	No							
	1.4.63	No	No							
1.5 Managing violence and aggression in emergency departments										
Liaison mental health										
Healthcare provider organisations and commissioners should ensure that every emergency department has routine and urgent access to a multidisciplinary liaison team that includes consultant psychiatrists and registered psychiatric nurses who are able to work with children, young people, adults and older adults.	1.5.1	No	Yes	Home Treatment are extending their role to offer response to both ED's overnight, which enhances the Trust's 24 hour liaison service. Assessments can be responded to in a timely manner from team.	Yes					
Healthcare provider organisations should ensure that a full mental health assessment is available within 1 hour of alert from the emergency department at all times.	1.5.2	No	Yes	The timeline of one hour can be met if the patient is triaged appropriately and referred to the team. medical and physical health needs may require treatment, observation and assessment	Yes					
Staff training										
Healthcare provider organisations should train staff in emergency departments in methods and techniques to reduce the risk of violence and aggression, including anticipation, prevention and de-escalation.	1.5.3	No	Yes	ED staff attend breakaway training and this incorporates de-escalation techniques	Yes					
Healthcare provider organisations should train staff in emergency departments in mental health triage.	1.5.4	No	Yes	The ED staff have received training in Mental Health triage and Trust Liaison team provide training or a bi-annual tasks to the staff.	Yes					
Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses).	1.5.5	No	Yes	The Liaison training programme incorporates case studies which highlights these presentations and allows the staff to discuss and consider the possible causes and ultimately diagnose and treat appropriately	Yes					
Staffing										
Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline.	1.5.6	No	No							
Preventing violence and aggression										
Understand mental health triage for all service users on entry to emergency departments, alongside physical health triage.	1.5.7	No	Yes	Triage of mental health problems currently occurs	Yes					
Healthcare provider organisations should ensure that emergency departments have at least 1 designated interview room for mental health assessment that: • is close to or part of the main emergency department receiving area • is made available for mental health assessments as a priority • can comfortably seat 6 people • is fitted with an emergency call system, an outward opening door and a window for observation • contains soft furnishings and is well ventilated • contains no potential weapons.	1.5.8	Yes	Yes	All recommendations met apart from - can comfortably seat 6 people	No					Room can accommodate up to 4 comfortably sitting and up to six standing
Staff interviewing a person in the designated interview room should: • inform a senior member of the emergency nursing staff before starting the interview • make sure another staff member is present.	1.5.9	Yes	Yes	Team inform referring agent that they attended to assess the patient and if additional staff are available and associated risks highlighted they can assess in pairs, however patients may be primary attenders and there is an unknown risk which may only become evident during the assessment	Yes					
Managing violence and aggression										
If a service user with a mental health problem becomes aggressive or violent, do not exclude them from the emergency department. Manage the violence or aggression in line with recommendations 1.4.1-1.4.45 and do not use exclusion. Report the situation as a psychiatric emergency and refer the service user to mental health services urgently for a psychiatric assessment within 1 hour.	1.5.10	Yes	No							

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
1.6 Managing violence and aggression in community and primary care settings										
Developing policies										
Health and social care provider organisations, including ambulance trusts, should ensure that they have up to date policies on the management of violence and aggression in people with mental health problems, and on lone working, in community and primary care settings, in line with this guideline.	1.6.1	No	Yes	We have lone working and MOVA policies	Yes					
Staff training										
Health and social care provider organisations, including ambulance trusts, should consider training staff working in community and primary care settings in methods of avoiding violence, including anticipation, prevention, de-escalation and breakaway techniques, depending on the frequency of violence and aggression in each setting and the extent to which staff move between settings.	1.6.2	Yes	Yes	All staff given MAPA training	Yes					
Health and social care provider organisations, including ambulance trusts, should ensure that staff working in community and primary care settings are able to undertake a risk assessment for violence and aggression in collaboration with service users known to be at risk and their carers, if possible. The risk assessment should be available for case supervision and in community teams it should be subject to multidisciplinary review.	1.6.3	No	Yes	We adhere to this with PQC guidance	Yes					
After a risk assessment has been carried out, staff working in community and primary care settings should: • share the risk assessment with other health and social care services and partner agencies (including the police and probation services) who may be involved in the person's care and treatment, and with carers if there are risks to them • be aware of professional responsibilities in relation to limits of confidentiality and the need to share information about risks.	1.6.4	No	Yes	We adhere to PQC guidance	Yes					
In community settings, carry out Mental Health Act 1983 assessments with a minimum of 2 people, for example a doctor and a social worker.	1.6.5	No	No							
Community mental health teams should not use manual restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police.	1.6.6	No	Yes	All staff in Home Treatment are suitably trained in MAPA and adhere to MOVA policy and Lone working policy	Yes					
1.7 Managing violence and aggression in children and young people										
Staff training										
Child and adolescent mental health services (CAMHS) should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children and young people. Training programmes should include the use of psychological methods to avoid or minimise restrictive interventions wherever possible. Staff who might undertake restrictive interventions should be trained: • in the use of these interventions in these age groups • to adapt the manual restraint techniques for adults in recommendations 1.4.22–1.4.33, adjusting them according to the child or young person's height, weight and physical strength • in the use of resuscitation equipment (see recommendation 1.4.3) in children and young people.	1.7.1	Yes	No							
CAMHS should have a clear and consistently enforced policy about managing antisocial behaviour and ensure that staff are trained in psychosocial and behavioural techniques for managing the behaviour.	1.7.2	No	No							
CAMHS staff should be familiar with the Children Act 1989 and 2004 and the Mental Health Act 1983, as well as the Mental Capacity Act 2005 and the Human Rights Act 1998. They should also be aware of the United Nations Convention on the Rights of the Child.	1.7.3	No	No							
Managing violence and aggression										
Manage violence and aggression in children and young people in line with the recommendations for adults in sections 1.1–1.6, taking into account: • the child or young person's level of physical, intellectual, emotional and psychological maturity • the recommendations for children and young people in this section • that the Mental Capacity Act 2005 applies to young people aged 16 and over.	1.7.4	Yes	No							
Collaborate with those who have parental responsibility when managing violence and aggression in children and young people.	1.7.5	No	No							
Use safeguarding procedures to ensure the child or young person's safety.	1.7.6	No	No							
Involve the child or young person in making decisions about their care wherever possible.	1.7.7	No	No							
Assessment and initial management										
Assess and treat any underlying mental health problems in line with relevant NICE guidelines, including those on antisocial behaviour and conduct disorders in children and young people, attention deficit hyperactivity disorder, psychosis and schizophrenia in children and young people, autism diagnosis in children and young people and autism.	1.7.8	No	No							
Identify any history of aggression or aggression trigger factors, including experience of abuse or trauma and previous response to management of violence or aggression.	1.7.9	Yes	No							
Identify cognitive, language, communication and cultural factors that may increase the risk of violence or aggression in a child or young person.	1.7.10	No	No							
Consider offering children and young people with a history of violence or aggression psychological help to develop greater self control and techniques for self settling.	1.7.11	No	No							
Offer support and age-appropriate interventions (including parent training programmes) in line with the NICE guideline on antisocial behaviour and conduct disorders in children and young people to parents of children and young people whose behaviour is violent or aggressive.	1.7.12	No	No							
De-escalation										

NICE recommendation	Guideline reference	Key priority for implementation	Is the recommendation relevant?	Current activity/evidence	Recommendation met?	Actions needed to implement recommendation	Is there a risk associated with not implementing this recommendation?	Is there a cost or saving?	Deadline	Lead
Use de-escalation in line with recommendations 1.3.12–1.3.20 for adults, modified for children and young people, and: • use calming techniques and distraction • offer the child or young person the opportunity to move away from the situation in which the violence or aggression is occurring, for example to a quiet room or area • aim to build emotional bridges and maintain a therapeutic relationship.	1.7.13	No	No							
Restrictive interventions Use restrictive interventions only if all attempts to defuse the situation have failed and the child or young person becomes aggressive or violent.	1.7.14	No	No							
When restrictive interventions are used, monitor the child or young person's wellbeing closely and continuously, and ensure their physical and emotional comfort.	1.7.15	No	No							
Do not use punishments, such as removing contact with parents or carers or access to social interaction, withholding nutrition or fluids, or corporal punishment, to force compliance.	1.7.16	No	No							
Manual restraint If possible, allocate a staff member who is the same sex as the child or young person to carry out manual restraint.	1.7.17	No	No							
Mechanical restraint Do not use mechanical restraint in children.	1.7.18	No	No							
Healthcare provider organisations should ensure that, except when transferring young people between medium- and high secure settings (as in recommendation 1.7.20), mechanical restraint in young people is used only in high secure settings (on those occasions when young people are being treated in adult high secure settings), in accordance with the Mental Health Act 1983 and with support and agreement from a multidisciplinary team that includes a consultant psychiatrist in CAMHS.	1.7.19	No	No							
Consider using mechanical restraint, such as handcuffs, when transferring young people who are at high risk of violence or aggression between medium- and high secure settings, and remove the restraint at the earliest opportunity.	1.7.20	No	No							
Rapid tranquillisation Use intramuscular lorazepam for rapid tranquillisation in a child or young person and adjust the dose according to their age and weight. If there is only a partial response to intramuscular lorazepam, check the dose again according to the child or young person's age and weight and consider a further dose.	1.7.21	No	No							
Monitor physical health and emotional impact continuously when undertaking rapid tranquillisation in a child or young person.	1.7.22	No	No							
Seclusion Decisions about whether to seclude a child or young person should be approved by a senior doctor and reviewed by a multidisciplinary team at the earliest opportunity.	1.7.23	No	No							
Report all uses of seclusion to the trust board or equivalent governing body.	1.7.24	No	No							
Do not seclude a child in a locked room, including their own bedroom.	1.7.25	No	No							
	1.7.26	No	No							

**PHA/HSCB SAFETY AND QUALITY ALERT (SQA)
3rd LINE OF ASSURANCE TEMPLATE
FOR COMPLETION BY HSC TRUSTS AND OTHER ARMS LENGTH BODIES**

The attached Safety and Quality Alert (SQA) is classified as a 3rd Line SQA and requires completion of sections 2 and 3 below by the date specified and forwarded to Personal Information redacted by the USI for consideration.

SECTION 1

SQA Title:	Serious Hazards of Transfusion Alert (SHOT): Preventing Transfusion Delays in Bleeding and Critically Anaemic Patients	SQA Ref:	HSC (SQSD) 6/22
Datix Unique ID:	Not Indicated	For Implementation by:	15th July 2022

SECTION 2

Actions required as per SQA	HSC Trust / other ALB Assessment of Compliance			
	If implemented in full by the due date detail the action/s taken	If action only partially implemented by the due date, detail:		
		Reason	Work that is ongoing	Planned completion date
Recommendation 1: Appoint an executive member of staff, supported by their designated senior leads for medical, nursing and pathology teams, to oversee the implementation of the actions outlined below:	Dr Mark Bridgham has been nominated as the Lead for this work and accepted. Dr Bridgham will work in conjunction with the Trust Transfusion Team to progress this work			Complete

Recommendation 2: 1. Reviewed and updated policies and procedures to cover: a. Rapid release of blood components and products for major haemorrhage, Autoimmune haemolytic anaemia (AIHA) and reversal of anticoagulants. b. Compliance with SHOT¹, NICE⁴ and BSH⁷ recommendations.	The clinical lead responsible for implementing the recommendations outlined in this nPSA has reviewed and updated (as necessary) all policies and procedures relating to 1a to 1f. A summary of these documents is outlined below: Recommendation 1 a. AIHA – Diagnosed and managed by Consultant Haematologist. Blood components issued by Blood Bank under cross match policy. - Guidelines for Massive Blood Loss 30/07/2020. - Cross match Policies - 1BBCROSSMATCHPOLICIES Revision 16. - Blood product, blood component issue & stock control - 1BBISSUEANDCONTROL Revision 52. - Anticoagulation: Warfarin Reversal in Cases of Over anticoagulation or in Preparation for Emergency Procedure CG0200[1] - Management of a Head Injury in Patients on Anticoagulants CG0262[4]. - Anticoagulation Emergency Management Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Overdose Protocol CG0301[1] - Anticoagulation Dabigatran-emergency management of surgery, haemorrhage and overdose CG 0296 [1] - Anticoagulation Emergency Management – Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Emergency Surgery Protocol CG 0299 [1] - Anticoagulation Emergency Management – Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Haemorrhage Protocol CG 0300[1] Recommendation 1B: - SHOT – Included in Alert review - NICE NG24 – Reviewed by Trust Transfusion Team March 2021 –			Complete
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	Following review of the previously completed baseline assessment tool, the SHSCT continues to identify 1 recommendation that is not complied with and where external barriers impeding implementation. This relates to recommendation 1.7.3: Section 1.7 Patient Safety – recommendation 1.7.3 Lack of funding / IT implementation of new digital software to progress the implementation of Blood Hound Regionally there are plans to develop an electronic blood tracking system within Northern Ireland. As well as being outlined in this NICE guidance this requirement has also been endorsed within the HSCNI Regional Review of Pathology Services. Various issues have been identified in relation to progressing this matter within SHSCT. These include staffing, training and education, IT infrastructure and the impact of COVID-19 on hospital staff, systems and service delivery. Trust Laboratory staff continue to explore this matter and to seek solutions to these issues. Section 1.2 Red blood cell thresholds and targets – recommendations 1.2.2, 1.2.3 and 1.2.4 It is noteworthy to highlight that Northern Ireland has a Regional Blood Transfusion Committee in place. This body has multidisciplinary representation from all five HSC Trusts and the Northern Ireland Blood Transfusion Service. Membership includes haemovigilance, laboratory and medical staff. The committee produces clinical transfusion guidance for use across HSCNI. It has previously published and audited guidance, prior to NG 24. These local recommendations have been followed by HSC Trusts and are similar, but not identical, to NG 24. Historically, Northern Ireland has had some of the lowest rates per capita of red cell transfusion, consistent with careful usage and restrictive prescribing practice.			
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c. Agreed criteria where rapid release of PCC is acceptable without the initial approval of a haematologist. d. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies. e. Criteria and pathways for laboratory escalation to a haematologist where transfusion is urgent, and the presence of antibodies might delay release of red blood cells. f. Treatment of patients who refuse transfusion of blood components and/or products	BSH Haematological Management of major Haemorrhage (2015) incorporated in to Guidelines for Massive Blood Loss 30/07/2020 and Blood Bank crossmatch policy. Recommendation 1C: • Blood product, blood component issue & stock control - 1BBISSUEANDCONTROL Revision 52. • Anticoagulation: Warfarin Reversal in Cases of Over anticoagulation or in Preparation for Emergency Procedure CG0200[1]. • Management of a Head Injury in Patients on Anticoagulants CG0262[4]. • Anticoagulation Emergency Management Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Overdose Protocol CG0301[1] • Anticoagulation Dabigatran-emergency management of surgery, haemorrhage and overdose CG 0296 [1] • Anticoagulation Emergency Management – Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Emergency Surgery Protocol CG 0299 [1] • Anticoagulation Emergency Management – Anti-Xa OAC (rivaroxaban, apixaban, edoxaban) Haemorrhage Protocol CG 0300[1] Recommendation 1D: • Crossmatch Policies - 1BBCROSSMATCHPOLICIES Revision 16 Recommendation 1E: • Crossmatch Policies - 1BBCROSSMATCHPOLICIES Revision 16 Recommendation 1F: Northern Ireland Pathway for Management of Adult patients who decline specified Blood Components/products – June 2020 Update 16/08/2022 Updated to include hospital liaison committee web link and approved by AD			
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Recommendation 3: Reviewed, updated, and implemented training programmes to include: a. Recognition of bleeding, importance of communication, processes for activation of major haemorrhage protocols and rapid access to blood components and products in clinical staff training programmes. b. Major haemorrhage drills, simulations and debriefs into regular staff training activities, including clinical and laboratory teams. c. Concessionary, rapid release of the best matched red blood cells for patients with red cell antibodies. d. A process for recording participation and identifying dates for re-training.	Recommendation 2A: - Guidelines for Massive Blood Loss (MBL) 30/07/2020 - Lanyard Cards for CAH & DHH in place with activation details and blood components available – updated December 2021 - RPRB Safe Transfusion Practice, delivered by Haemovigilance Practitioners includes information on massive blood loss procedure and importance of communication. Recommendation 2B: - All MBL reviewed by Trust Transfusion Team; updates provided to Trust Transfusion Committee (most recent update 21/04/2022). - Drills ongoing between Blood Bank, Porters & Clinical areas. - Learning outcomes from Drills and Live activations shared with teams Recommendation 2C: - Crossmatch Policies - 1BBCROSSMATCHPOLICIES Revision 16 Recommendation 2D: - Blood Bank – SOP (1TRAINBLOODTRANSFUSION) for Training and competency includes MBL with staff annual update; Included in Drills organised by clinical areas. - Clinical – LearnPro module 'Blood Components & Indications for Use' includes information on Massive Transfusion, staff update every 3 years; part of obstetric PROMPT training; MBL incorporated into Trust Safe Transfusion practice training provided by Haemovigilance Practitioners; Drills undertaken in ED and Maternity Services			Complete
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e. Treatment of patients who refuse transfusion of blood components and/or products.	<u>Update 16/08/2022</u> Information on SHSCT MBL has been added to Medical Induction information Recommendation 2E: Northern Ireland Pathway for Management of Adult patients who decline specified Blood Components/products – June 2020 <u>Update 16/08/2022</u> Updated to include hospital liaison committee web link and approved by AD			
Recommendation 4: Implemented processes to audit and investigate all transfusion delays, using appropriate investigation tools to identify system factors for improvement.	All MBL reviewed by Trust Transfusion Team; updates provided to Trust Transfusion Committee (most recent update 21/04/2022) <u>Update 16/08/2022</u> Trust Transfusion Team have reviewed and updated the Investigation Forms to include Human Factors			Completed
Recommendation 5: Ensure arrangements are in place for the timely reporting to SHOT and through the HSC Serious Adverse Incident (SAI) process of any deaths and serious harm related to delayed transfusion: https://www.shotuk.org/reporting/	SOP 1BTSABRE – Investigation and Reporting of Transfusion Related Serious Adverse Reactions and Events is in place which outlines the SHSCT Transfusion Team reporting mechanisms for SHOT and SABRE.		SOP 1BTSABRE – Investigation and Reporting of Transfusion Related Serious Adverse Reactions and Events is currently being reviewed / updated by the team to include escalation processes within the Trust for SAI procedures where a blood transfusion may have caused harm or death to a patient.	31/12/2022 Trust Transfusion Team

