

Appendix 7 ICNARC Guidance

ICNARC exists as a result of the success of the ICS UK APACHE II Study; a large research study, conducted in the late 80s/early 90s, on patient outcomes from intensive care units (ICUs).

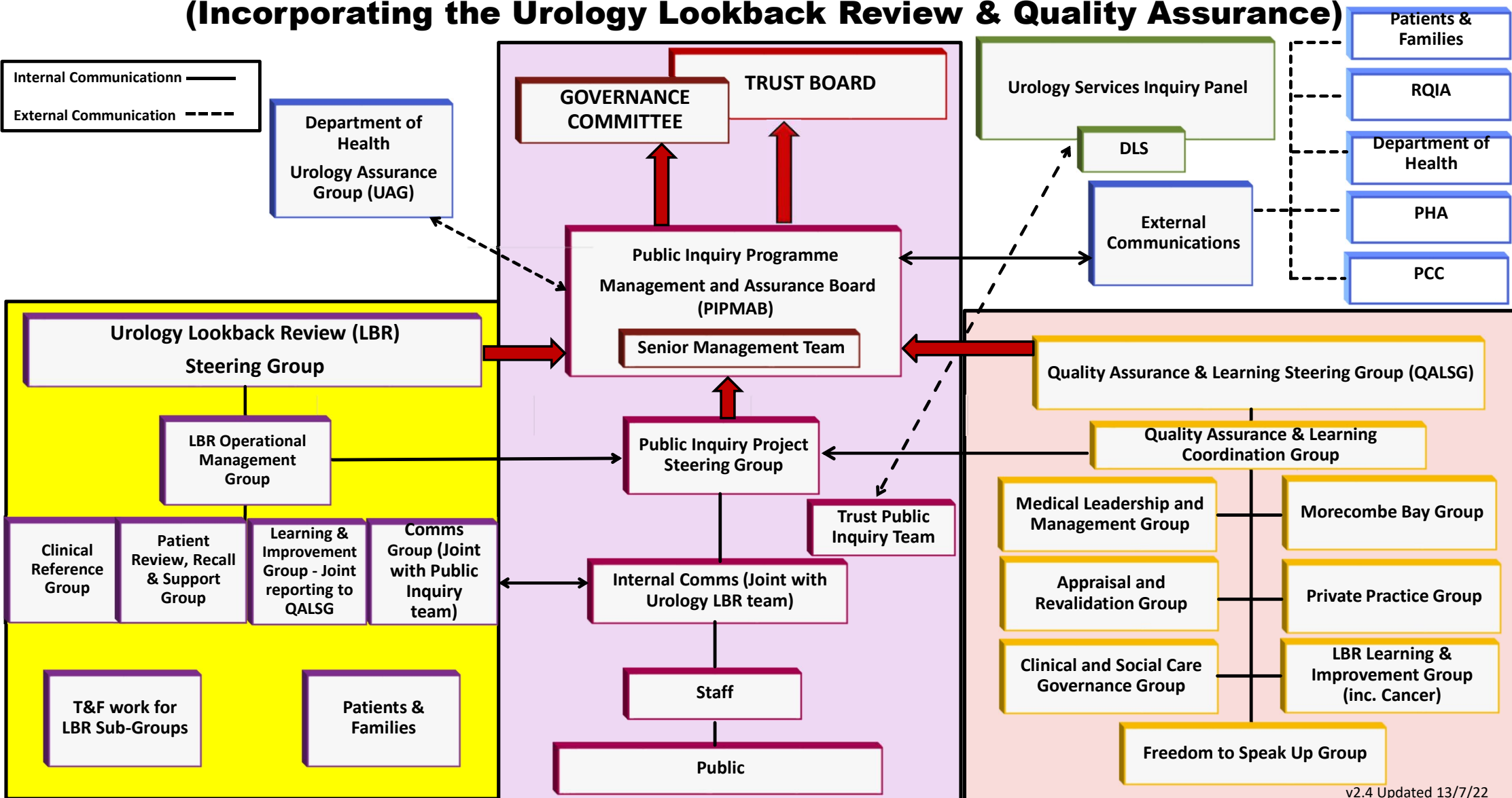
In 1991, Dr Kathy Rowan, on behalf of the Intensive Care Society (ICS), submitted a proposal to set up a national centre for comparative audit and research in intensive care, to the Department of Health.

As a result of the study, and in response to the lack of information available on intensive care, in 1993 financial support was obtained from the Department of Health and the Welsh Health Common Services Authority for two years – to pump-prime the establishment of ICNARC.

ICNARC was set up in 1994, separate from the ICS, to provide an independent, national resource for the monitoring and evaluation of intensive care. Intensive care practitioners had (and still have) little or no data as to what is, or is not, effective with regard to how intensive care is organised or to the therapies employed

Southern Trust Intensive Care Unit participates in the Case Mix Programme (CMP). Which is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.

Public Inquiry Programme Structure (Incorporating the Urology Lookback Review & Quality Assurance)



Public Inquiry Programme - Quality Assurance and Learning

Quality Assurance and Learning Steering Group Terms of Reference	
GROUP	Quality Assurance and Learning Steering Group
PURPOSE	As a workstream of the Trust's Public Inquiry Programme the purpose of the Quality Assurance and Learning aspect of the PI programme is to ensure there is effective quality assurance process regarding professional and operational governance of the clinical teams providing urology (and other specialties as appropriate) services. In addition, Quality Assurance and Learning aspect of the PI programme will address the application of learning to all clinical services (not confined to urology) as appropriate and to ensure implementation of recommendations from other pertinent investigations / reviews external to the Southern Trust. To that end, the Quality Assurance & Learning Steering Group will provide oversight of the work for the following workstreams: - o Medical Leadership and Management Group - o Appraisal and Revalidation Working Group - o Clinical and Social Care Governance Working Group - o Private and Paying Patients Working Group - o Freedom to Speak up Working Group - o Morecambe Bay Working Group - o Learning and Improvement Group. The Steering Group have an executive responsibility over the programme of work and outcomes for each of the workstream.
MEMBERSHIP	The Medical Director will chair the Quality Assurance and Learning Steering Group. Membership will consist of but not limited to –

	Dr Damian Scullion, Interim Medical Director and Deputy Medical Director for Revalidation and Appraisal Dr Damian Gormley, Deputy Medical Director for Clinical and Social Care Governance Dr Aisling Diamond, Deputy Medical Director for Deputy Medical Director, Workforce and Education Vivienne Toal, Director of Human Resource and Organisational Development Caroline Doyle, Assistant Director for Clinical and Social Care Governance Mr Mark Haynes, Divisional Medical Director, Urology Quality Improvement Dr Shahid Tariq, Divisional Medical Director, Cancer Services Dr Raymond McKee, Divisional Medical Director, ATICS Mr Ted McNaboe, Divisional Medical Director, Surgery and Elective Care Barry Conway, Assistant Director, Cancer and Clinical Services Ronan Carroll, Assistant Director, Surgery & Elective Care & ATICS Charlotte-Anne Wells, Assistant Director of Acute Services Mary Burke, Acting Assistant Director of Unscheduled Care and Acute Medicine Caroline Keown , Assistant Director, Integrated Maternity and Women's Health Grace Hamilton, Assistant Director Safety, Quality and Nursing Experience Paula Tally, Assistant Director, Performance and Quality Improvement Simon Gibson, Assistant Director, Medical Education and Workforce Stephen Wallace, Assistant Director, Systems Assurance
DUTIES	Function as the Trust Board and SMT's reporting line of sight from the various workstreams to ensure adequate oversight

	of the actions and/or issues that impact governance, performance and patient safety Provide senior advice and lead on the development of an agreed strategy for the implementation of recommendations pertaining to INI and other relevant reports; Ensure effective alignment of activity between working groups; Consider and approve proposed activity and timescales to be undertaken by the working groups; Promote collaborative working and consistency in Trusts response to implementation of recommendations; Receive briefings from each individual working group regarding actions, progress and issues within those groups; Ensure regular and timely updates are provided to PIPMAB and oversee the development of a protocol that outlines the roles and responsibilities of each workstreams with respect to information sharing. This should include escalation process to ensure that the Medical Director and the Responsible officer a kept abreast with developments that may impact performance, governance and patient safety. Respond to and action queries and requests for information and advice from the various working groups to facilitate the delivery of agreed project outcomes; Provide oversight and final approval for proposed actions and timescales; Liaise with colleagues, programmes, committees and others within the Southern Trust and where relevant outside the Trust, including the clinical domains and relevant directorates, to keep abreast of, and provide Working Groups with information regarding, wider areas of work were appropriate; Serve as a conduit for information flows between the Working Groups, Public Inquiry Steering Group, PIPMAB and SMT; Where appropriate, coordinate activity between working groups with the objective of developing solutions, including coordinating the provision of relevant advice and guidance.
AUTHORITY	The Quality Assurance and Learning Steering Group is authorised by the Public Inquiry Programme Management and Assurance Board (PIPMA), to undertake any activity within its Terms of Reference. The Chair will report on progress as required to SMT/ PIPMA.