Recommendation 6:

Actions to be completed as soon as possible and no later than 15 July 2022

SHSCT 3rd Line SQA template presented at Acute S&G Forum for approval on 5th July 2022; submitted to SPPG on 6th July 2022
SHSCT 3rd Line SQA template presented at Acute S&G Forum for approval on 16th August 2022; submitted to SPPG on 18th July 2022
Update request against recommendation 5 received from SPPG on 11th September 2022 – assurance template updated and approved on 27/09/2022 at Acute Standards and Guidelines Forum and signed by Acute Director 03/10/2022

SECTION 3

To: Strategic Planning and Performance Group (SPPG) of the Department of Health
Mailbox at Personal Information redacted by the USI

I confirm that the designated senior manager/s have been advised of this response and are content that it should be submitted to the HSC Board.

Signed:	Personal Information redacted by the USI
Name and Designation of person submitting response:	Trudy Reid Interim Director SEC, CCS & IMWH
Name of HSC Trust or other ALB:	SHSCT
Date:	03.10.2022

Wamsley, Chris

From: NICE News for Health and Social Care
Sent: 28 September 2022 13:01
To: Warr, Christopher
Subject: NICE News for Health and Social Care | September 2022

Follow Up Flag: Follow up
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NICE National Institute for
Health and Care Excellence

NICE News for Health and Social Care

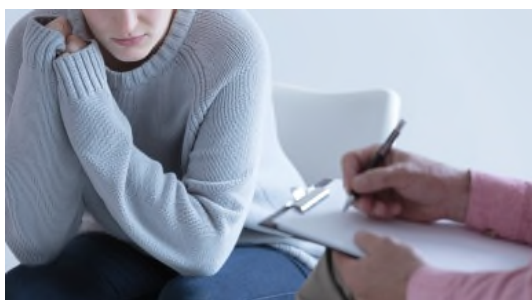
Bringing you our latest news, features and guidance.

September 2022

[Guidance and advice published in September 2022](#)

[News](#) | [Social care](#) | [Get involved](#) | [Blogs](#) | [Events](#)

News



[Self-harm is everyone's business](#)

We've published evidence-based
recommendations for assessment,

management and preventing recurrence of self-harm. The guidance sets out the responsibilities of non-specialists when caring for people who self-harm. This includes health and social care professionals working in primary care, non-mental health emergency department professionals, those working in general hospital settings and in social care. There are also recommendations for paramedics and for people working in education and criminal justice settings.



[Transplant with good bacteria taken from poo recommended](#)

Hundreds of people with recurrent bacterial infections could be treated with gut bacteria taken from a healthy donor's poo. [We've recommended a faecal microbiota transplant](#) (FMT) is offered to people who have been treated for 2 or more *Clostridium difficile* infections without success. FMT treatment aims to restore a healthy population of gut bacteria. It involves transferring gut bacteria and other microorganisms from healthy donor poo into the gut of the recipient.

Watch this short video to hear from Professor Nav Kapur, topic expert for the NICE self-harm guideline committee, and professor of psychiatry and population health at the University of Manchester.



Catch up on our latest news



NICE talks

Self-harm: how can we help and support people?

We speak to Professor Nav Kapur, topic expert on our assessment, management and preventing recurrence of self-harm guideline committee. He outlines what our recommendations say and how people who self-harm can best be supported.

Listen to our podcast on self-harm

Social care

Help prevent deaths and illnesses associated with cold homes in winter

Our quick guide for home care managers provides simple, well-planned, preventative action to support people at risk of death or illness associated with cold homes.

Home care managers can take simple steps to help care staff by having a plan that includes:

- Contact details for reporting concerns to local authority health and housing services.
- Details of local sources of advice and support that can be shared with vulnerable people.
- Training for care staff that covers recognising those at risk, considering and assessing vulnerability and how to document and share concerns appropriately.

[Read our cold homes quick guide](#)

UK Malnutrition Awareness Week

[UK Malnutrition Awareness Week](#) takes place from Monday 10 to Sunday 16 October 2022. The campaign aims to increase understanding of the dangers, risk factors and signs of malnutrition and dehydration.

NICE has produced a guideline on nutrition support for adults. It covers identifying and caring for adults who are malnourished or at risk of malnourishment, in hospital, home or care home settings.

[Read nutrition support for adults guideline](#)

Get involved

NICE News for Health and Social Care - help us improve our newsletter

Thank you for subscribing to our monthly newsletter. We want to make sure it's as useful to you as possible and are keen to hear your views. Our short survey should take you no more than 8 minutes to complete.

The survey is open until 5pm on Wednesday 19 October 2022. Please take the time to share your views before then.

[Take our quick survey](#)

Join our quality standards advisory committee

We are looking for:

- audit and measurement professionals
- general practice professionals
- secondary care practitioners
- public health practitioners
- commissioners of health, public health or social care services
- a safety expert.

Our advisory committee helps to develop NICE quality standards. These set out priority areas for quality improvement in health and care and highlight areas with identified variation in current practice.

The closing date for applications is 5pm on Wednesday 5 October 2022.

[Apply to join quality standards committee](#)

We also have a number of vacancies for health and care professionals to join our other committees. Topics include breast cancer, cirrhosis in over 16s and highly specialised technologies. Join us and have an active role in producing a guideline or quality standard.

[See all our committee vacancies](#)

Comment on a consultation

Our current consultations include:

- [Intrapartum care for healthy women and babies](#)
Submit your comments by Monday 3 October 2022.
- [Alcohol-use disorders](#)
Submit your comments by Tuesday 4 October 2022.
- [Barrett's oesophagus and stage 1 oesophageal adenocarcinoma: monitoring and management](#)
Submit your comments by Wednesday 5 October 2022.
- [Fractures \(complex\): assessment and management](#)
Submit your comments by Wednesday 5 October 2022.
- [Urinary tract infections in adults](#)
Submit your comments by Tuesday 11 October 2022.
- [Diabetes in adults - type 1 and type 2](#)
Submit your comments by Tuesday 18 October 2022.

Consultation is a key part of our guidance development process. It enables those with an interest in our guidance to comment at specific stages and feedback into the decision-making process.

[See all our open consultations](#)

Observe a meeting

Our advisory committee meetings, technology appraisal appeal hearings and public board meetings are open to the public. Holding them in public supports our commitment to having processes in place that are rigorous, open, and transparent. We're currently holding all our public meetings virtually.

[See all our public meetings](#)

Blogs



Do not make decisions for the public, make them with the public

Mark Rasburn, senior public involvement adviser at NICE, outlines how we involve people who use services, carers and the public in the development of our guidance. Mark's written his blog in support of World Evidence-Based Healthcare (EBHC) Day.

[Read Mark's blog on the World EBHC Day website](#)



Supporting doctors' appraisals and promoting quality involvement

Chris Bird, programme manager for patient safety at NICE, explains how NICE and the General Medical Council (GMC) have been working in partnership to help doctors through revalidation. Through this important collaboration, they've supported improved implementation of NICE guidance and the GMC's aim of supporting

doctors to deliver high-quality, person-centred care. Chris's blog supports World Evidence-Based Healthcare (EBHC) Day 2022.

[Read Chris's blog on the World EBHC Day website](#)

Events



Join the #WorldEBHCDay on Thursday 20 October 2022

This year's World Evidence-Based Healthcare (EBHC) Day focusses on partnerships for purpose. It highlights how partnerships can bridge research, policy and practice to realise the potential of evidence-based healthcare.

As an official partner, we're encouraging you to:

- Hold a Twitter chat in the lead-up to the day, discussing the partnerships for purpose theme.
- Share your story, experiences and ideas on the day, through the Twitter thread.

Get involved with World EBHC Day



Positively equal: How NICE is working to help reduce health inequalities

 Thursday 3 November 2022

 2:30pm to 3:45pm

 Virtual event

NICE

Positively equal: how we are working to help reduce health inequalities

Join us to discover how implementing our recommendations ensures care is effective, makes efficient use of resources and reduces inequalities and unwarranted variation.

- Thursday 3 November 2022, 2:30pm to 3:45pm, online.

Register for health inequalities event

[Unsubscribe from this list](#)



LEARNING MATTERS MEDICATION

EDITION 23
SEPTEMBER 2022

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Controlled Drugs Medication**

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[Link below to previous Learning Matters:
Learning Matters Newsletters | HSC Public
Health Agency \(hscni.net\)](#)

Welcome to edition 23 of the Learning Matters Newsletter. Health and Social Care in Northern Ireland endeavours to provide the highest quality service to those in its care. We recognise that we need to use a variety of ways to share learning therefore the purpose of this newsletter is to complement the existing methods by providing staff with short examples of incidents where learning has been identified.



Health and
Social Care



Know, Check, Ask



All medication errors are potentially avoidable and can therefore be greatly reduced or even prevented. Reducing medication errors is a priority for everyone, including healthcare professionals, service users and carers.

Medicines are the most commonly used medical intervention in Northern Ireland (NI), and at any one time 70%

of our people take prescribed or over the counter medicines to treat or prevent ill health.

The Department of Health launched a medication safety campaign entitled **Know, Check, Ask (KCA)** which has been developed as part of the NI strategic plan “[Transforming Medication Safety in NI](#)” to support the World Health Organisation (WHO) 3rd Global Patient Safety Challenge [Medication without Harm](#). The aim of the WHO challenge is to reduce severe avoidable harm by 50% globally over the next 5 years.

KCA was launched initially with messages tailored to the general public as part of the [Living Well](#) campaign in community pharmacies. Staff engaged with patients around their understanding of their medicines, and a ‘My Medicines List’ for people to record their medicines.

The campaign will encourage all healthcare professionals to use the same simple **KCA 3 step checking system** before you prescribe, supply or administer a medication.



KNOW the medications you are prescribing, supplying or administering, what do they do, what benefits do they have and what are the side effects?



CHECK that they are right for each individual patient, based on their health conditions and any other medications they are taking.



ASK a colleague if you are unsure about, or don't understand anything, or think something is not quite right. Ask the patient if they understand and suggest that keeping a list of their medicines can help them.

Key Guidance

For further information see <https://online.hscni.net/our-work/pharmacy-and-medicines-management/medication-safety/know-check-ask/>



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Incorrect administration of Controlled Drugs Medication

Two Serious Adverse Incidents (SAIs) occurred recently relating to maladministration of medication in the hospital setting.

In the first case, a patient presented to the Emergency Department (ED) and was administered Oramorph® (morphine sulfate 10mg/5ml oral solution) via the intravenous route (IV), instead of via the oral route (PO) for pain relief. The patient was discharged the following day. Oramorph® is an oral medication and should not be administered intravenously.

In the second case, a patient was an inpatient in a surgical ward. Due to ongoing nausea, vomiting and abdominal pain, the patient was commenced on medication through a syringe driver. When the contents of the syringe driver were being reviewed 2 days later, an error was made, and one of the medications added to the syringe driver was incorrect. Instead of Oxycodone 55mgs being added to the syringe driver, Midazolam 55 mgs was added. The staff nurse on night duty later that night reported that an error had occurred, the syringe driver was stopped and held for a period of 4 hours. The doctor was informed and the patient was assessed, the syringe driver was then restarted with the correct prescribed medication.

KEY LEARNING

In relation to controlled drugs (CD) in Trusts, the standard operating procedure (SOP) for the management of controlled drugs for wards must be followed. Specifically, two practitioners, authorised to administer medicines should be present during the whole administration procedure and should witness the preparation of the CD, the CD being administered to the patient and the destruction of any surplus drug.





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Assessing and Monitoring the Risk of Venous Thromboembolism (VTE)

A frail older patient with significant co-morbidities, advanced kidney disease, advanced dementia and Type 2 diabetes was admitted to the Emergency Department via the on call medical team, following an episode of weakness at home. An initial working diagnosis was made of Non-ST Elevation Myocardial Infarction (NSTEMI) and Acute Coronary Syndrome (ACS), due to an elevated Troponin T result. The patient was admitted to the Cardiology ward and prescribed 40mg Enoxaparin twice daily (treatment dose), until review by the Cardiologist. The Cardiologist concluded that this patient did not have a NSTEMI or ACS and therefore discontinued the Enoxaparin 40mg twice daily dose. This decision was based on the patient's history of renal dysfunction and high risk of falls. No prophylactic enoxaparin was prescribed. The patient was transferred to a Care of the Elderly (CoE) ward for ongoing medical treatment and social care input. On day 6 of admission the patient was found vomiting, pale and unwell. The patient rapidly deteriorated and a cardiac arrest call was made. CPR was commenced and during resuscitation blood was obtained for a D-dimer test to exclude a possible thrombus. The patient sadly passed away. The result of the D-Dimer was >8. During the patient's stay on the CoE ward no prophylactic dose of enoxaparin had been re-prescribed and there had been no re-review of the patient's VTE risk assessment, however the patient continued on background aspirin 75mg daily. The post mortem results showed a Pulmonary Embolus and Deep Vein Thrombosis.

KEY LEARNING

- ✓ A VTE risk assessment must be completed on ALL hospitalised adults.
- ✓ VTE risk should be re-assessed by medical staff within 24 hours of hospital admission and updated whenever clinical condition or diagnosis changes. Where indicated an appropriate dose of anticoagulation should be prescribed.
- ✓ When administering medicines, nursing staff must consider the patient's mobility status and the need for anticoagulation to be prescribed, unless contraindicated. If no anticoagulation has been prescribed, this must be escalated immediately to the prescriber for VTE risk assessment.
- ✓ Clinical pharmacists should check VTE risk assessment when undertaking medicine reconciliation on admission/review and escalate any issues to medical staff.



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Safe Warfarin Discharge

Patient A was an inpatient on an acute medical ward and planned for discharge. The discharge letter was written in advance and medicines had been dispensed and stored in the bedside locker. One of Patient A's medications was warfarin. The dispensing label for warfarin will not specify a particular dose as it is subject to change according to the international normalised ratio (INR). The label would have referred the patient to the dose in the updated warfarin anticoagulant yellow book. The post discharge doses of warfarin had not been prescribed for the discharge date, as the INR result was still pending. Pending the INR result, patient was discharged from the ward:

- ▶ without a copy of the discharge letter and warfarin chart (for GP or anticoagulant clinic).
- ▶ without an updated warfarin anticoagulant yellow book that includes daily warfarin dose.
- ▶ without a referral for an INR blood test to be rechecked post discharge.

Patient A decided to take their pre-admission warfarin dose and was re-admitted to hospital 14 days later with melaena, high INR of 7.4 and weakness.

Discharge Arrangements (information below must be completed prior to discharge)		
	Signature	Date
1. Patient Education • At therapy initiation • On discharge		
2. Patient has NPSA Oral Anticoagulant Therapy Pack (Newly commenced patients only)		
3. Patient has dosing record book		
4. Date of next INR • Date: • INR date arranged by • Patient informed by		
5. Dose until next INR check entered in dosing record book		
6. Copy of prescription sent to GP		

• Please send most recent chart or yellow record book to Pharmacy with the discharge prescription
• Top copy (white) – send to GP
• Middle copy (pink) – file in patient's notes
• Bottom copy (blue) – remain in pharmacy

KEY LEARNING

- ✓ An INR level should be taken and reviewed prior to patient discharge to ensure appropriate warfarin dosing plan is prescribed and communicated to the patient and GP.
- ✓ The warfarin discharge checklist must be completed before discharge – this can be found on the warfarin prescription or in some Trusts on the discharge prescription. Completion of this improves safe discharge for patients taking warfarin.
 - Patient is educated about warfarin and the dose of warfarin to take.
 - Patient receives an anticoagulant therapy pack.
 - They have a yellow record book and doses are documented up to their next INR test.
 - A date for their next INR is arranged.
 - A copy is sent to the GP.
- ✓ The staff handover process at the beginning and end of each shift must highlight all outstanding tasks to be completed for each patient.
- ✓ Induction training for all staff should include warfarin and how to safely discharge patients who take warfarin.
- ✓ Please consult your local Trust policy for specific guidance on the discharge of patients on warfarin.



Prescription Writing – When a Quick Fix is Not Enough



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Patient A was admitted to hospital with abdominal pain.

Fourteen days later whilst continuing to receive treatment, the patient required their medicine kardex to be rewritten. This was undertaken by a doctor and when rewriting the medicine kardex an error was made when prescribing Aspirin 75mgs. The doctor recognised their error; however, instead of re-writing the full prescription, which is the correct procedure, they amended the prescription. The amended prescription was not clear to nursing staff, nor was it queried; as a result the patient missed their daily dose of Aspirin 75mgs for 4 consecutive days.

KEY LEARNING

- ✓ When a correction is required to an existing prescription, no amendments should be made. Instead, the original prescription and remainder of the administration section should be scored out (see illustration). A new prescription for the medicine should be written so that the prescription is clear to read.
- ✓ Medicine kardexes should be written/ rewritten in a quiet area with no interruptions and with sufficient given to completing the task.
- ✓ All rewritten medicine kardexes should be double checked and countersigned by two members of staff.
- ✓ Medical staff should verbally communicate with nursing staff any change to prescription medication for all patients and ensure any changes are appropriately recorded on the kardex.
- ✓ Nursing staff must query all unclear, ambiguous medication prescriptions with medical colleagues.
- ✓ Patient's medicine kardex should be actively reviewed by the doctor leading the daily ward round.

The images below illustrate how a medication was initially written up as 2.5mg before realising that the intended dose was 5mg.

- ✓ If an error is made during prescribing, or a correction is required to an existing prescription, no amendments to the prescription should be made.

Instead, the original prescription and remainder of the administration section should be scored out as shown above. A new prescription for the medicine should be written, as shown below.

- ✓ All prescriptions must be clear, accurate and legible.



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Outpatient Treatment Advice Notes – Think Patient Not Paperwork

Two cases have highlighted the need for care when recommending, prescribing or dispensing medications following outpatient appointments. In both cases a check of the medication against the patient should have spotted the error.

Case 1: Bisoprolol for a constipated child

A GP pharmacist read a poorly handwritten outpatient advice note as bisoprolol 5mg tablets instead of bisacodyl 5mg tablets and produced a prescription. A GP signed the prescription and it was dispensed by a community pharmacy. The error was noticed by reception staff when a repeat prescription was ordered some weeks later.

Case 2: Lorazepam ten-fold dosing error

A consultant psychiatrist handwrote an outpatient advice note as lorazepam 10mg BD instead of 1mg. A GP issued a prescription for the same, which a community pharmacy dispensed and residential care staff administered later that evening. The patient became very agitated and not as responsive as usual. The error was detected the next morning on contact with psychiatry. The patient attended the ED for observation.

KEY LEARNING

- ✓ **Outpatient clinics** should use an electronic format for advice notes whenever possible.
- ✓ If you are a **GP pharmacist** keep the advice note with the prescription until it is signed.
- ✓ If you are the **signing GP / prescriber** check the final prescription against the original advice note.
- ✓ If you are a **Community Pharmacist** pay particular attention to newly prescribed medication as part of the clinical check.
- ✓ **Everyone:** step back and think- does this medication make sense for this patient?





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Right Device but Wrong Insulin

A patient had been prescribed Novomix 30 Flexpen® 'by their GP'. The pharmacy generated a correct label for Novomix 30 FlexPen® but the wrong insulin Novorapid FlexPen® was dispensed. The medication was delivered by a delivery driver. There was no check with the patient to confirm that they had received their normal insulin. It is normal procedure for the pharmacy staff (when insulin is dispensed) to confirm with the patient that it is their usual insulin. This check however only occurs if the patient or carer collects their medication at the pharmacy. If insulin is delivered to the patient's home this check does not occur.

The patient noticed the insulin was different but continued to administer it, assuming the doctor had changed it. The patient was admitted to hospital with Diabetic Ketoacidosis. Staff sought advice and guidance on usual insulin regime. On arrival to the ward the patient informed staff that the insulin they were currently administering was Novorapid FlexPen®, however on NIECR record Novomix 30 FlexPen® was noted. Following this the error was discovered.

KEY LEARNING

For the community pharmacy:

- ✓ This is a known look-alike, sound alike error. Suggest inclusion of strategies to prevent miss selection e.g. separate fridge storage locations or use of shelf-edge labelling.
- ✓ Check that both the device and the type of insulin are correct before dispensing. Where possible a second member of staff should be involved in the checking process.
- ✓ The patient / carer should be asked to look at the insulin and confirm that it is the product that they are expecting.
- ✓ Delivery personnel for community pharmacies should be made aware of insulin deliveries and know to confirm the missing product with the patient / carer, where possible. Any queries should then be directed to community pharmacist.
- ✓ The use of clear bags by community pharmacy for dispensing insulin should be considered to facilitate the patient / carer check.





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Wrong Person or Wrong Address

A number of cases have occurred where patients' medications have been delivered to the wrong person by a community pharmacy delivery service.

Generally the patient or carer notices. However community pharmacy staff and homecare providers should be aware for the potential of error and ensure procedures to check correct patient / correct medication are adhered to.

CASE 1: A patient had an arrangement with a community pharmacy whereby his medication was delivered to his own home, a common arrangement. The delivery driver put medication through the letterbox at the patient's home. The medication delivered was not intended for that patient.

This resulted in the patient taking several naproxen tablets which were contraindicated for this patient as they had a history of peptic ulceration. They suffered a gastric bleed requiring hospital treatment.

CASE 2: A verbal arrangement had been made with a delivery driver to leave medications with a neighbour if not in. The medications in question included temazepam, diazepam and gabapentin. On the day in question the medications were apparently left with the neighbour's son. The medications went missing and were never recovered.

KEY LEARNING



Ideally deliveries should be accepted by the patient/carer in person with a check made on correct name/correct address, however procedures should acknowledge this is not always possible.



Delivery by 'letterbox drop' should only be in exceptional circumstances and covered by pharmacy procedures.



Delivery to a neighbour should be with written consent and requires a particularly robust audit trail.



Review your delivery set-up.

► Could mobile technology be used to track delivery?

► Does the delivery driver require physical resources such as a clipboard folder?



If you have any comments or questions related to this Edition of Learning Matters please get in contact by email at learningmatters@hscni.net