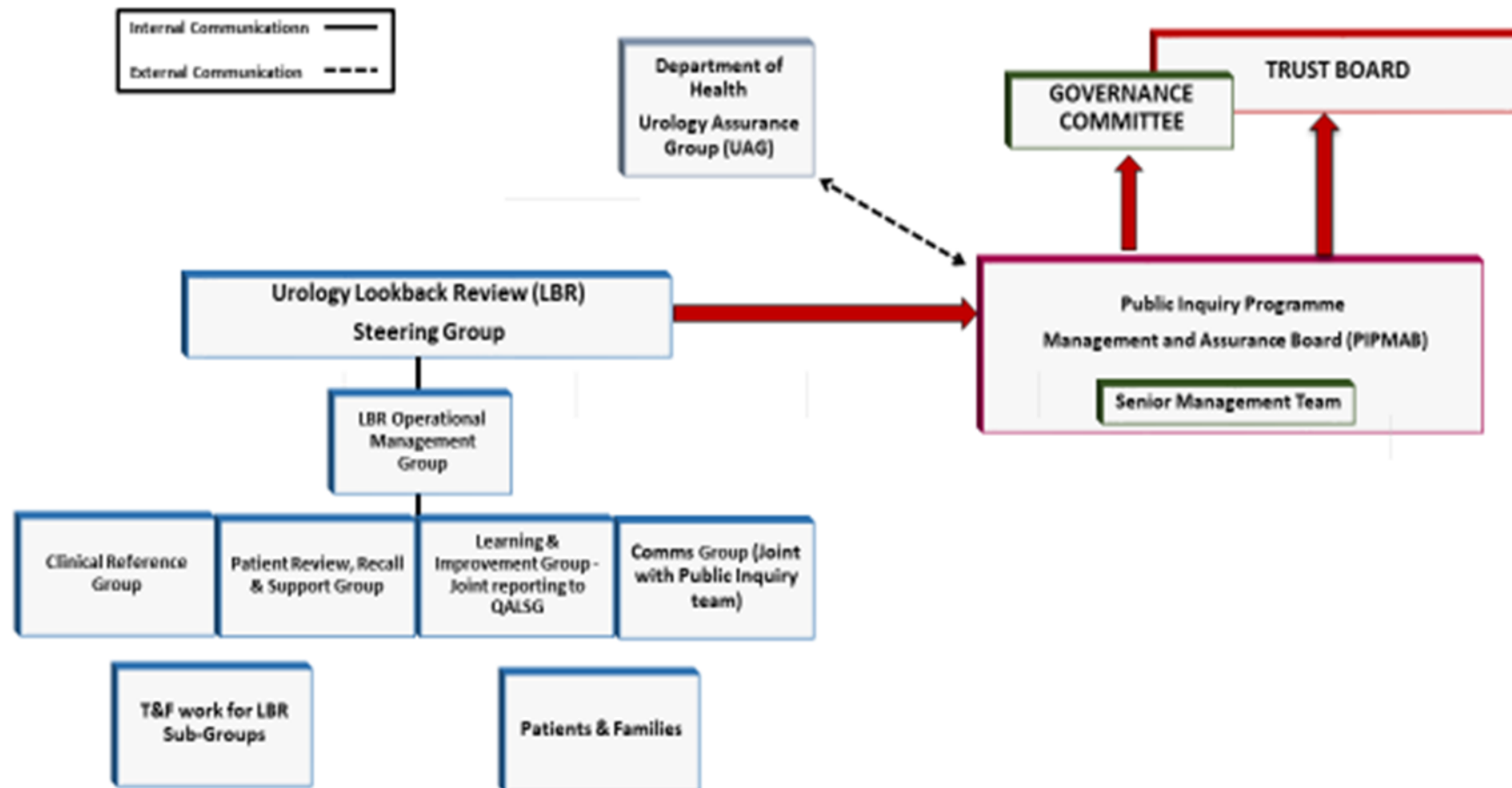
MEETINGS	Frequency of Meetings: This group will meet as necessary in line with the phases of the implementation of the workplan of the Quality Assurance and Learning Group
REPORTING	The Quality Assurance and Learning Group, through its Chair and members, will work closely with the Public Inquiry Project Management and Assurance Board to support the undertaking of its role and function and any activity undertaken will be reported by the Chair of the Quality Assurance and Learning Group. The Chair will report to the Public Inquiry Project Management and Assurance Board any significant matter under consideration and / or for escalation or higher level decision-making
CONFLICT/DECLARATION OF INTEREST	The Chair will seek and record any Declaration or Conflict of Interest from members prior to every meeting of the group.
REVIEW	These Terms of Reference and operating arrangements will be reviewed as and when required.

TERMS OF REFERENCE	
LOOKBACK REVIEW (LBR) STEERING GROUP	
GROUP	Urology LBR Steering Group
PURPOSE	Oversee the undertaking and communication of all stages and phases of the Urology Lookback Review. Responsibility for the commissioning of appropriate groups and sub-groups to complete the Lookback Review in a way that is compassionate, timely and comprehensive.
MEMBERSHIP	• SRO (Chair) • Medical Director • Associate Medical Director Primary Care • Director Surgery and Cancer Services (Chair of Operational Management Group) • Assistant Director of Nursing – Quality & Patient Experience • Assistant Director Clinical Assurance • Assistant Director Clinical Governance & Risk Management • Assistant Director Finance • Assistant Director IT • Assistant Director for PPI • Stakeholders from ○ SPPG ○ PHA ○ RQIA • Lay Representatives x 2 • Chair of: ○ Operational Management Group (as above) ○ Clinical Reference Group ○ Patient Review, Recall & Support Group

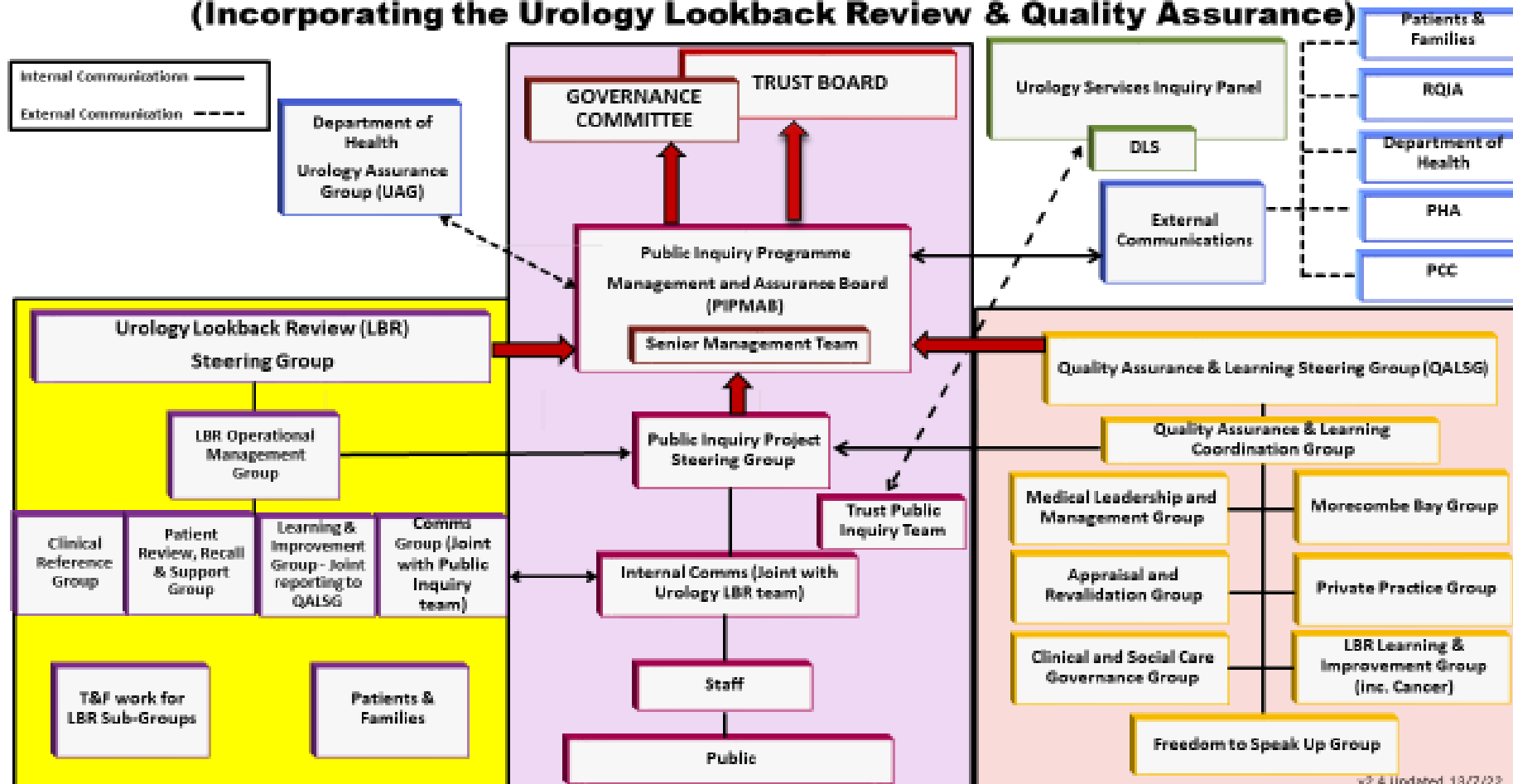
	○ Learning and Improvement Group ○ Communication Group ● Admin /Secretary
DUTIES	● Provide oversight of, and an Accountability Framework for, all aspects of the Urology Lookback Review process including ongoing discovery of the all aspects of the LBR project to the USI. ● Agree methodology for conducting the Lookback Review process and ensure effective alignment of activity to the regional Lookback Review guidance. ● Agree scope and ToRs of various groups delivering the Lookback Review ● Ensure robust reporting arrangements for the Lookback Review process including the response of any independent service provider who will undertake the assessment element of the exercise ● Ensure that contingencies are in place within the service to deal with additional health care demands should they arise ● Communicate internally and externally in line with the Lookback Review communication strategy ● Ensuring appropriate support is in place for service users and their families who may be impacted by the Lookback Review ● Agree interim and final reports which will be submitted to the Public Inquiry Programme Management and Assurance Board, Trust Board and UAG. ● Identify recommendations for any further action including extending the Lookback Review period. ● Ensuring communication and implementation of recommendations from the Lookback Review insofar as they apply to SHSCT policies and /or procedures
AUTHORITY	The Urology Lookback Steering Group is authorised by the SHSCT Public Inquiry Programme Management and Assurance Board to undertake any activity within its Terms of Reference