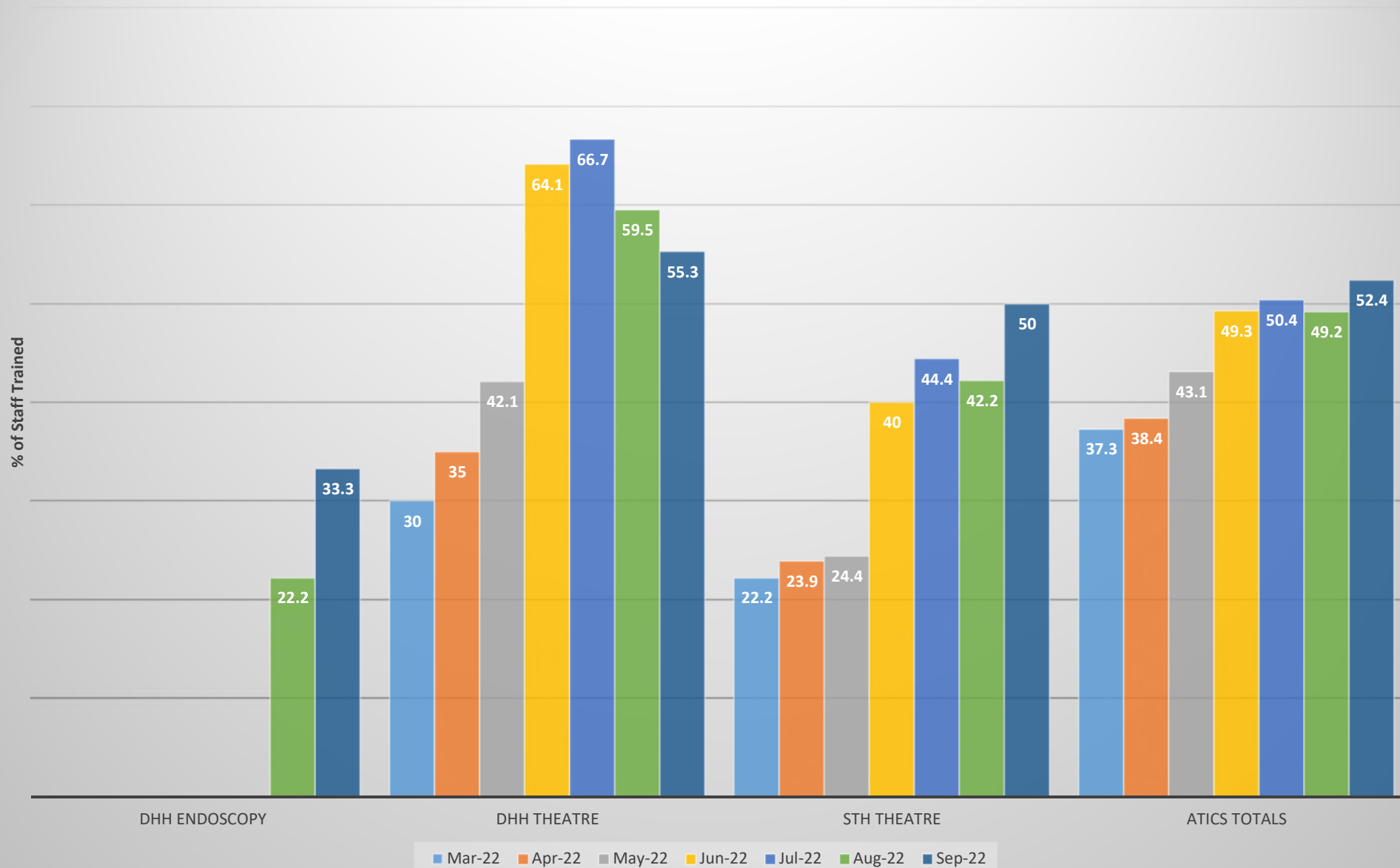
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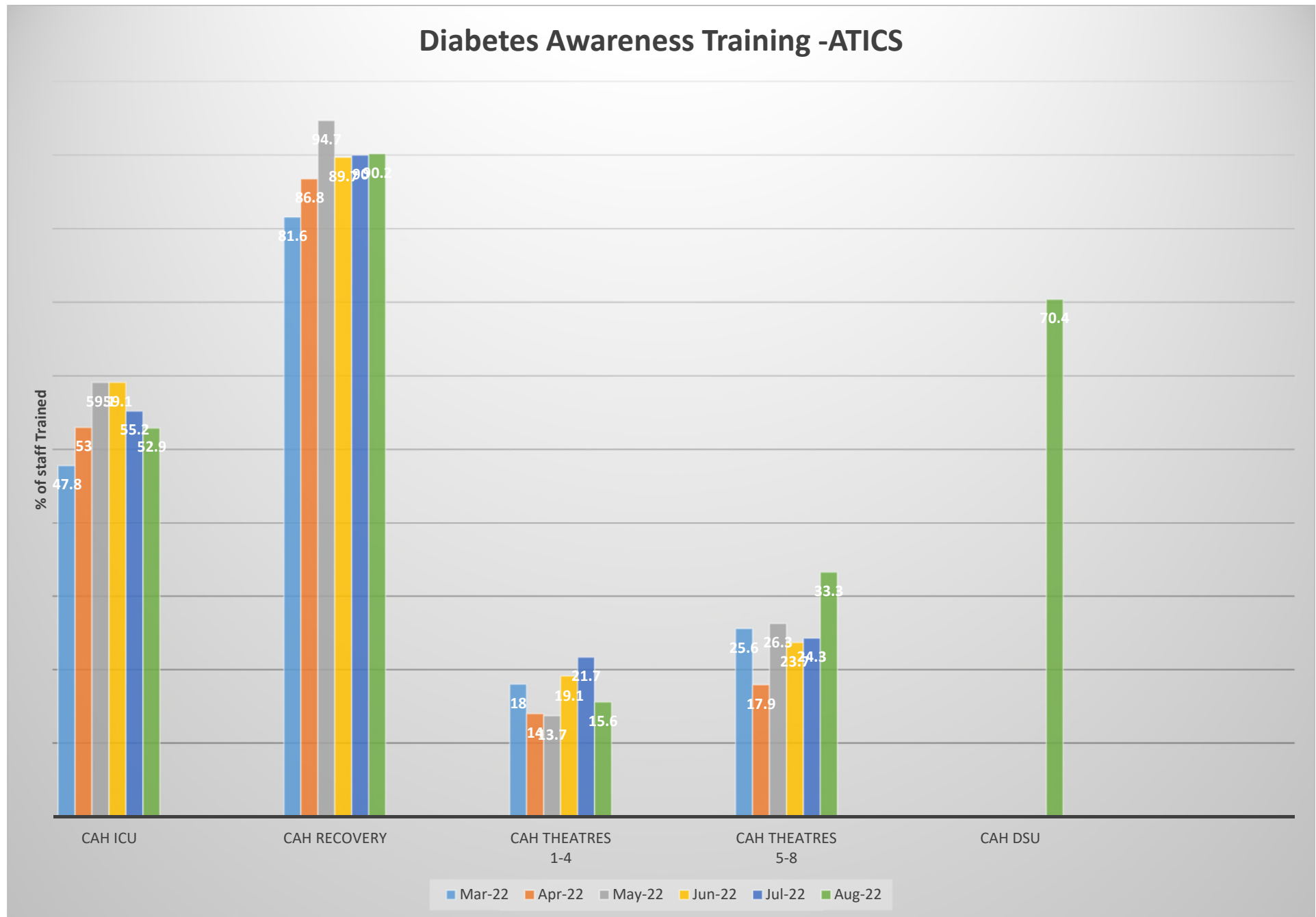
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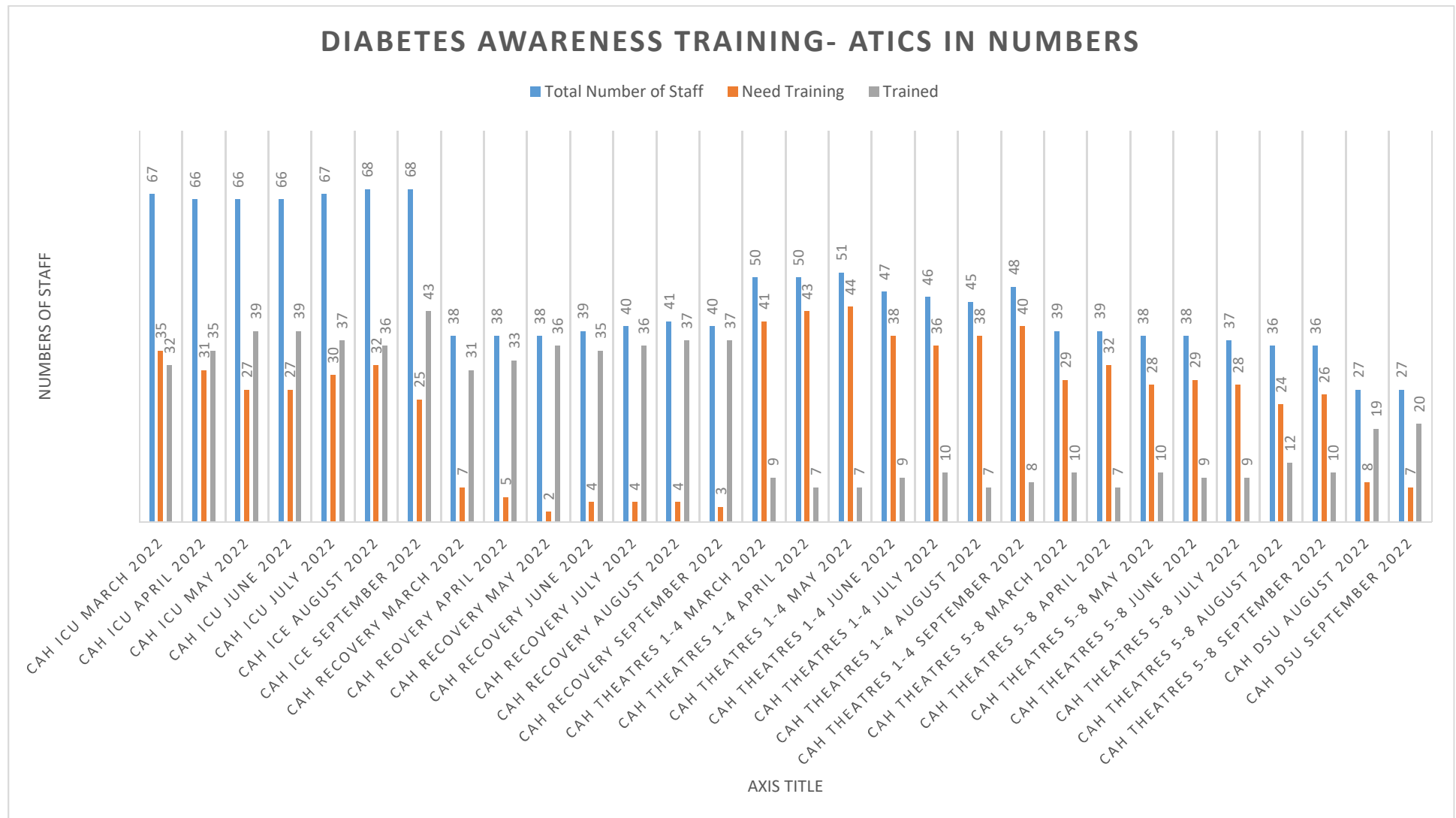
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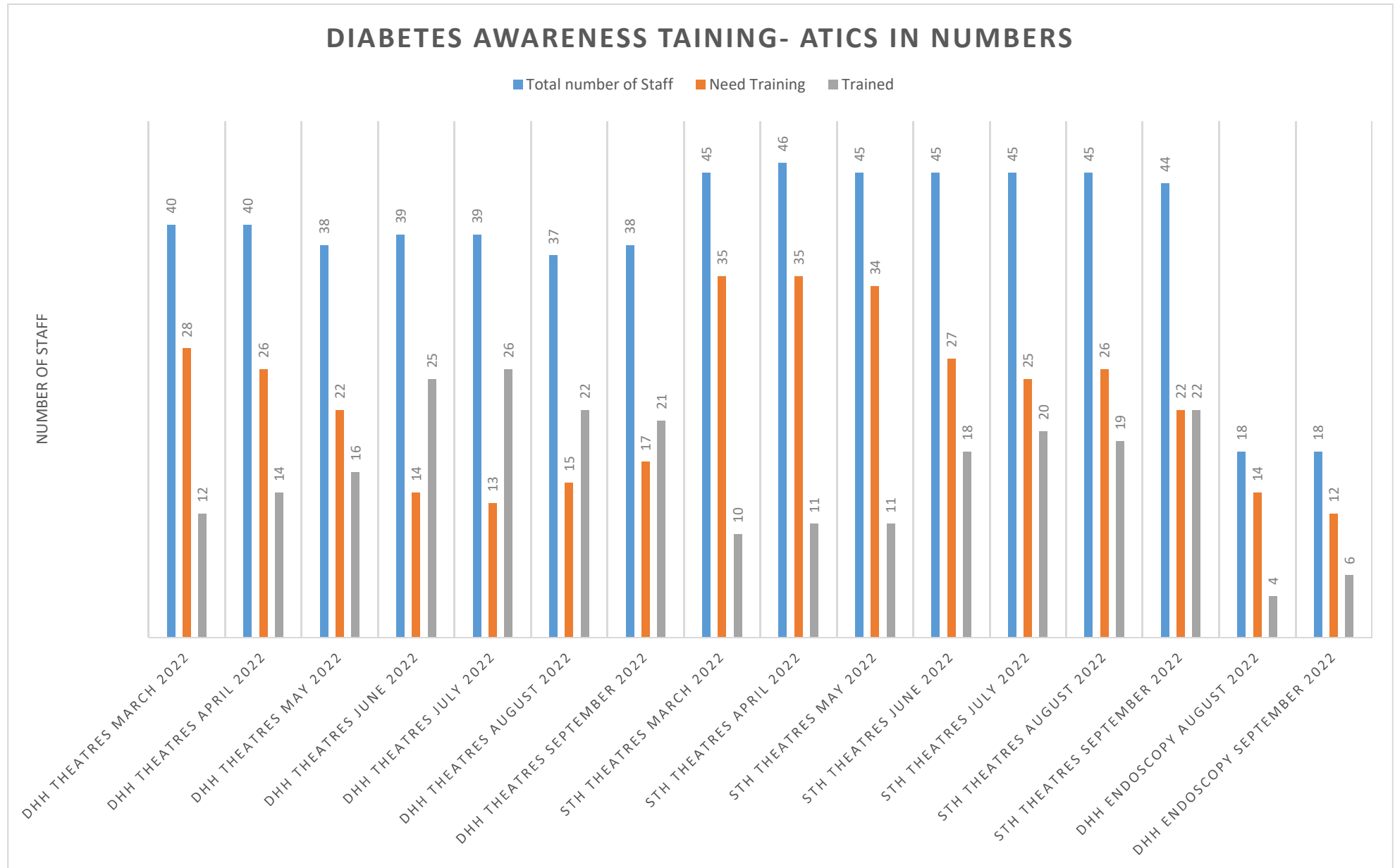
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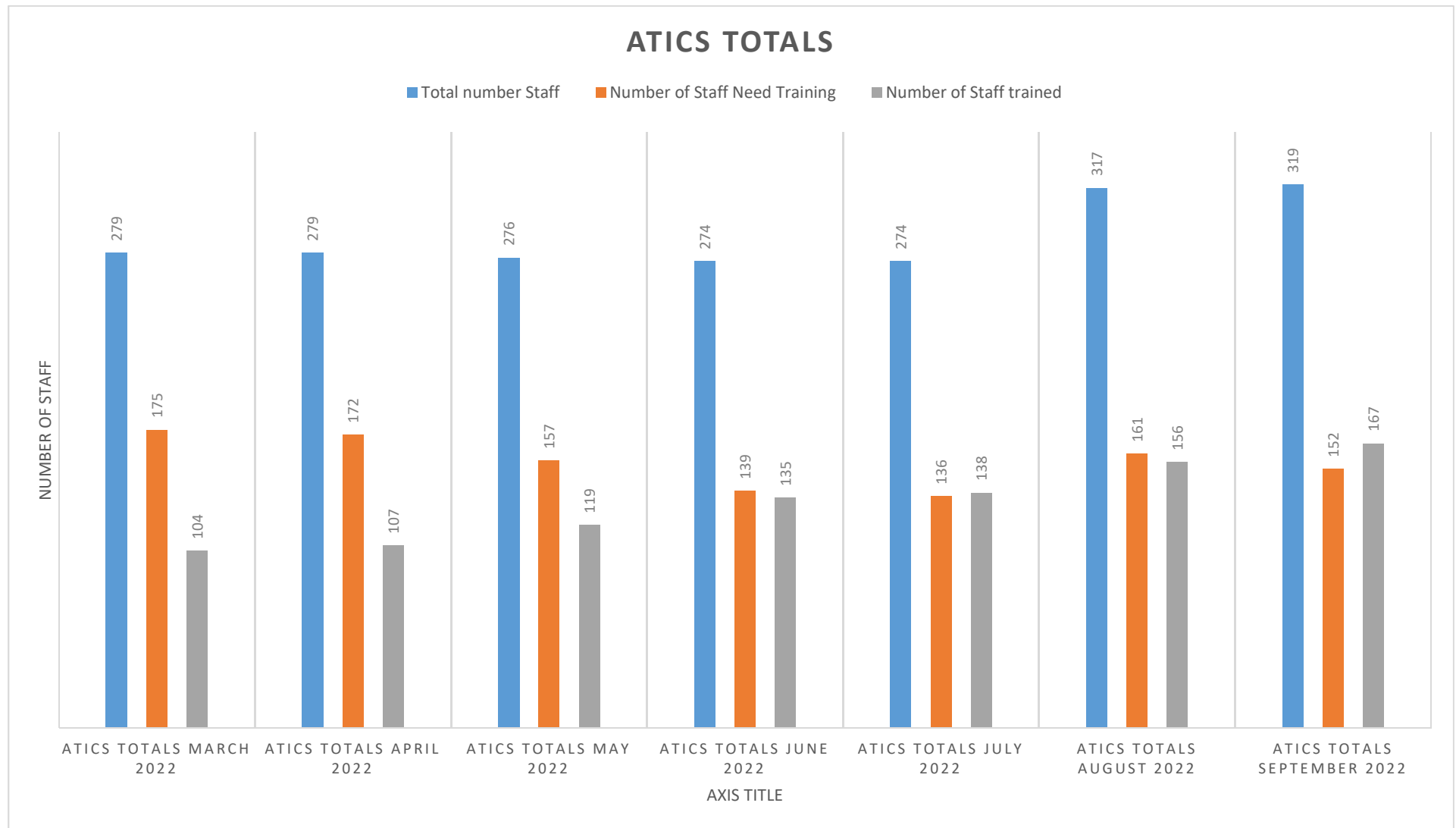
Diabetes Awareness Training - ATICS

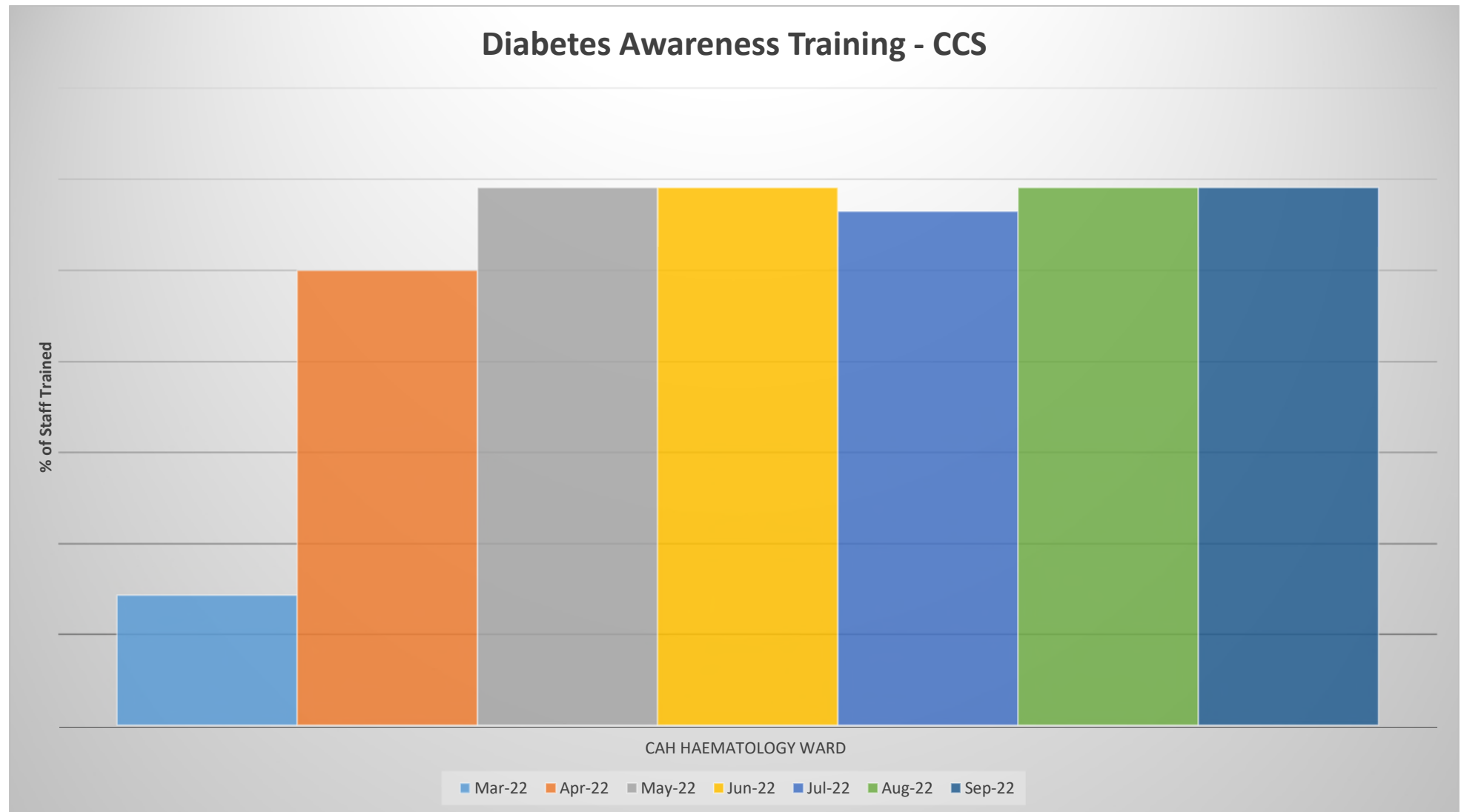


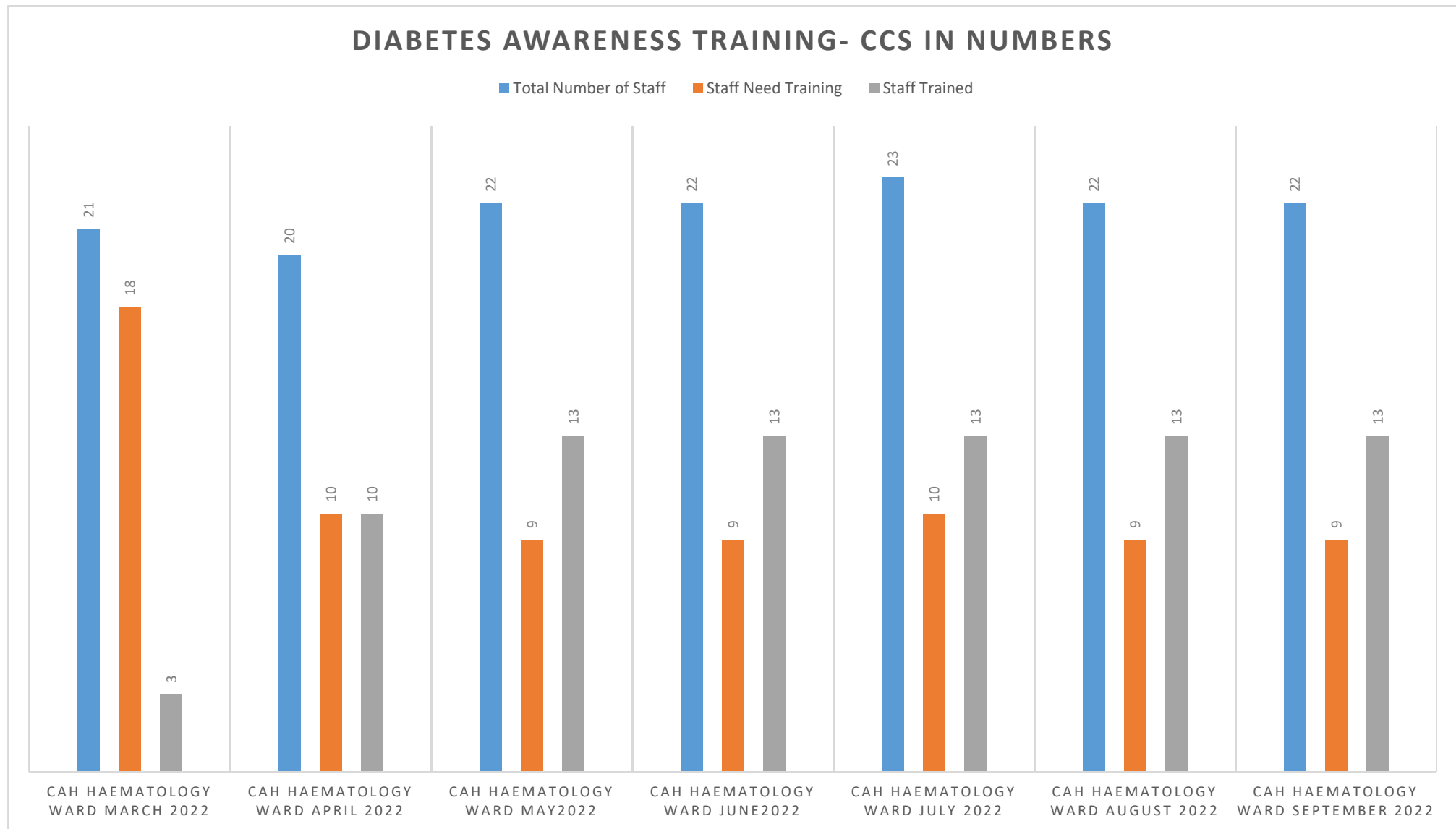




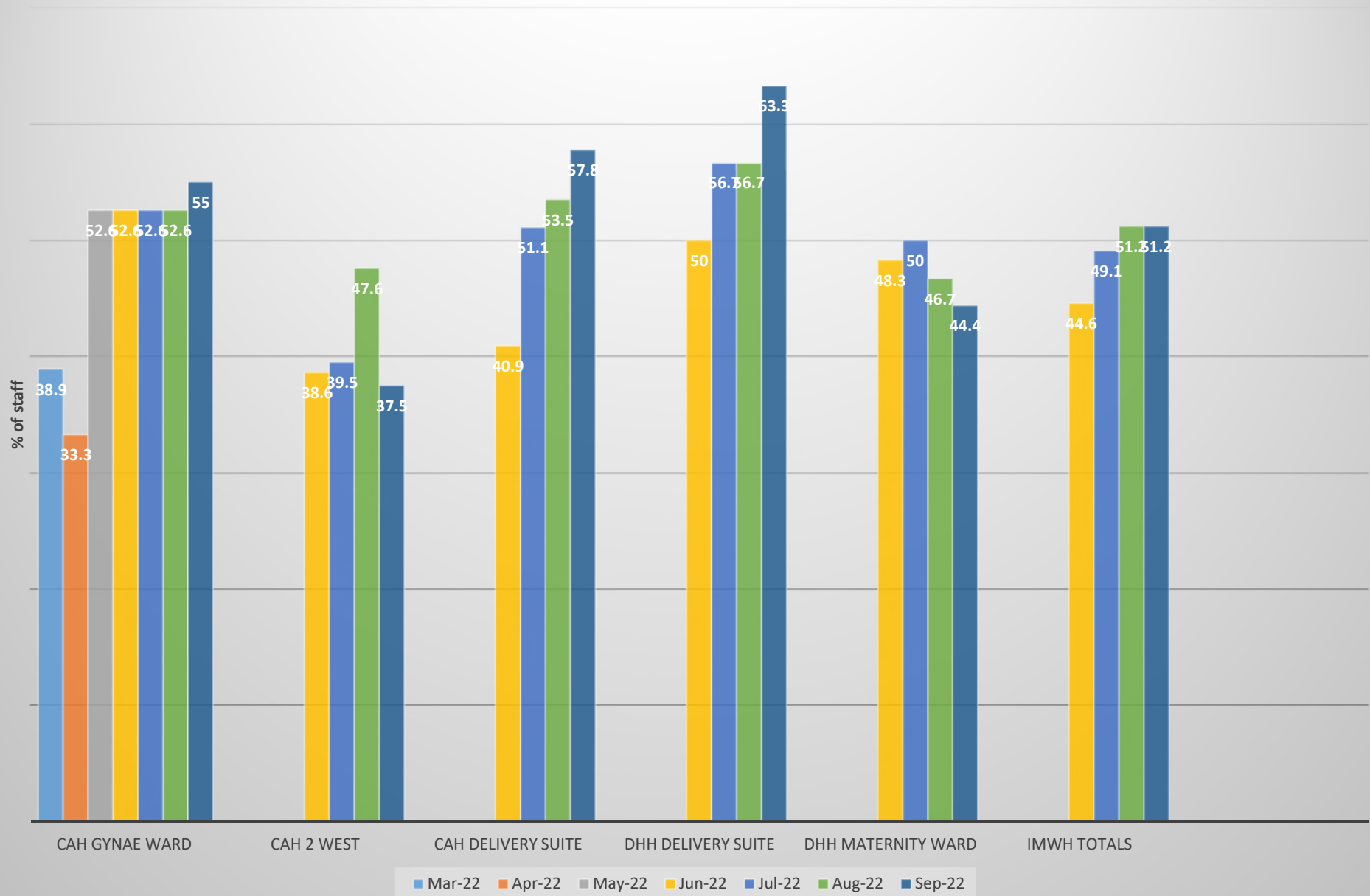






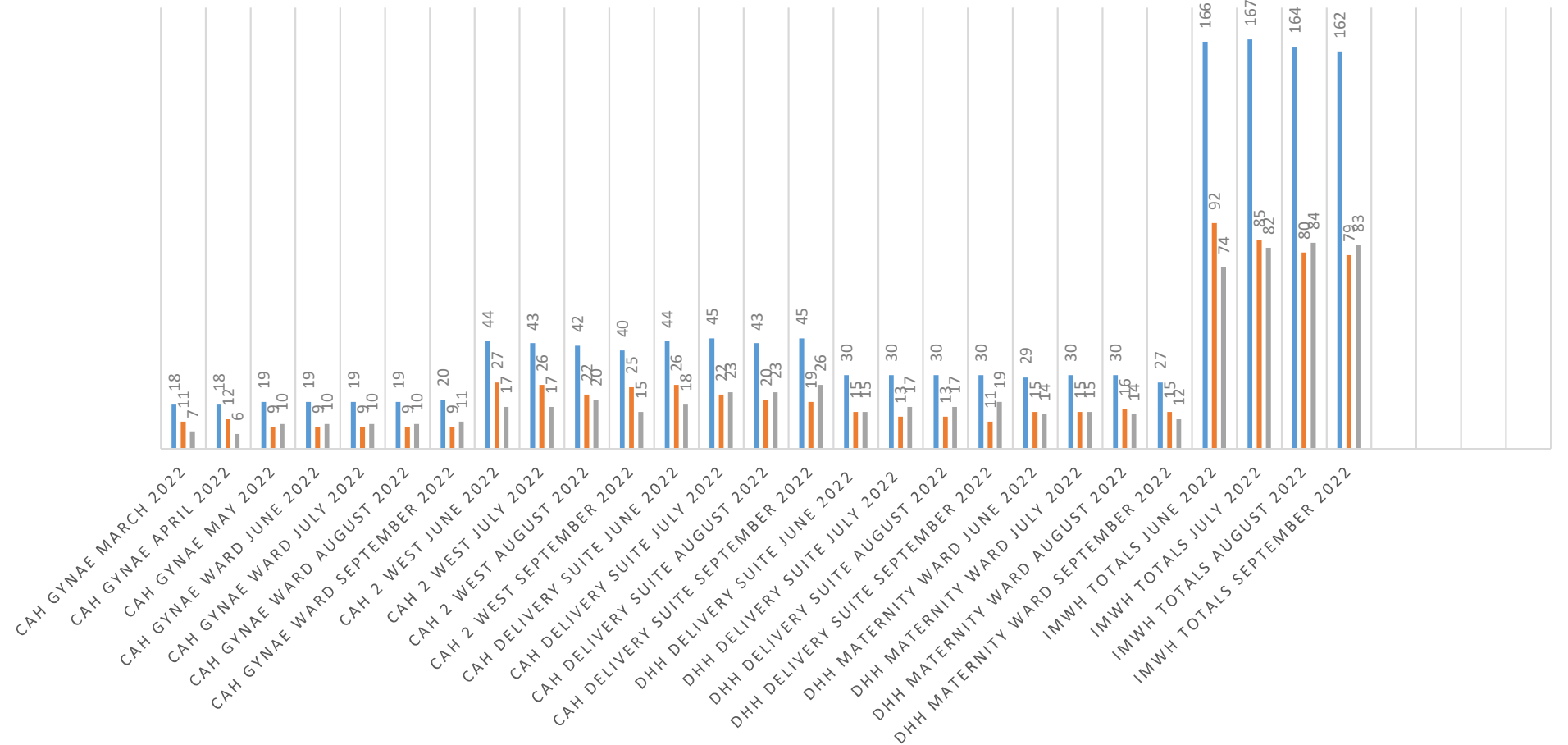


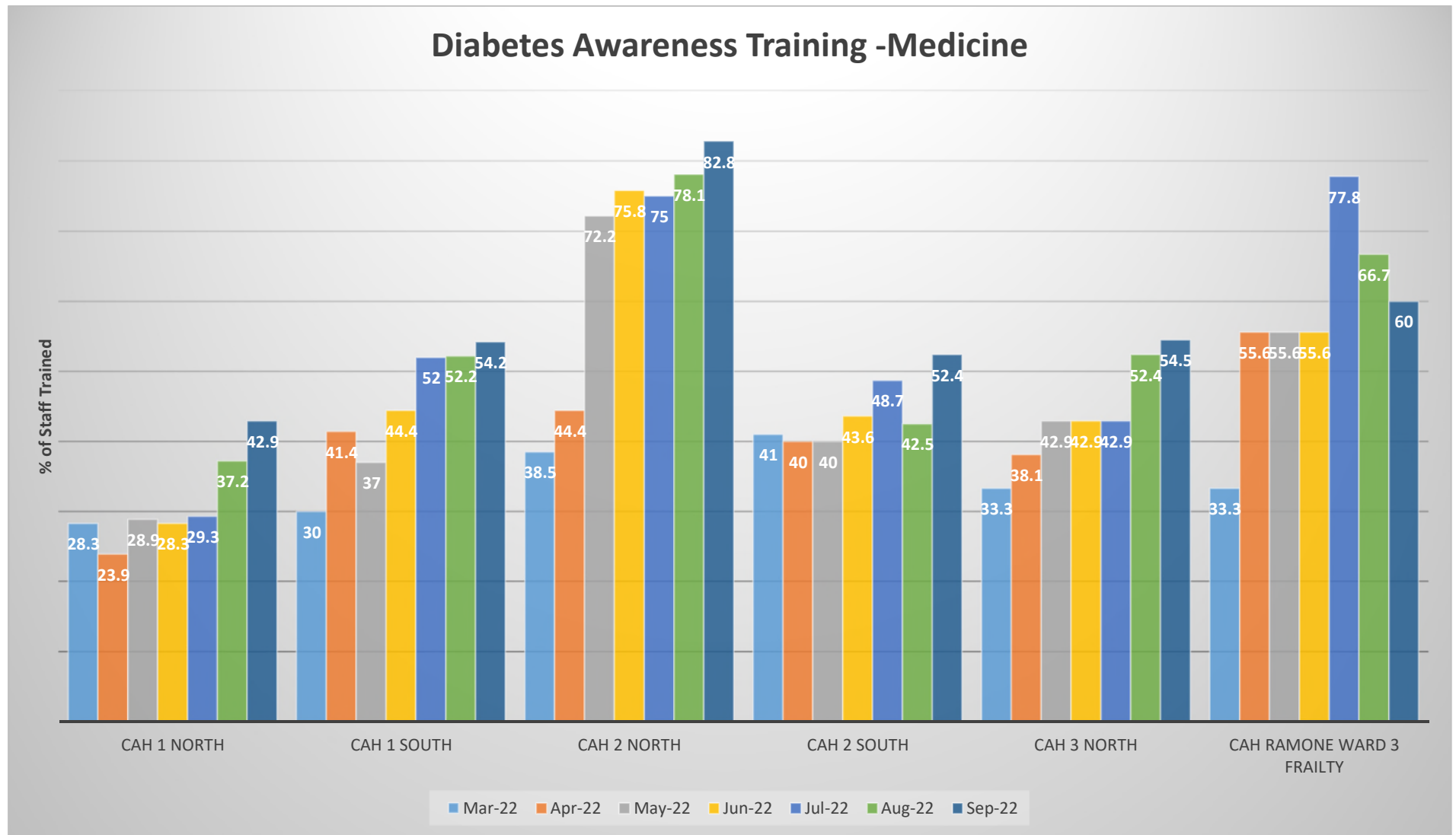
Diabetes Awareness Training - IMWH



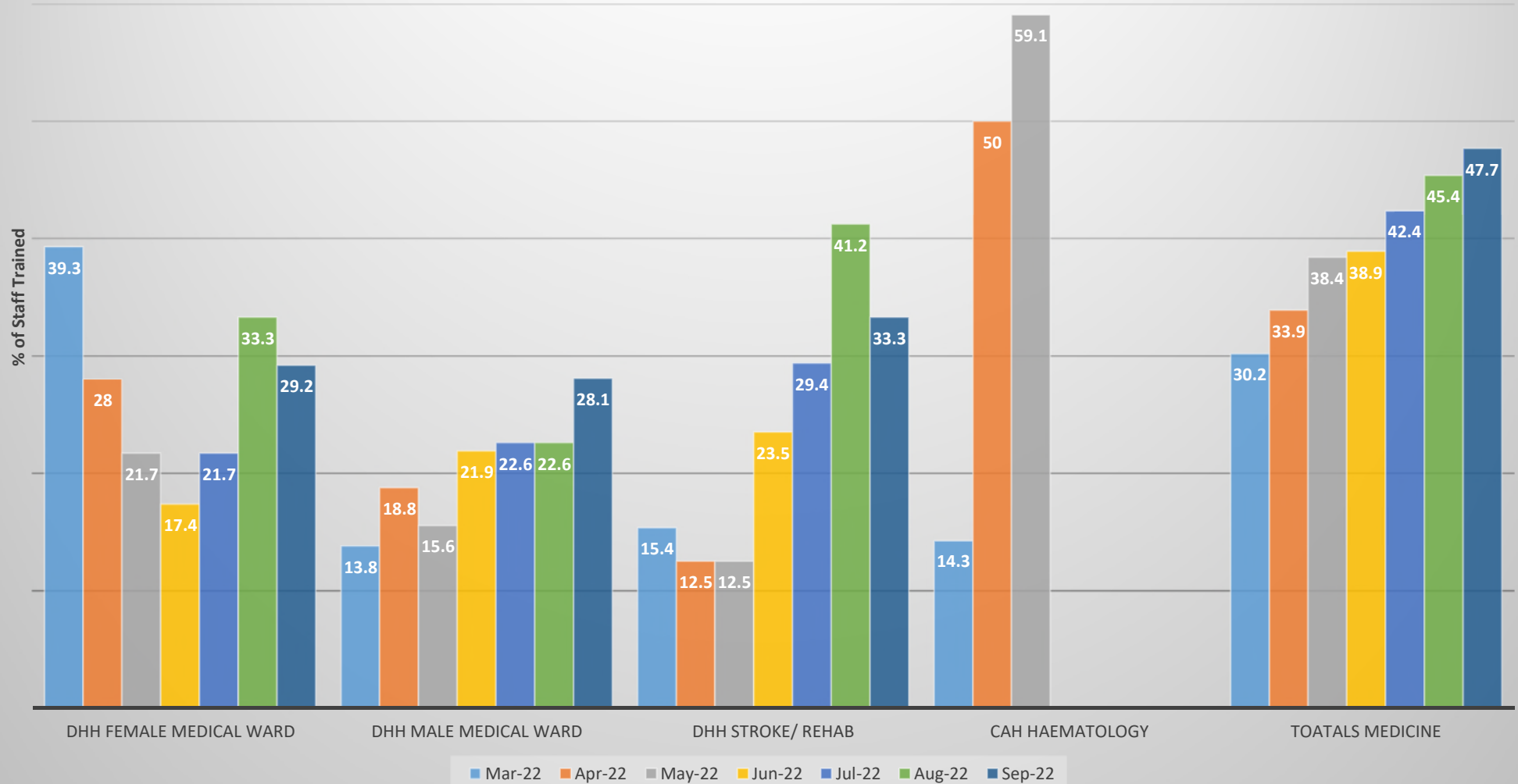
DIABETES AWARENESS TRAINING- IMWH IN NUMBERS