MEETINGS	Frequency of Meetings: Monthly. Papers: Agenda and papers will be disseminated electronically at least 3 working days before the date of the meeting. Individuals in attendance: Individuals invited for a specific item will be asked to withdraw following completion of that item.
REPORTING	The Urology Lookback Steering Group will: ➤ Report formally, regularly and on a timely basis to Urology Public Inquiry Management & Assurance Board. This includes verbal updates on activity, the submission of minutes and written reports as required. ➤ Report on all aspects of the Lookback Review to the DOH Urology Assurance Group ➤ Provide all updates and reports as ongoing discovery to the USI via the Trust's PI team. ➤ Bring to the attention of the SHSCT Public Inquiry Management & Assurance Board any significant matter under consideration of the Urology Lookback Steering Group. ➤ Ensure appropriate escalation arrangements are in place to alert the Trust Board, via the Chief Executive and Executive Team and DOH Urology Assurance Group of any urgent / critical matters that may compromise patient / client care and affect the operation and / or reputation of the Trust.
CONFLICT/DECLARATION OF INTEREST	The Chair will seek and record any Declaration or Conflict of Interest from members prior to every meeting of the group. During the course of a meeting, if a Conflict of Interest is established, the member concerned should withdraw from the discussion / meeting and play no part in the relevant discussion or decision. The Conflict of Interest should be recorded in the minutes.
REVIEW	These Terms of Reference and operating arrangements will be reviewed as and when required.

Urology Lookback Review Operational and Accountability Framework



Public Inquiry Programme Structure (Incorporating the Urology Lookback Review & Quality Assurance)



Performance Assurance Template

DRAFT v1

This template is to be completed by the Clinical Director / Divisional Medical Director as part of the doctors Job Planning meeting. Upon completion this template should be returned to the Medical Revalidation Team (medical.revalidation@southerntrust.hscni.net)

1. Meeting Details

Member of Staff	
Speciality	
Division	
Clinical Director / Divisional Medical Director undertaking meeting	
Date of Meeting	

2. Performance Assurance Review

	Domain Reviewed	Was information available / adequate for purpose?		Assurance on performance achieved?		Comments
		Yes	No	Yes	No	
1	Mortality CHKS information					
2	Mortality M&M Scorecard					
3	Outstanding Dictation					
4	Readmission Rates					
5	Review Waiting Lists					
6	Serious Adverse Incidents					
7	Complaints					
8	Litigation / Coronial					

3. Assurance Actions Required

If required following review adequate assurances were not obtained please list actions required to meet assurance requirements

Domain	Action Required	Date Action Required By	Escalation of issue to Medical Director / Operational Director Required?

			Yes	No

Proposed Date of Follow up Meeting	
---	--

4. Form Completion

	Please tick as appropriate
I confirm that the performance assurance objectives for this staff member have been reviewed by myself and I am content these have been met for the previous year	
I confirm that the performance assurance objectives for this staff member have been reviewed by myself and these have not been met for the previous year and will be subject to further review. Any immediate safety concerns identified have been escalated to the Medical Director and Operational Director	

	Printed Name	Signed
Clinical Director / Divisional Medical Director		
Staff Member		

Performance Assurance Template Guidance

- 1 The Clinical Director / Divisional Medical Director and Consultant will complete this template as part of the annual Job Planning meeting.
- 2 Prior to the meeting the Clinical Director/ Divisional Medical Director will need to access the following metrics/ information:

Data required	Date range	Provided by
Mortality CHKS information	Previous 12 months	
Mortality M&M Scorecard	Previous 12 months	
Outstanding Dictation	Previous 12 months	
Readmission Rates	Previous 12 months	
Review Waiting Lists	Previous 12 months	
Serious Adverse Incidents	Over 3 year period	Clinical and Social Care Governance team
Complaints	Over 3 year period	Clinical and Social Care Governance team
Litigation / Coronial	Over 3 year period	Litigation Team

- 3 Each metric should have a pre agreed mark for assurance applicable to all consultants within the relevant speciality.
- 4 As part of completing the template there will be a discussion regarding each metric as to the following:
 - Was information available / adequate for purpose?

- If so, has the data and discussion provided assurance on performance achieved?
- 5 If required following review adequate assurances were not obtained a list of actions will be required to meet assurance requirements. These will be discussed and agreed as part of the meeting and a follow up date to check progress agreed.
- 6 The Clinician Director/ Divisional Medical Director will then confirm outcome
- Based on metrics and discussion performance assurance objectives have been achieved
 - Performance assurance objectives have not been met and will be subject to further review. *(In the event of any immediate safety concerns, these must be escalated to the Medical Director and Operational Director)*
- 7 The form should be signed by both parties and returned to the Medical Revalidation Team.



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

Private Practice / Medico-Legal Structured Reflective Template

Principles agreed by the Academy of Medical Royal Colleges April 2020

Name of doctor:	GMC No:																					
Date reflective template completed:	Appraisal Year:																					
Where have you undertaken your private practice / medico-legal over the last twelve months? (Tick all that are appropriate) <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;"></th> <th style="width: 10%; text-align: center;">Y/N</th> <th style="width: 55%; text-align: center;">Estimated % of Private Practice</th> </tr> </thead> <tbody> <tr> <td>NHS Hospitals</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Independent Clinics</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Home / Domestic Premises</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Virtual Clinics</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Medico-Legal Work</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Event Support (Sporting etc)</td> <td style="text-align: center;">☐</td> <td style="text-align: center;"> </td> </tr> </tbody> </table>			Y/N	Estimated % of Private Practice	NHS Hospitals	☐		Independent Clinics	☐		Home / Domestic Premises	☐		Virtual Clinics	☐		Medico-Legal Work	☐		Event Support (Sporting etc)	☐	
	Y/N	Estimated % of Private Practice																				
NHS Hospitals	☐																					
Independent Clinics	☐																					
Home / Domestic Premises	☐																					
Virtual Clinics	☐																					
Medico-Legal Work	☐																					
Event Support (Sporting etc)	☐																					
Job Planning – Is your private practice / medico-legal activity fully declared in your Trust job plan?																						
Medical Protection / Indemnity Arrangements Describe your arrangements for medical protection / indemnity regarding your medico-legal / private or independent practice? GMC requires private practitioners to arrange adequate and appropriate insurance or indemnity (even if this work takes place on NHS or HSC body premises). This applies even if the work is in addition to work you do for an NHS or HSC body.																						
Scope of Practice – Describe the nature of your private practice / medico-legal work (Consider factors including; are you doing a low volume of work of this type? Are you deliberately limiting your scope of practice? Are you returning to this type of work after a prolonged break for some reason?):																						
Volume worked in the last twelve months – How much private practice / medico-legal work have you undertaken over the last twelve months of practice? (Is your work evenly spread throughout the year or do you regularly have significant breaks e.g. > 6 weeks? Please describe your annual arrangements. When was the last time you did any work of this type?):																						

**Experience**

What prior experience do you bring to this role? How long have you worked as a qualified doctor in this type of work?

And/or If appropriate, explain how many skills based clinical procedures of this type you have done in the past and how you have kept your skills up to date.

Duration of working in this way and future plans

How long have you been working in your current way, and what are your plans?

- If you do a low volume of work in this role, will you increase, maintain or decrease the volume of your work over the coming year?

And/or

- If you have a limited scope of practice, will you be changing this over the coming year?

And/or

- If you are coming back to work after a prolonged absence, what induction and support will you have / have you already had?

Record Keeping

Please describe how you manage and process private practice / medico-legal records

- As a private practitioner who collects and holds information about patients have you registered as a data controller with the Information Commissioner's Office?

- What processes do you have for responding to a Subject Access Requests? - that is, a request for access to the notes you hold about a patient. The request could be made for a number of different reasons, including clinical negligence claims.

- What processes do you have to meet requirements of General Data Protection Regulation 2018 (GDPR) and Department of Health Code of Practice for Records Management. Although, as a private practitioner, you are working outside the HSC / NHS, and are therefore technically exempt from the Public Records Acts, the GMC guidance in 'Confidentiality' (2009) makes clear that everyone should use the retention schedule and does not distinguish between private and HSC / NHS records.