■ Total Number of Staff ■ Need Training ■ Trained

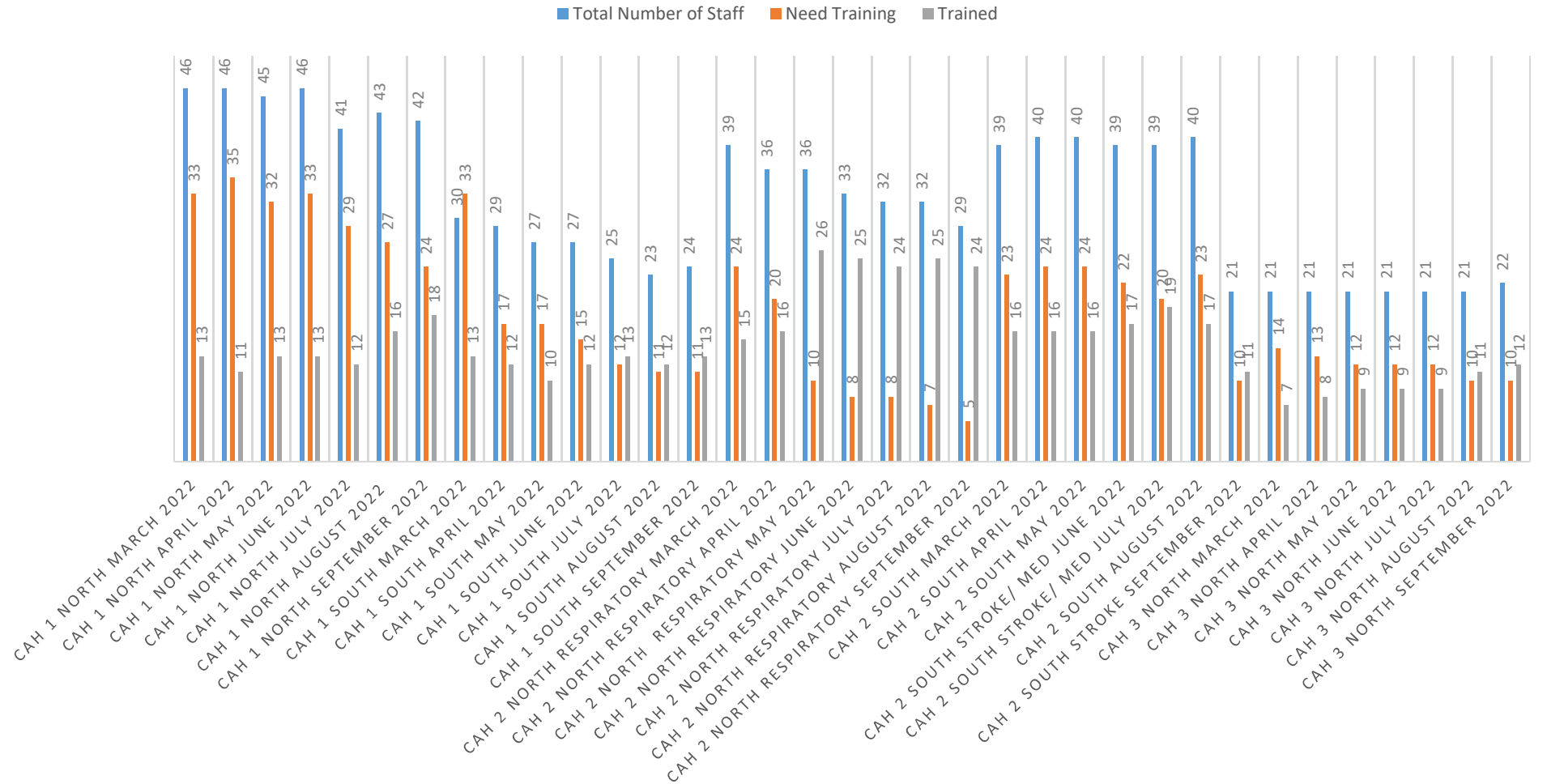




Diabetes Awareness Training- Medicine contd

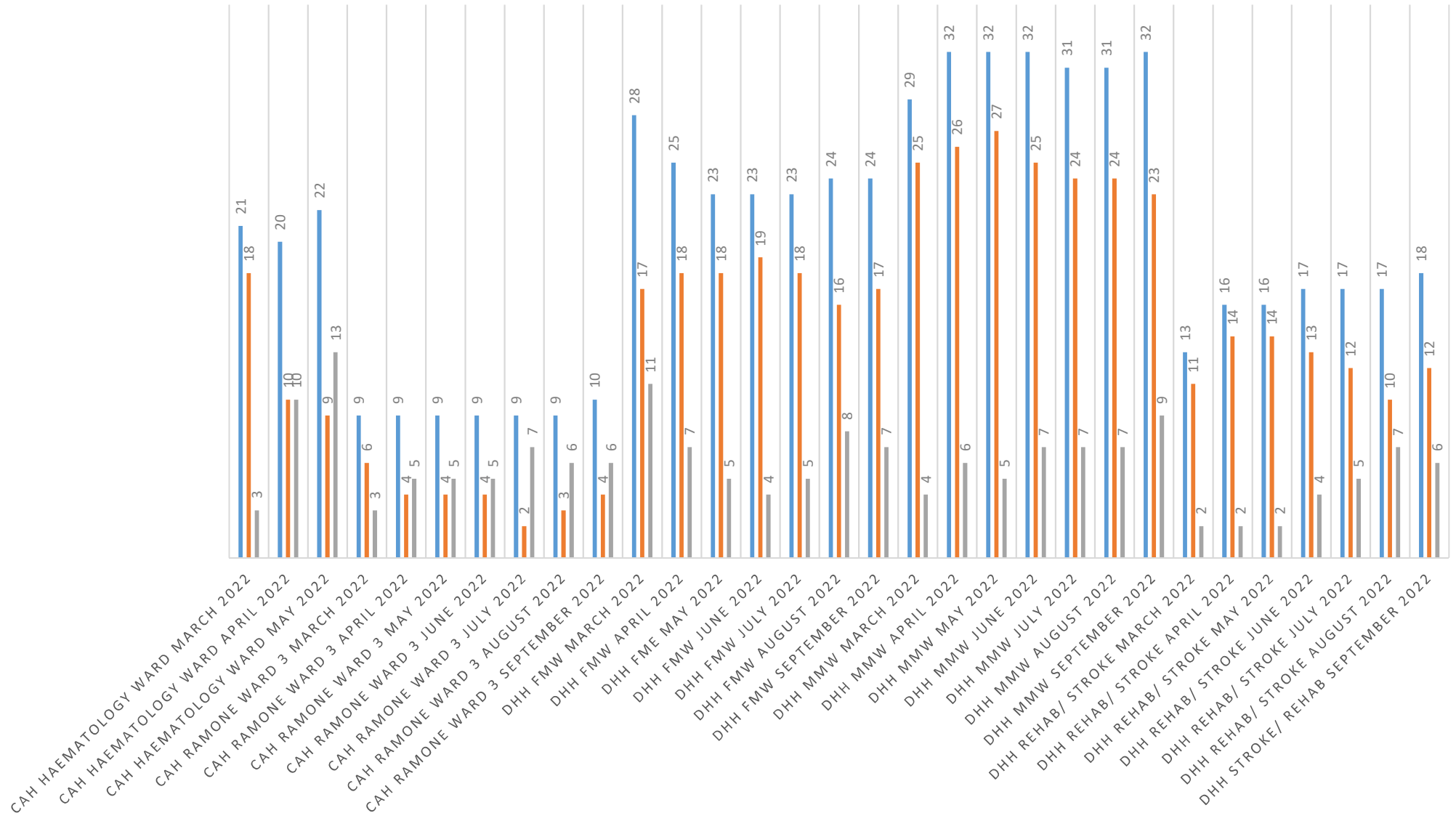


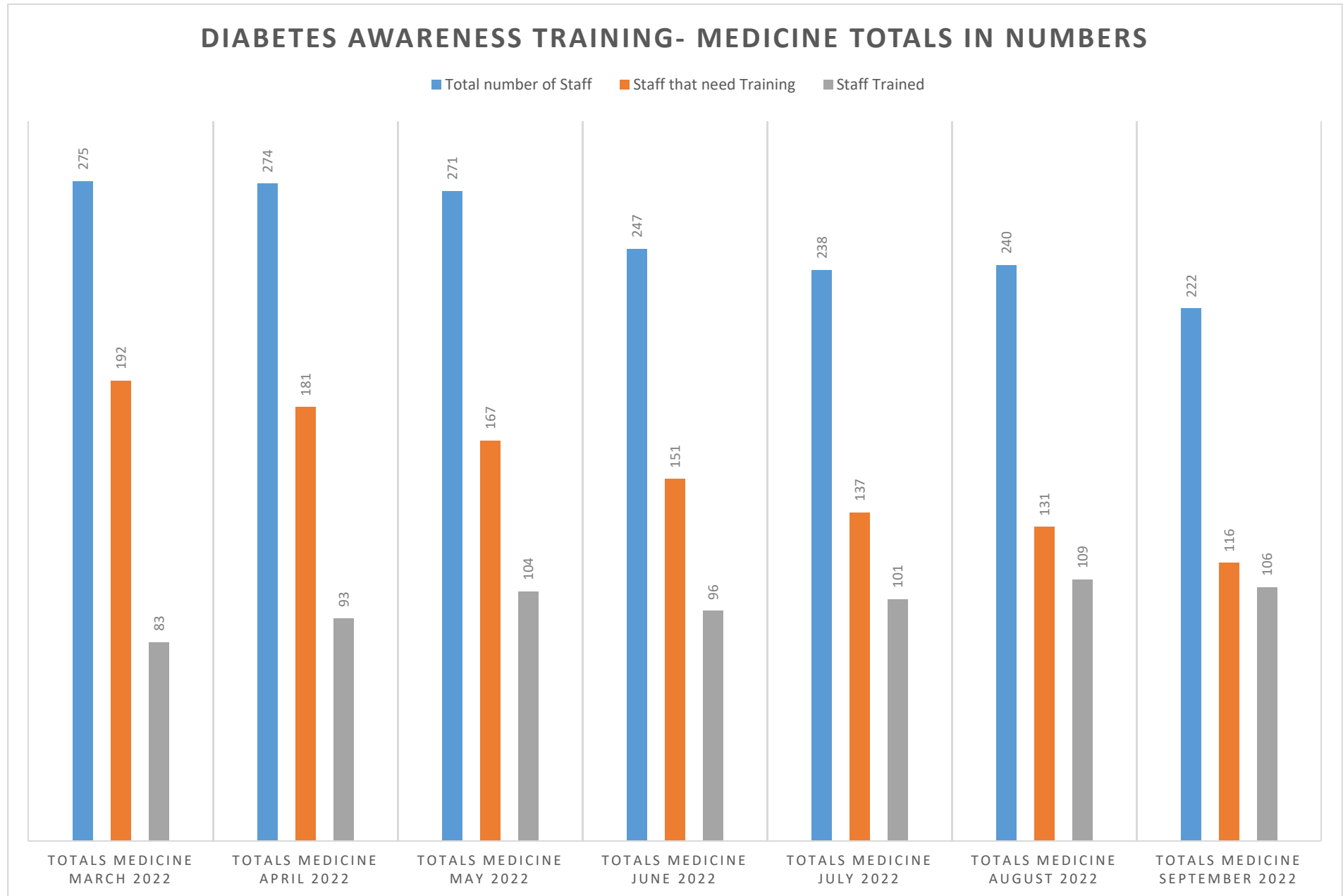
DIABETES AWARENESS TRAINING- MEDICINE IN NUMBERS



DIABETES AWARENESS TRAINING- MEDICINE IN NUMBERS CONT.