- If you are planning to end your private practice, as long as you hold information, you will need to be able to fulfil your duties as a data controller under GDPR. Please give details of your arrangements to meet this requirement

**Overlap with other roles**

Please describe the overlap between this part of your scope of practice and other roles you may currently have / have recently had. How well does the experience from your other roles help you to maintain your knowledge and skills for this one?

Benchmarking, integration and support

Are you able to compare your scope of practice in this role with that of your peers? For example:

Do you receive organisationally generated data on your activity which compares you to your peers? Do you meet regularly with your peers to discuss your work, e.g. multidisciplinary team meetings? Do you have easy access to support and advice from your peers (either through work or externally)?

Personal approach to risk and governance around your private practice

How do you limit the impact of your private practice / medico-legal on any risk to your patients (e.g. How do ensure that continuity of care is provided if you have an unforeseen absence?, how you access diagnostic testing?)

Do you regularly ask for patient feedback that is undertaken by an independent body and can you provide examples/statistics?

What arrangements do you have in place to stay within the boundaries of your competence? (e.g. when a patient presents with a condition that is beyond the scope of your private practice services what processes do you follow, onward referrals etc?)

If you move around, what actions do you take to ensure you have access to adequate induction and systems information?

How do you ensure you are informed promptly of complaints and any other patient safety incidents? And, how do you report these to the organisations you work in?

Continuous Professional Development (CPD)

Please describe how your approach to CPD helps to ensure you are up to date for your scope of practice.

Does your CPD give you an ongoing exposure to the breadth of your potential workload such as to mitigate any reduction in experience?



**Southern Health
and Social Care Trust**

Quality Care - for you, with you

Do you access any other learning through groups or social media discussion forums?
Do you rely predominantly on advice from peers on site?

Are you able to confidently access up to date, authoritative factual information about issues relevant to your scope of practice?

Actions

Going forward are there any further actions you feel may be necessary to ensure you retain your competencies across your scope of practice and support your development?

You may wish to formulate these as ideas for a Personal Development Plan or as actions to take forward with your employers in relation to the governance around your role

Feedback after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)



COMMITTEE REPORT SUMMARY SHEET

Meeting:	Governance Committee
Date:	11 th February 2021
Title:	Clinical and Social Care Governance Report
Lead Director:	Dr Maria O'Kane, Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	Information
<u>Overview:</u> The purpose of this paper to provide a report to Governance Committee (February 2021) on a number of Trust Clinical and Social Care Governance Indicators. This report provides information on Incident Reporting, SAI, Catastrophic Incidents, Patient Safety and Quality Measures, Complaints and Ombudsman cases.	
<u>Outcomes from SMT Discussions:</u> • Discussion regarding the number of outstanding adverse incidents requiring review • Discussion on the future use of the HCAT tool to drive quality improvement • Discussion on the detail provided on Moderate and Major incidents • Discussion of early alerts and the volume attributed to OPPC (GP Out of Hours Cover)	
<u>Key areas for Committee consideration:</u> • In general the pandemic has resulted in a more unstable reporting picture with more variation than previously observed." Incident reporting has returned to pre-pandemic rates after significant decline in wave 1 Increase in the number of Incidents reported during October – December with a Moderate and Major Severity • Number of Incidents that have not been categorised continues to increase • 63 out of the 85 open SAI's remain outside of the HSCB Timescales • The number of unapproved Incidents continues to rise- 21.8% of unapproved incidents are >1 year old • Slight drop in the number of Formal Complaints • Based on the data there has been no significant change in crash call rates • NEWS compliance whilst not reaching the target has shown significant improvement of 2 of the 3 months of the reporting period where two upper limit breaches have occurred • There has been no significant change in the falls rate however there have significant improvement in compliance in Falls Bundle B with two upper confidence limit breaches .	
<u>Human Rights/Equality:</u> None to declare	

Clinical and Social Care Governance Report February 2021



Contents

1.0 Purpose of Report.....	4
2.0 Incident Reporting.....	5
3.0 Patient Safety Indicators.....	23
4.0 Service User Feedback (Complaints).....	28
5.0 Service User Feedback (Compliments).....	34
Appendix 1.0 Healthcare Complaints Analysis Tool	

1.0 Purpose of Report

This report is to provide information to Trust Governance Committee regarding the Clinical and Social Care Governance 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 **01 October – 31 December 2020 (Quarter 3)**, with the exception of Patient Safety & Quality measures which are for the previous qtr. **(Jul – Sept 2020, Quarter 2)**. 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 future occurrence.

To set the wider context, this quarterly reporting period – **01/10/2020 – 30/12/2020** reports on Clinical and Social Care Governance indicators during the Corona Virus pandemic period.

2.0. Incident Reporting (via Datix)¹

2.1 Total No. Incidents Logged via Datix

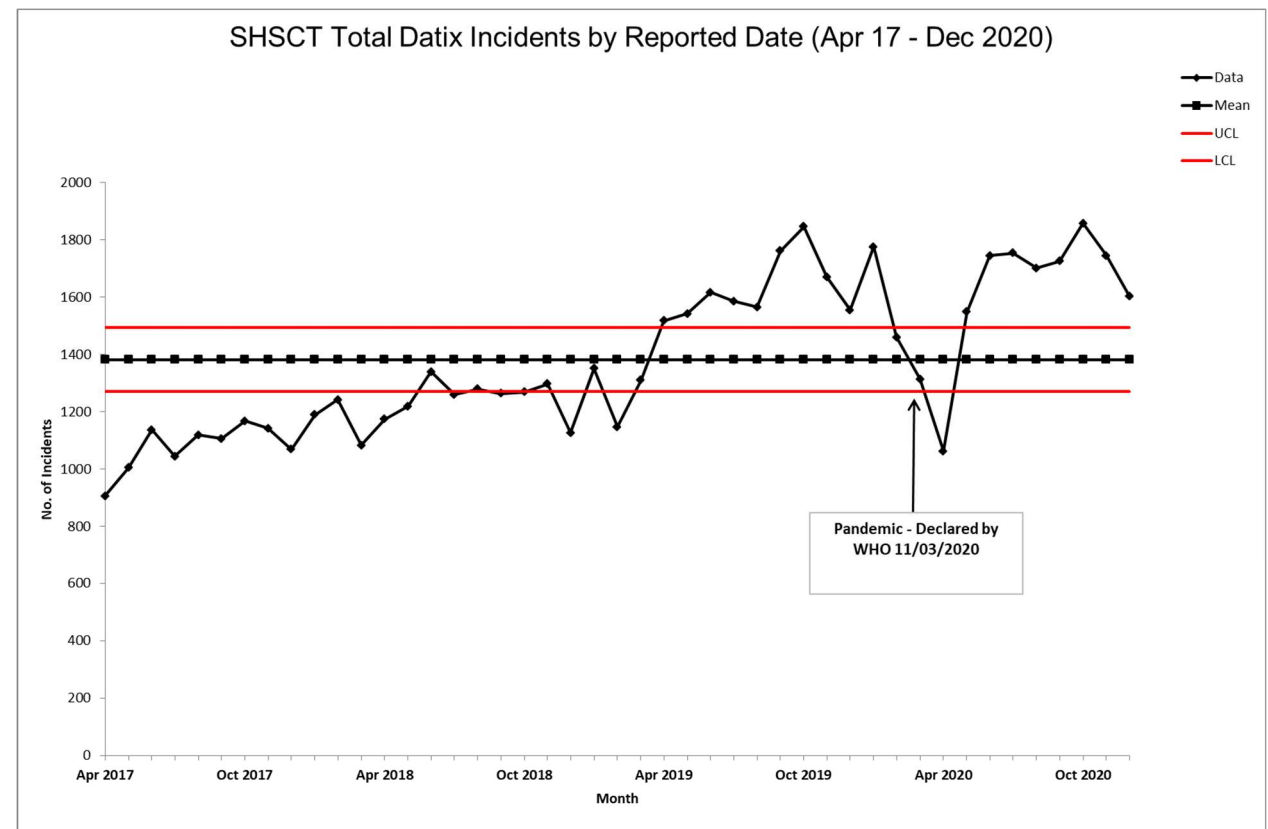
Overall Trust Position

In Q3 2020 - SHSCT directorates reported:

- 5207 IR1 incidents
- Proj. 2020/21 – **19,657 ↑2.3%**
- 2019/2020, **19,207** IR1 incidents **↑28%**
- 2018/2019, **15,043** IR1 incidents **↑14%**
- 2017/2018, **13,219** IR1 incidents

Incident reporting dropped significantly at the beginning of the Covid 19 Pandemic. Incident reporting has continued to remain above the UCL since May 2020, with a peak in November 2020.

Fig 1.0 – Total SHSCT Incidents by Month 01 April 2017 – 31 December 2020.



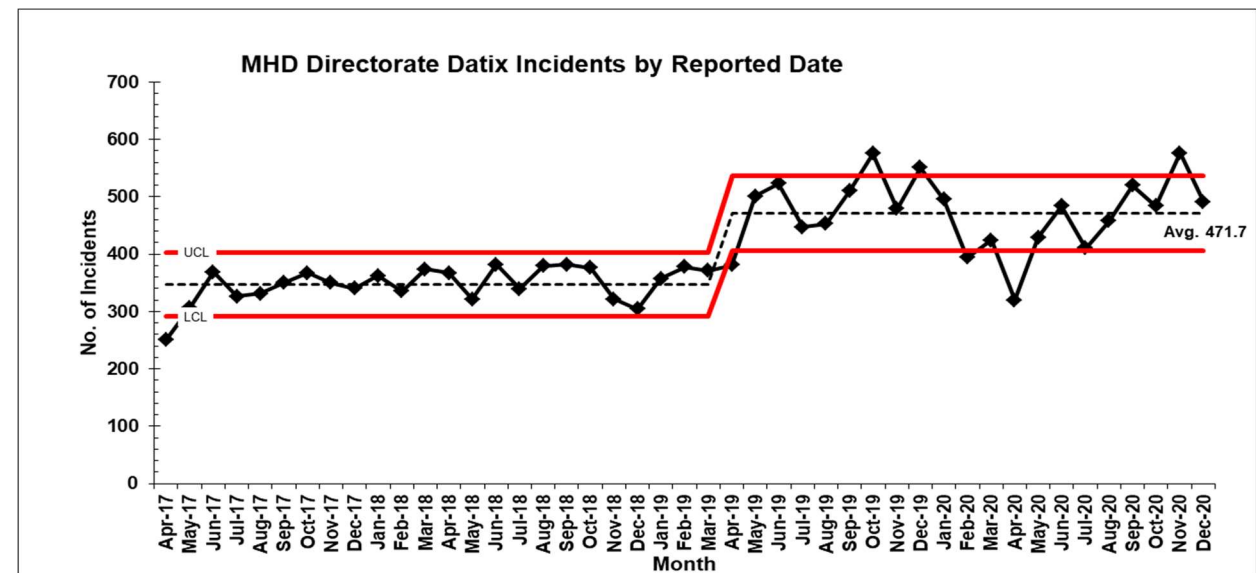
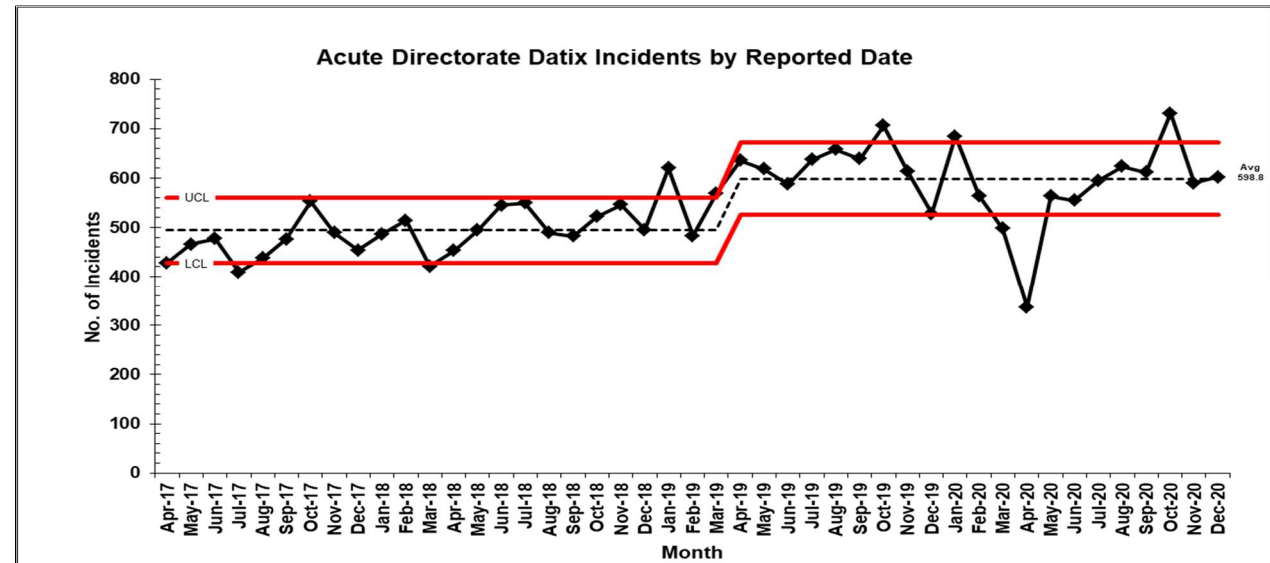
¹ Monthly incidents are now reported on the basis of the date on which the incident was reported via Datix and not the date that the incident occurred.

Fig 2.0 Operational Directorate Monthly Datix Incidents 01 April 2017 – 31 Dec 2020.

In Fig 2.0 the control charts average position has been re-set from April 19 to reflect the shift in reporting that occurred from that time point shown in Fig 1.0 above.

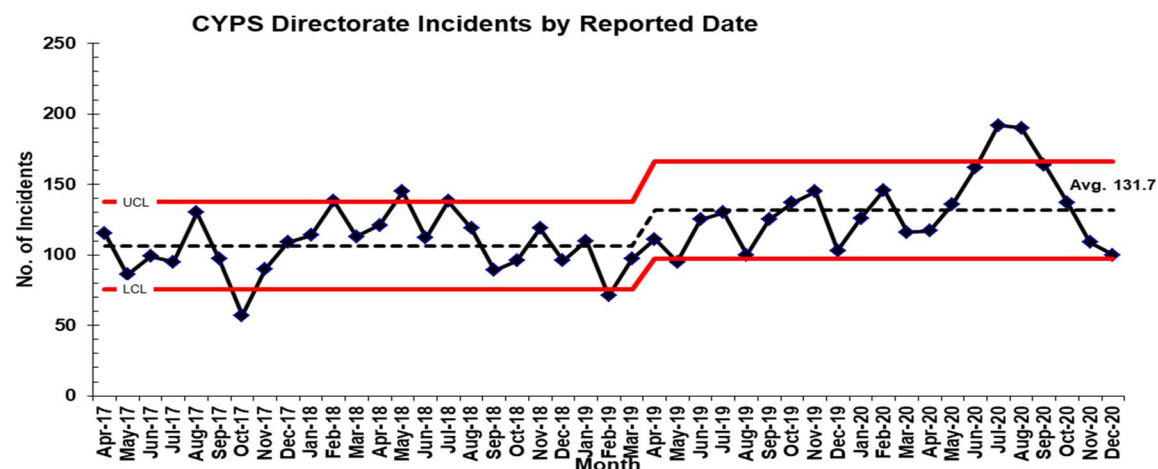
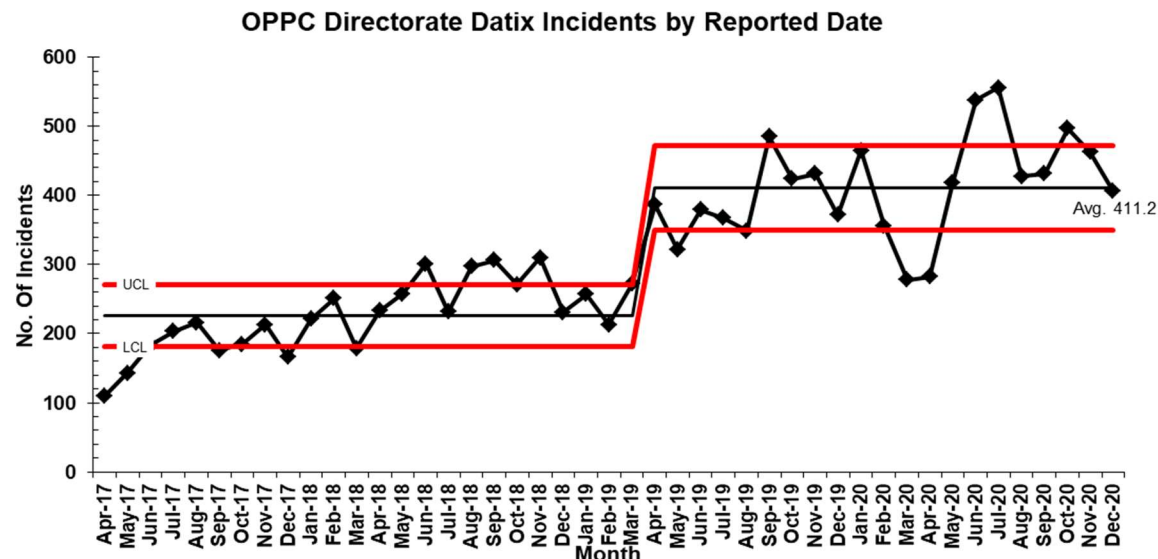
Directorate Position

- Acute 1923 Reported Incidents Compared to 1829 last quarter. One upper confidence limit breach occurred in October indicating a significant increase in incidents reported.
- MHD 1551 Reported Incidents Compared to 1388 last quarter. Cumulative increase mainly in 3 wards within Bluestone Unit linked. One upper confidence limit breach occurred in November indicating a significant increase in incidents reported.



- OPPC - 1366 reported incidents quarter ending September 2020, compared with 1415 reported incidents this quarter December 2020. Incident numbers remain consistent between both quarters.

- CYPS 346 Reported Incidents compared to 546 last quarter. The return to normal levels of reported incidents relates to decreased incidents in residential care due a change in arrangements for a number of high risk young people, eg. Moving to secure accommodation. There was also a decrease in reporting from the Paediatric Service and CAMHS.