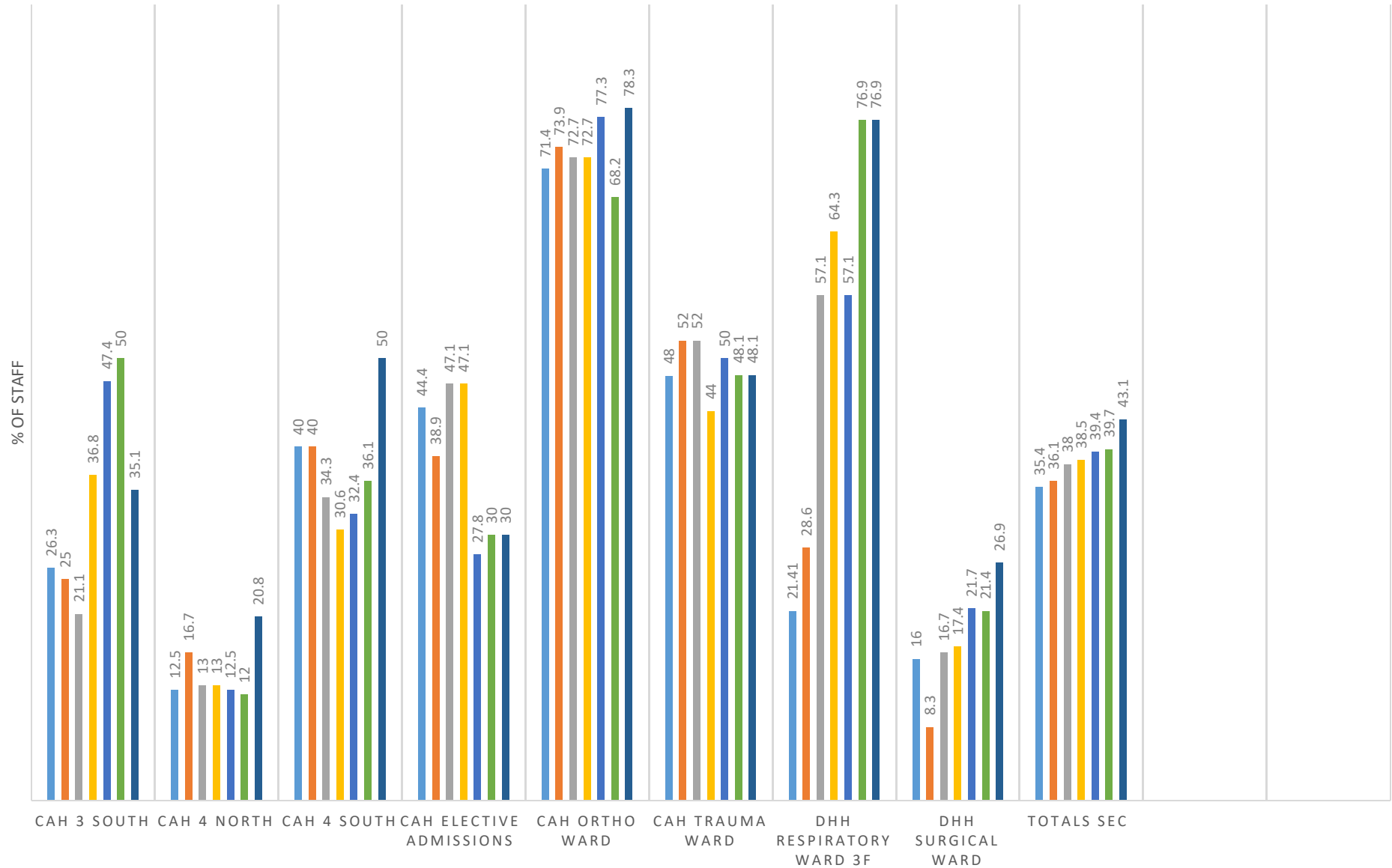
■ Total Number of Staff ■ Staff Need Training ■ Staff Trained





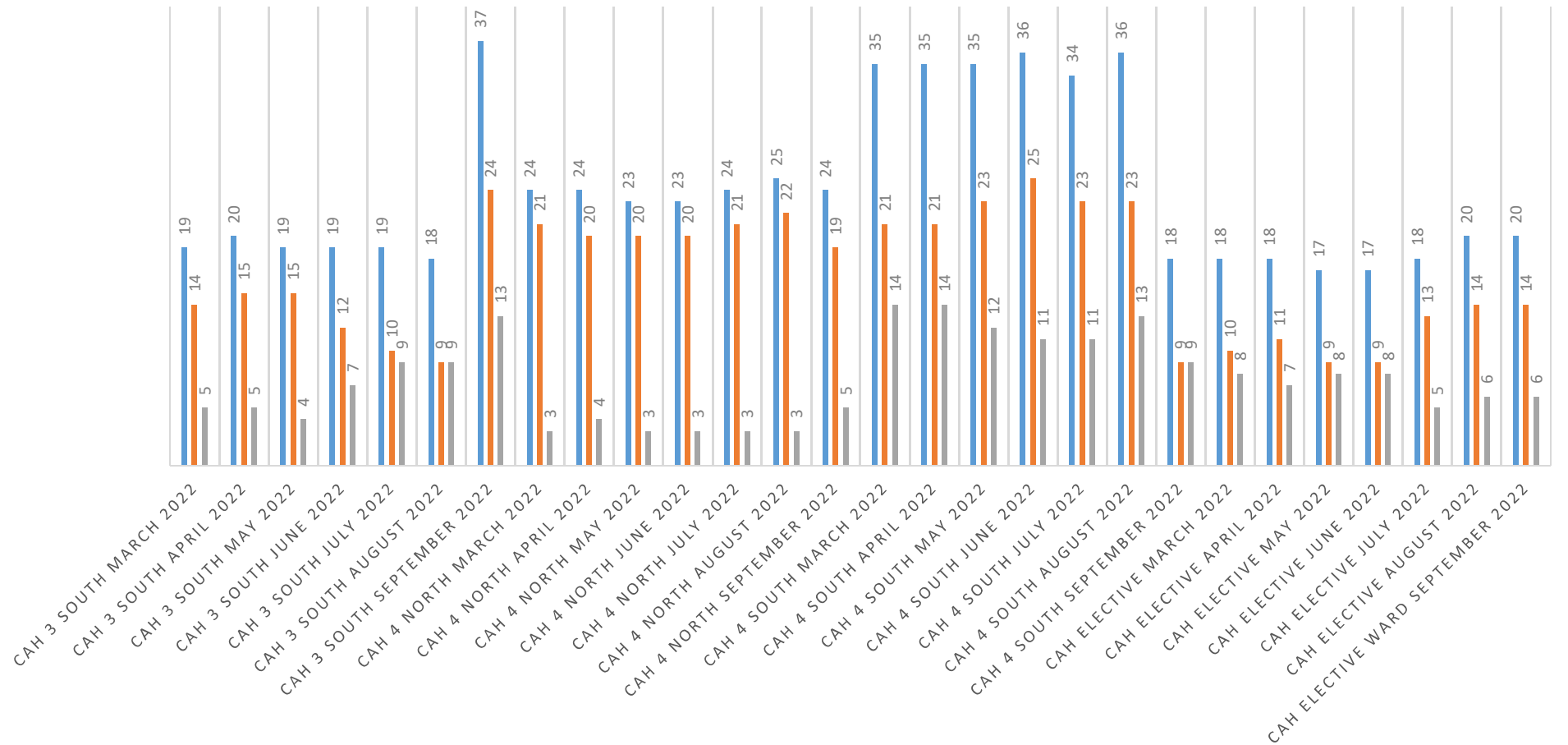
DIABETES AWARENESS TRAINING -SEC

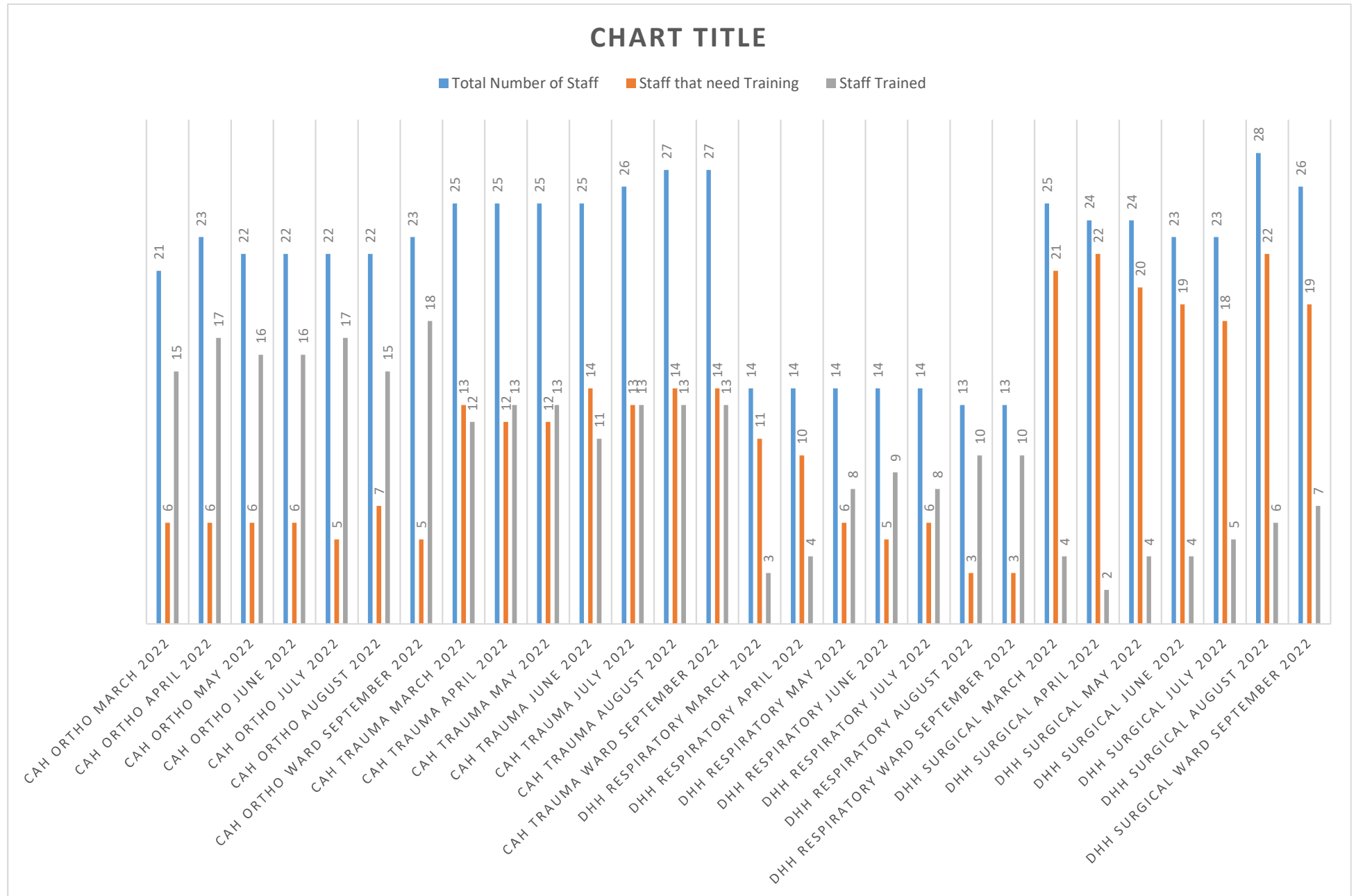
■ Mar-22 ■ Apr-22 ■ May-22 ■ Jun-22 ■ Jul-22 ■ Aug-22 ■ Sep-22