2.2 Incident Severity²**Q3 2020/2021 (Oct - Dec 2020)**

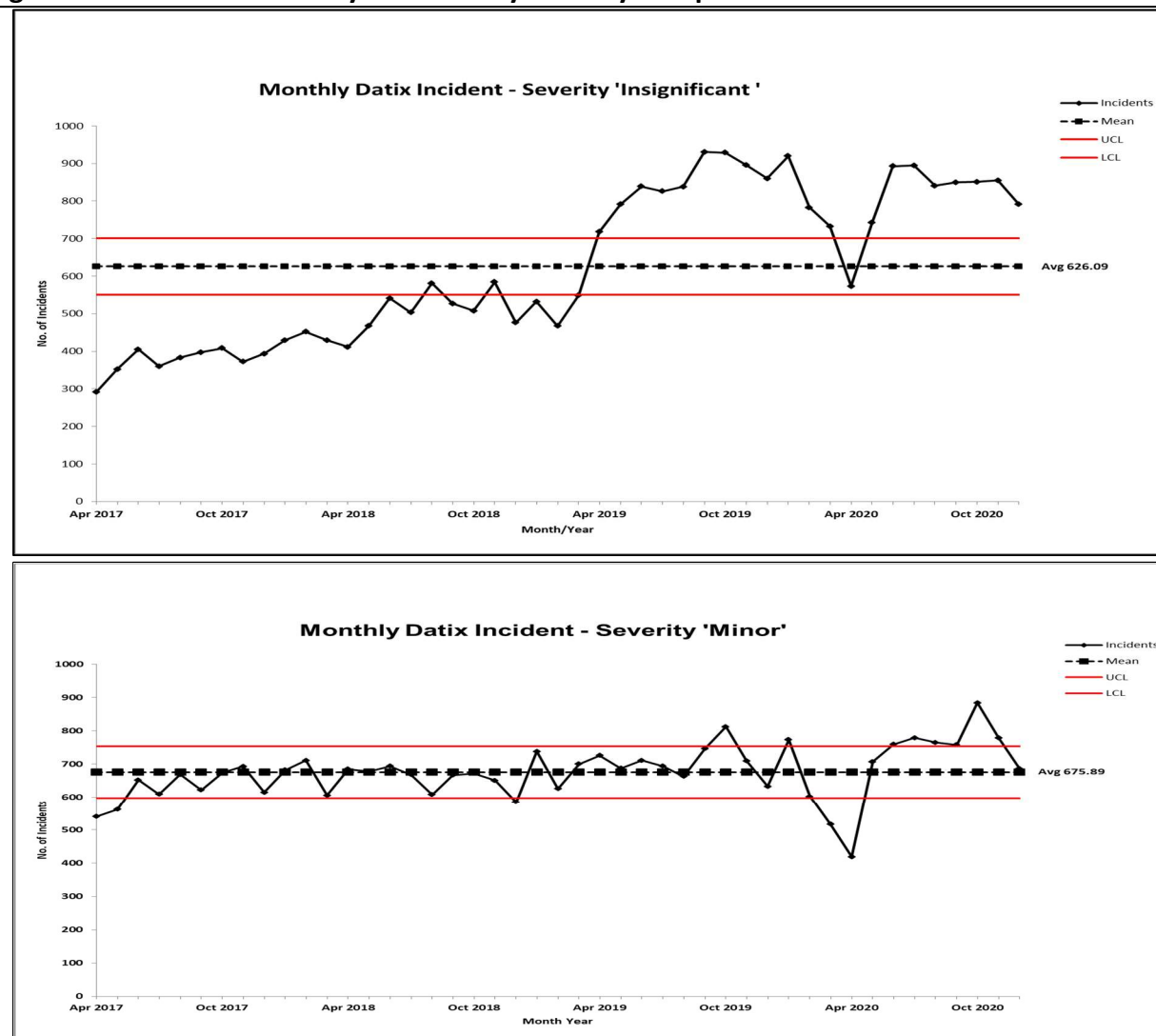
48% of SHSCT IR1 Incidents categorised as severity 'Insignificant'

In 19/20 the reporting of insignificant incidents rose significantly to **52.5%** of all incidents, compared to **41%** in 18/19. The projection for 20/21 is **49%**.

Increased reporting of lower severity incidents reflects a positive culture of reporting. Such a culture contributes to learning, helps to prevent re-occurrence, reducing avoidable harm and increasing safety and quality.

45% of SHSCT IR1 Incidents categorised as severity 'Minor'

Minor incidents have shown more significant variation of late. With several episodes of special cause variation. There was a particular peak in October 2020, including incidents relating to staff shortages due to COVID-19.

Fig 3.0 - Total SHSCT Monthly Incidents by Severity 01 April 2017 – 31 December 2020

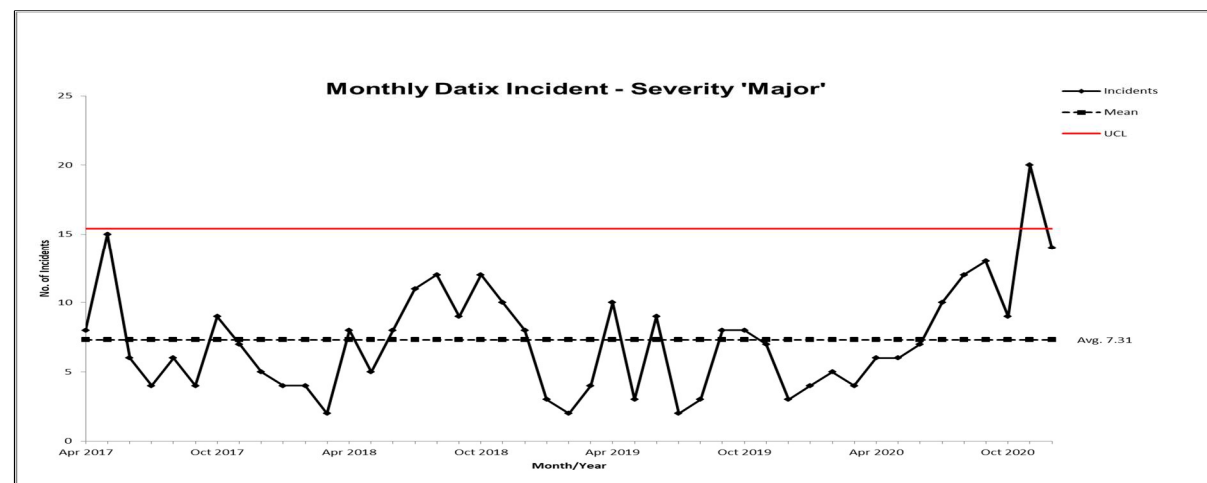
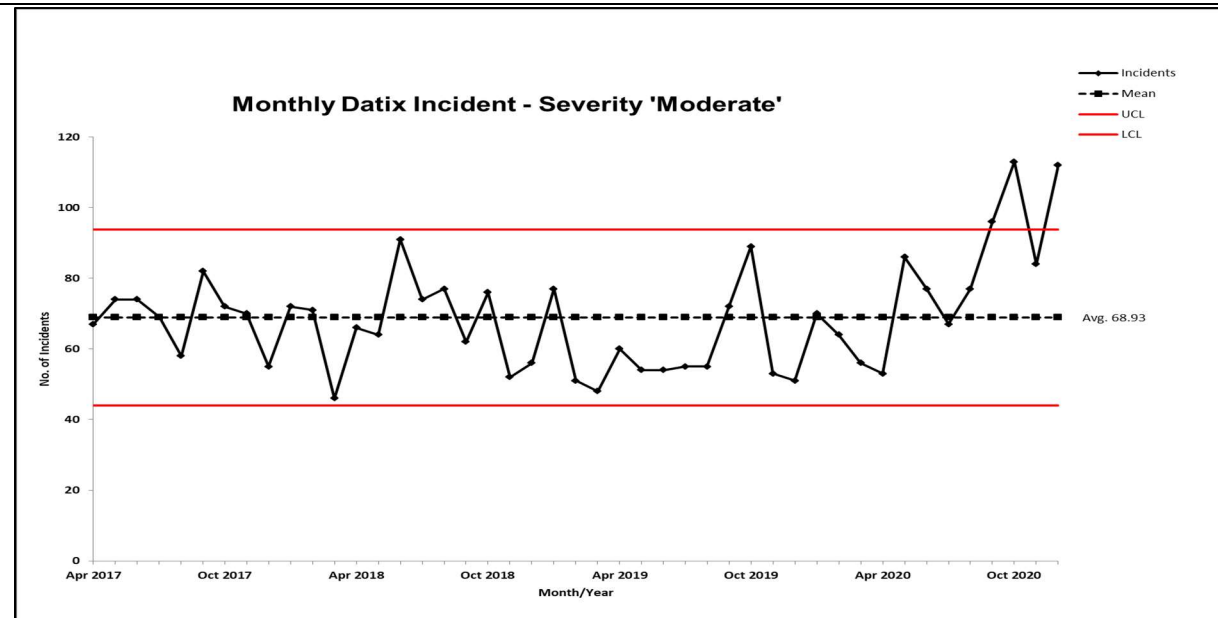
² Includes incident Severity for 'unapproved incidents' (2021) which could be subject to change on final approval of the incident

6% of SHSCT IR1 Incidents categorised as severity 'Moderate'

Previously there had been no significant change (outside of control limits) in incidents of a moderate severity since April 2017. In September 2020 and December 2020 there was a significant increase in Moderate incident reporting, this correlates to fluctuations in COVID-19 environmental exposure incidents (October 43 incidents, November 15 incidents and December 26 incidents)

0.8% of SHSCT IR1 Incidents categorised as severity 'Major'

Numbers of major incidents remain low. There had been no significant changes (outside control limits) since May 2017. November experienced an increase in major severity incidents, (n-20, Behaviour 1, Communication 1, Diagnostic Processes 2, Medical Gases/Oxygen 1, Medication 2 Therapeutic Processes1 and 12 yet to be coded.

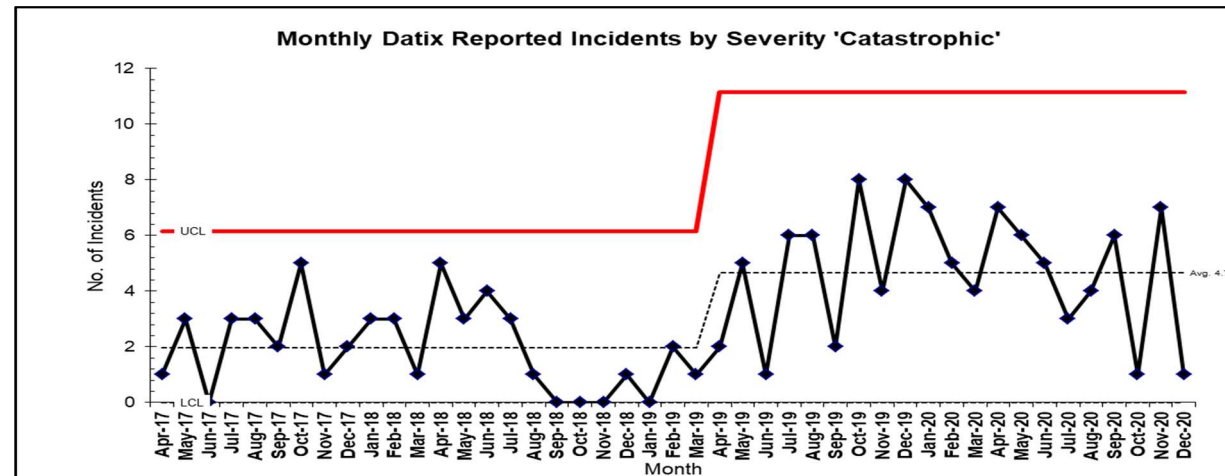


0.17% of SHSCT IR1 Incidents categorised as severity 'catastrophic'

Numbers of catastrophic incidents remain low. Overall there was a significant increase in catastrophic incidents from April 2019 and this has been maintained

Table 1.0 provides the breakdown of all SHSCT catastrophic incidents by Directorate since Oct 2019.

Table 1.1 details overall proportion of incidents in each severity category year on year.



Directorate/Catastrophic Incidents	Oct - Dec 19	Jan - Mar 20	Apr - Jun 20	July - Sept 20	Oct - Dec 20
Acute Services	5	3	4	3	3
CYPS	4	2	0	1	0
MHD	9	5	11	8	6
OPPC	0	0	2	1	0
Grand Total	18	10	17	13	9

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%
% Proj. Q3 20/21	49.38%	44.12%	5.49%	0.67%	0.26%

Table 1.2 Details Total Trust Incidents by year, by severity Increases in catastrophic, major and moderate based on current Q3 projections to year end.	FY	Minor	Moderate	Major	Catastrophic	Unallocated	Grand Total
	2017/18	7634	810	75	27	2	13219
	2018/19	7967	801	92	20	18	15043
	2019/20	8245	743	68	58	13	19207
	Proj. 20/21	8672	1080	132	52	14	19656

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

Between 01 October 31st December 2020 – 9 catastrophic incidents (0.17%) were recorded. 7 of these incidents have also been notified to the HSCB as SAI's. In addition a further 13 SAI's were also reported to the HSCB and are set out in Table 4.0 below.

Summary: Total Number 22

Catastrophic Incident occurred during period, not SAI – 2

Catastrophic Incident occurred during period and reported as an SAI between 01/10/2020 – 31/12/2020 – 6

Catastrophic Incident occurred during period and reported as an SAI outside reporting period - 1

Other Incidents reported as SAI's – 13 (1 minor 8 moderate and 4 major).

Table 2.0 – Catastrophic Incidents and / or SAI's notified to the HSCB 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
121707	24/07/2020	13/10/2020	Delay in screening.	Delay in recognition of deteriorating patient	Acute	Minor	Yes	No immediate learning.

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 by USI	25/07/2019	29/10/2020	Delay in screening.	Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.	Acute	Moderate	Yes	No immediate learning.
	18/04/2019	29/10/2020	Delay in screening.	Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.	Acute	Moderate	Yes	No immediate learning.
	20/08/2019	12/11/2020	Delay in screening.	Diagnosed with high grade prostate cancer July 2019. MDM outcome to commence an LHRHa, arrange a CT Chest and bone scan and for subsequent MDM review.' MDM recommendations not followed. Patient now deceased.	Acute	Major	Yes	Patient started on appropriate treatment at the time this was identified.
	16/11/2020	31/12/2020	Case discussed at M&M initially	Family has raised serious concerns in relation to the rationale for surgical intervention and subsequent transfer from the ICU to the ward.	Acute	Catastrophic	Yes	No immediate learning.
	16/06/2020	13/11/2020	Delay in screening.	2019 Audit of cervical screening has revealed an error with patients	Acute	Moderate	Yes	No immediate learning.

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 by USI				cervical smear result. Initial report reported a negative result. On review there was scanty high grade dyskaryosis identified.				
	17/07/2018	19/11/2020	Initially an internal investigation which was subsequently upgraded to Level 1.	Patient had CT renal performed March 2018. CT renal reported suspected renal cancer. There was a delay in the follow up process for cancer care management	Acute	Moderate	Yes	Once identified , patient contacted and appointment made to attend outpatients.
	28/01/2020	28/10/2020	Delay in screening.	Patient was brought in by ambulance from Downpatrick to Daisy Hill Hospital Emergency Department. At triage patient denied any suicidal ideation. Following discussion with NIAS it was noted patient had absconded. Absconding policy was implemented; the patient was brought by the PSNI back to DHH ED. The patient had a self-inflicted stab wound to his abdomen with the knife still insitu and was in severe pain.	Acute	Moderate	Yes	No immediate learning.
	06/10/2020	20/10/2020	Delay in screening.	Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined	Acute	Moderate	Yes	No immediate learning.

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 by USI				investigations. On maximum androgen blockade - No onward oncology referral was made.				
	26/06/2020	13/11/2020	Delay in screening.	Audit of 2019 cervical screening invasive cancer audit, has revealed, on review, smear, which was reported as negative, to have glandular dyskaryosis present.	Acute	Major	Yes	No immediate learning.
	16/06/2020	13/11/2020	Delay in screening.	Audit of 2019 invasive cancer has revealed smear, 51721470, reported as negative. On review, there is scanty high grade dyskaryosis.	Acute	Moderate	Yes	No immediate learning.
	15/09/2020	24/11/2020	Delay in screening.	Planned admission for laparotomy for end colostomy on 15/09/2020. Following laparotomy the patient deteriorated on the ward, it was noted there was no stoma output.	Acute	Major	Yes	Patient returned to theatre.
	27/08/2020	n/a	n/a	Patient had h/o MRSA dating back to 2018. On transfer to ward 1 south MRSA decolonisation procedure not followed up. Poor iv access. In emergency setting right arm was used to facilitate IV access. Patient eventually developed thrombophlebitis/cellulitis in right	Acute	Catastrophic	No	No immediate learning.

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 by USI				arm. Patient had positive blood cultures for MRSA bacteremia. Further MRSA positive blood cultures. Patient was undergoing treatment for this infection as well as suspected T12 osteomyelitis when she deteriorated and passed away.				
	07/11/2020	06/01/2021	Delay in screening.	Patient admitted with severe Covid pneumonia. Pt had an unwitnessed fall in the bathroom. A CT brain scan showed a traumatic subarachnoid haemorrhage. The patient was discussed with neurosurgery but was not for intervention. Patient died peacefully	Acute	Catastrophic	Yes	No immediate learning.
	26/10/2020	12/11/2020	Information gathering.	Safeguarding incident involving an inpatient in the Dorsy Unit	MHD	Moderate	Yes	No immediate learning.
	08/11/2020	17/11/2020	Information gathering.	Suspected suicide of a service user in the community.	MHD	Catastrophic	Yes	No immediate learning.
	02/11/2020	05/11/2020	N/A	Suspected suicide of a service user in the community.	MHD	Catastrophic	Yes	No immediate learning.