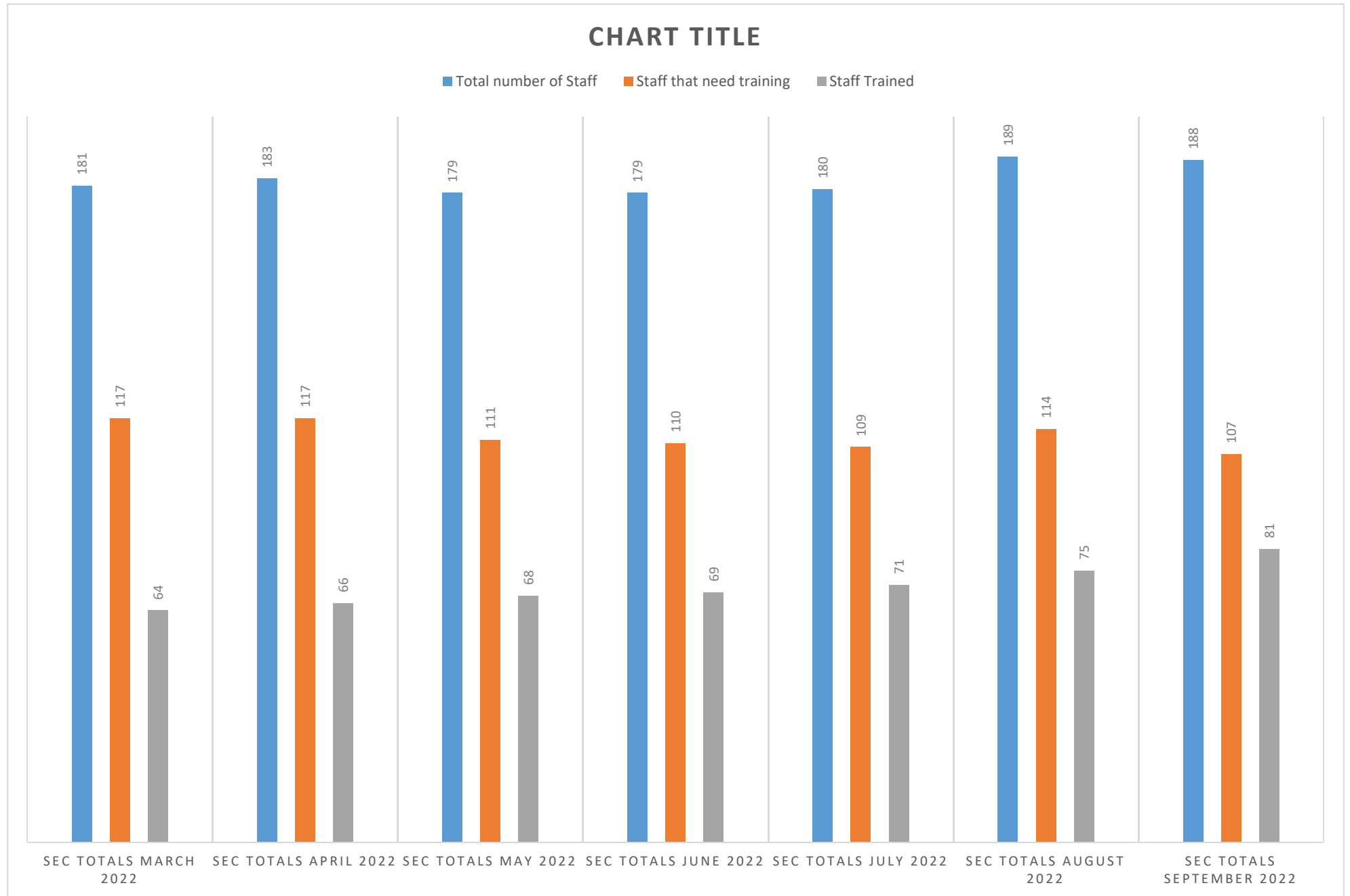


DIABETES AWARENESS TRAINING- SEC IN NUMBERS

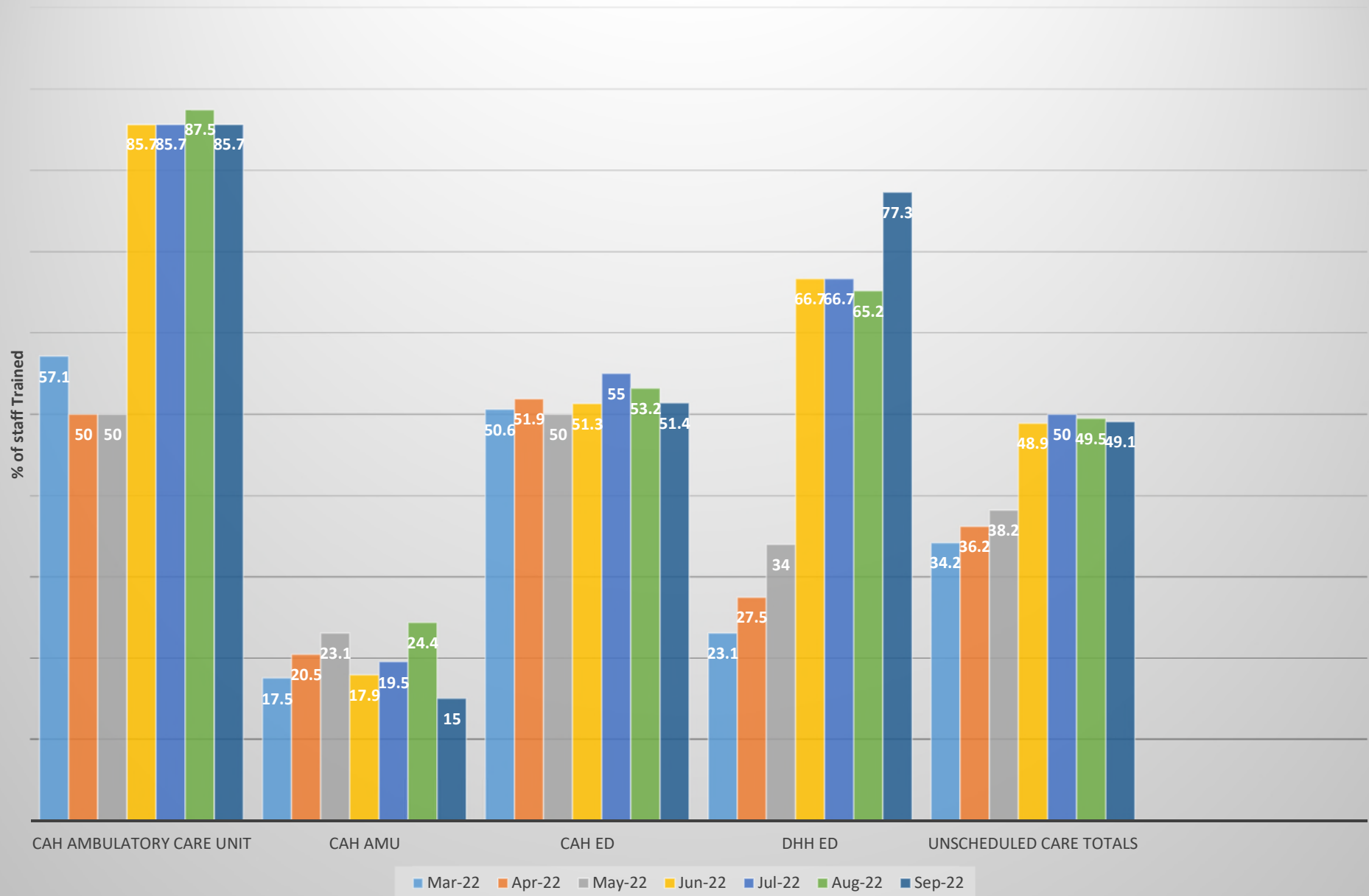
■ Total Number of Staff ■ Need Training ■ Trained

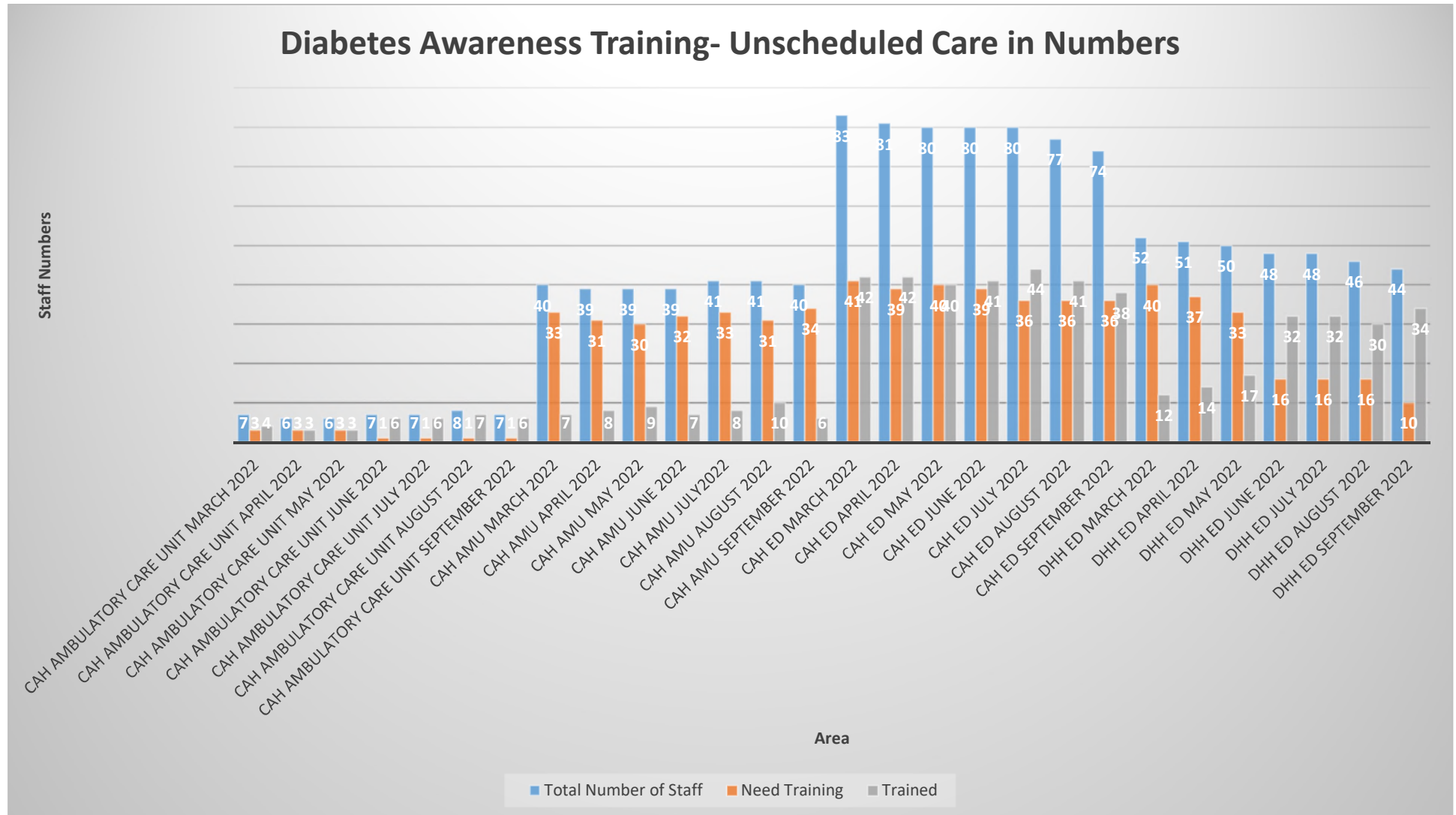


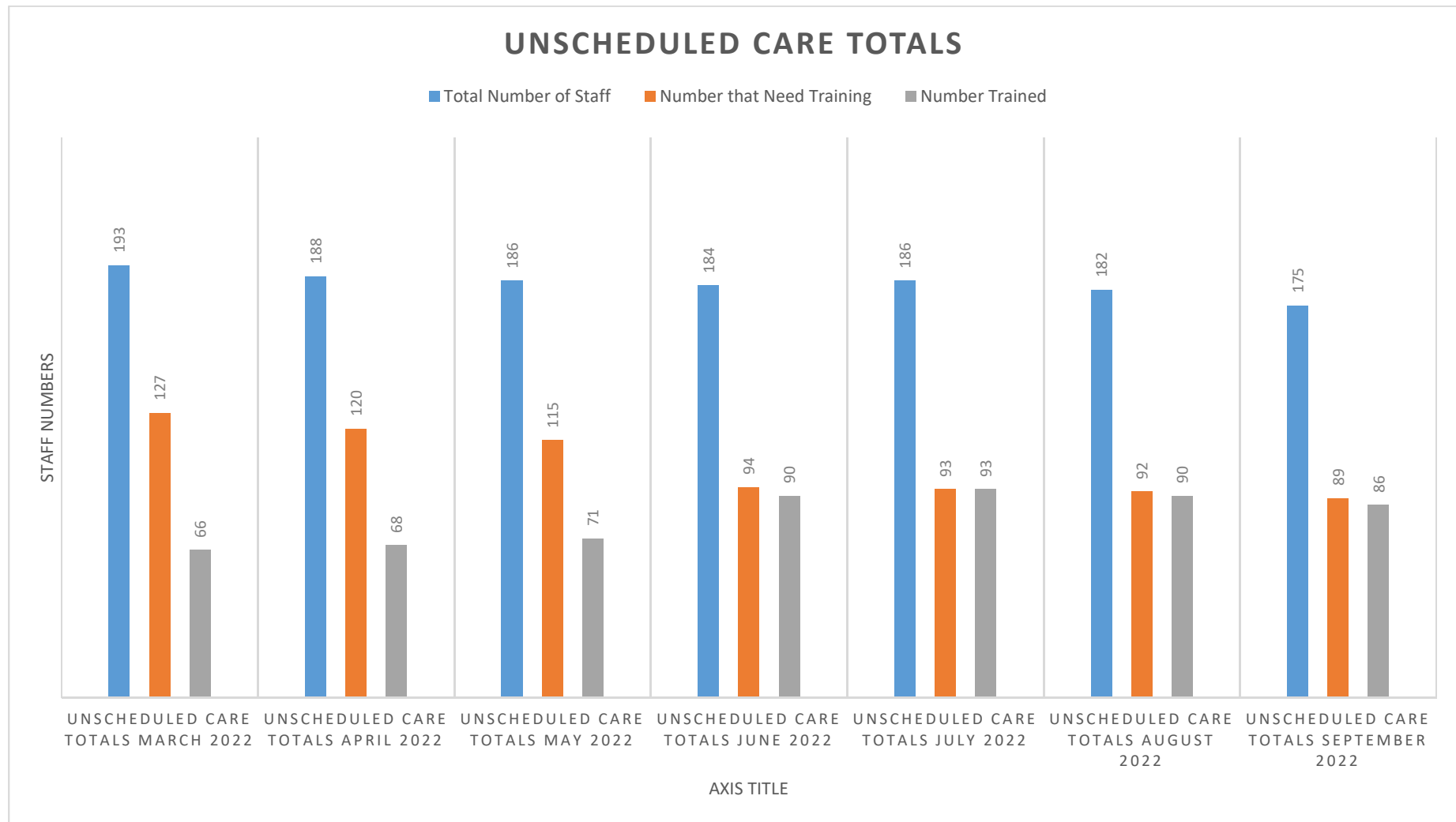




Diabetes Awareness Training - Unscheduled Care







HealthRoster Reports

Skill Group: All
Skill: All

Cluster: Diabetes Awareness
Include Grace Period Exclusions: Yes

Report Date: 30/09/2022		Target %	CAH 1 North			CAH 1 South			CAH 2 North Respiratory			CAH 2 South Stroke			CAH 2 west		
			No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained
			24	18		11	13	54.2%	5	24		10	11		25	15	
Diabetes Awareness	Diabetes Awareness (CEC Program)	100.0%															
	Diabetes Resource Folder	100.0%						100.0%									
	'The 6 Steps to Insulin Safety' (E-Learning)	100.0%															
			24	18		9	15		3	26		16	5		8	32	

HealthRoster Reports

Skill Group: All
Skill: All

Cluster: Diabetes Awareness
Include Grace Period Exclusions: Yes

Report Date:																	
			CAH 3 North Medicine			CAH 3 South			CAH 4 North			CAH 4 South			CAH Ambulatory Care Unit		
30/09/2022		Target %	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained
Diabetes Awareness	Diabetes Awareness (CEC Program)	100.0%	10	12		24	13		19	5		9	9		1	6	
	Diabetes Resource Folder	100.0%	12	10		6	31		9	15		5	13		4	3	
	'The 6 Steps to Insulin Safety' (E-Learning)	100.0%	6	16		14	23		10	14		2	16		2	5	

HealthRoster Reports

Skill Group: All
Skill: All

Cluster: Diabetes Awareness
Include Grace Period Exclusions: Yes

Report Date:																	
			CAH AMU			CAH Day Surgery Unit			CAH Delivery Suite			CAH ED			CAH Elective Admissions Ward		
		Target %	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained
Diabetes Awareness	Diabetes Awareness (CEC Program)	100.0%	34	6		7	20		19	26		36	38		14	6	
	Diabetes Resource Folder	100.0%	35	5		15	12		32	13		9	65		16	4	
	'The 6 Steps to Insulin Safety' (E-Learning)	100.0%	27	13		9	18		4	41		36	38		4	16	

Skill Group: All
Skill: All

Cluster: Diabetes Awareness
Include Grace Period Exclusions: Yes

Report Date:		Acute															
		CAH Gynae Ward				CAH Haematology Ward 5			CAH ICU			CAH Orthopaedic Ward			CAH Ramone Ward 3 Frailty		
		Target %	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained	No. Staff Requiring Training	No. Staff Trained	% Trained
Diabetes Awareness	Diabetes Awareness (CEC Program)	100.0%	9	11	55.0%	9	13	59.1%	25	43	63.2%	5	18	78.3%	4	6	60.0%
	Diabetes Resource Folder	100.0%	18	2	10.0%	6	16	72.7%	5	63	92.6%	1	22	95.7%	2	8	80.0%
	'The 6 Steps to Insulin Safety' (E-Learning)	100.0%	15	5	25.0%	4	18	81.8%	4	64	94.1%	1	22	95.7%	4	6	60.0%