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 by USI	03/11/2020	26/11/2020	Information gathering.	Suspected suicide of a service user in the community.	MHD	Catastrophic	Yes	No immediate learning.
	29/10/2020	16/11/2020	Information gathering.	Suspected suicide of a service user in the community.	MHD	Catastrophic	Yes	No immediate learning.
	28/12/2020	07/01/2021	Establishing possible cause with coroner	Unexpected/unexplained death of a service user in the Bluestone Unit.	MHD	Catastrophic	Yes	No immediate learning.
	19/10/2020	N/A	n/a	Service user passed away following fire at own home.	MHD	Catastrophic	No	No immediate learning.
	17/11/2020	30/11/2020	Delay in notification to HSCB due to consideration of whether this met the criteria for SAI notification.	16 year old Looked After Child, who resides in a Trust residential facility. Young person had swallowed three razor blades from a razor. Pt underwent emergency keyhole surgery to remove the blades.	CYPS	Major	Yes	No immediate learning.

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 upon³.

³ Screening process as at Jan 2020.

2.3 Incidents Classification⁴

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 summarise:

- ❖ Total incidents (across all directorates) for the period Oct - December 2020, by who was involved.
- ❖ Trust Top 10 categories
- ❖ **23% incidents – uncategorised at the time of reporting.**

Table 3.0 - Who was involved

Incident Involved	Q3 20/21 No. of Incidents	% Total	Q2 20/21	% Total	Q1 20/21	% Total	Q4 19/20	% Total	Q3 19/20	% Total
Patient & Service User	2855	55	3116	60	2699	62	2542	62	2641	58
Staff	936	18	723	14	754	17	635	16	702	15
Public / Visitors	26	0	25	0	23	1	32	1	46	1
Organisational	182	3	143	3	142	3	153	4	145	3
Uncategorised	1208	23	1172	23	737	17	732	18	1022	22
Total	5207		5179		4355		4094		4556	

Table 4.0.

Categorised incidents cover 68% of the 5207 incidents, excluding 'uncategorised' and 'other'.

SHSCT 'Top 10' By Incident Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Uncategorised at time of Reporting	646	424	114	22	4	1210↑
Behaviour (Including Violence and Aggression)	808	556	25	1	2	1392↓
All Accidents/Falls (Patient, staff and Public)	505	374	15	3	1	898↑
Medication/Biologics/Fluids	179	188	30	5	0	402↑
Exposure to Environmental Hazards	83	203	84	2	0	372↑
Pressure Ulcers	30	187	9	0	0	226↓
Other	46	64	6	1	1	118↑
Service Disruptions (environment, infrastructure,	32	57	2	0	0	91↑
Communication	24	42	3	2	0	71↓
Diagnostic Processes/Procedures	24	37	3	2	0	66↓
Other Categories outside Top 10	120	217	18	5	1	361↓
Grand Total	2497	2349	309	43	9	5207

In this quarter the number of Uncategorised incidents has risen as well as the Incidents categorized as Exposure to Environmental Hazards.

Tables 5.0 – 8.0 provide a further drill down listing the top 10, by involvement, category and severity⁵.

Table 5.0. Incidents involving Service Users - 54%. Falls and pressure ulcers are key patient safety areas further reported in section 3.0. 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.

⁴ 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.

⁵ 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.

Q3 Oct	Dec Patient/Service User Incidents by Category	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
	Behaviour	558	332	20	1	2	913↓
	Patient Accidents/Falls	462	306	12	3	1	784↑
	Medication/Biologics/Fluids	175	173	29	5		382↓
	Pressure Ulcers	30	187	9			226↓
	Other	46	64	6	1	1	118↓
	Communication	24	42	3	2		71↓
	Diagnostic Processes/Procedures	24	37	3	2		66↓
	Maternity Care	4	44	7	1		56↓
	Medical Devices, Equipment, Supplies	7	18	2			27↑
	Documentation	11	15				26↓
	Other Categories outside Top 10	56	117	8	4	1	186
	Grand Total	1397	1335	99	19	5	2855

Table 6.0. Incidents involving Staff – 17%

Q3 Oct	Dec 2020 Staff Incidents by Category	Insignificant	Minor	Major	Moderate	Grand Total
	Behaviour (Including Violence and Aggression)	241	219		5	465↓
	Exposure to Environmental Hazards	73	188	1	82	344↑
	Accidents/Falls	41	63		3	107↑
	Property	8	12			20↑
	Grand Total	363	482	1	90	936

Table 7.0. Incidents at an Organisational Level – 3.49%.

Q3 Oct	Dec 2020 Organisational Incidents by Category	Insignificant	Minor	Moderate	Major	Grand Total
	Service Disruptions (environment, infrastructure, human resources)	32	57	2		91
	Fires, Fire Alarms and Fire Procedures	36	9			45
	Medication/Biologics/Fluids	4	15	1		20
	Security of Organisation's Property, Data and Buildings	6	9	3		18
	IT Systems	1	6		1	8
	Grand Total	79	96	6	1	182

Table 8.0. Incidents involving the public – 0.49%

Q3 Oct	Dec 2020 Organisational Incidents by Category	Insignificant	Minor	Grand Total
	Behaviour	9	5	14
	Accidents/Falls	2	5	7
	Exposure to Environmental Hazards	2	1	3
	Property	1	1	2
	Grand Total	14	12	26

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 1392 recorded incidents of Behaviour / Abuse by Severity.

Table 9.0⁶

Person Affected - Patient/Service User	Severity					
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Catastrophic	Grand Total
Self-harming Behaviour	176	87	4	1	2	270
Missing Patient (absconded/abducted patient)	105	91	4			200
Patient Behaviour that challenges	120	60	5			185
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	98	44	2			144
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	29	38	4			71
Use/Possession of Prohibited/Stolen Goods	12	3	1			16
Patient refusal of diagnostic/therapeutic recommendations/interventions	6	7				13
Inappropriate/Aggressive Behaviour towards a Patient by Staff	6	2				8
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	5					5
Persons Performing Unauthorised Acts	1					1

Table 10.0 & 11.0

Person Affected - Staff Member	Severity				
Type of Behaviour/Abuse	Insignificant	Minor	Moderate	Major	Grand Total
Inappropriate/Aggressive Behaviour towards Staff by a Patient	226	207	5		438
Other	11	8			19
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	1	2			3
Use/Possession of Prohibited/Stolen Goods	1	1			2
Inappropriate/Aggressive Behaviour towards Staff by Staff	1	1			2
Persons Performing Unauthorised Acts	1				1

Person Affected - Visitor	Severity		
Type of Behaviour/Abuse	Insignificant	Minor	Grand Total
Other	7	4	11
Inappropriate/Aggressive Behaviour towards a Visitor by a Visitor	2	1	3

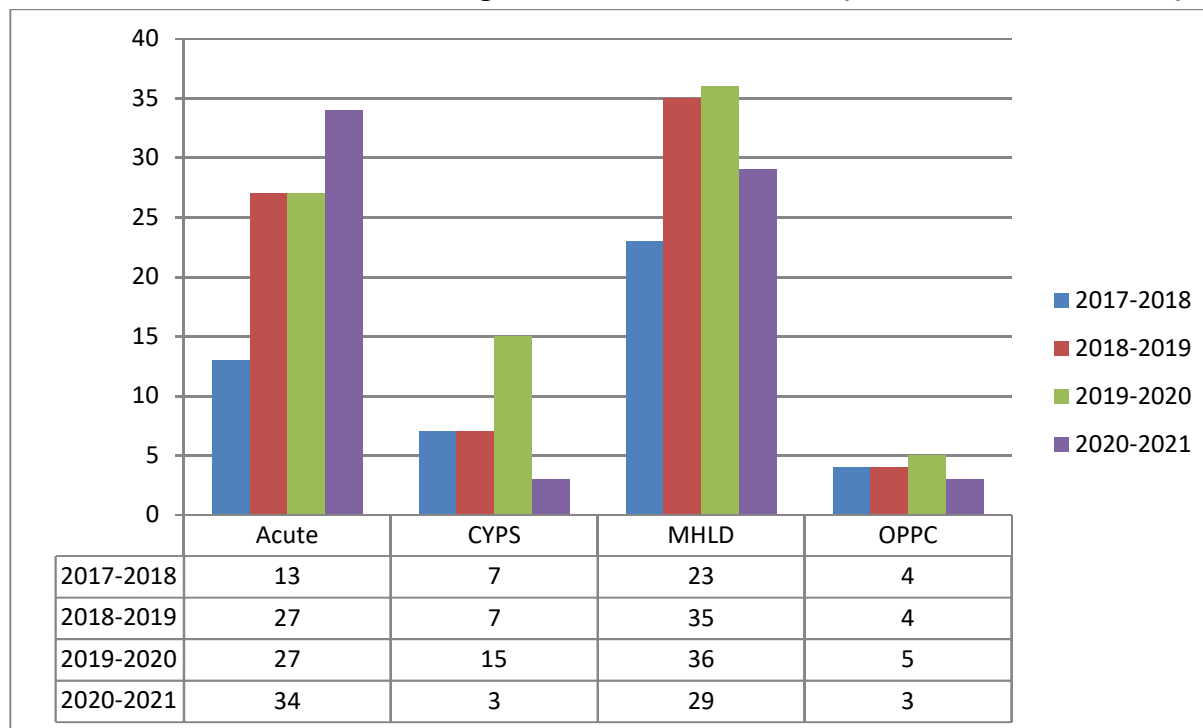
2.5 Incidents of / or attempted absconding and Absent Without Leave (AWOL)

Table 12.0 below provides a further breakdown, by category, directorate and severity of the 200 recorded incidents of missing or absconded or AWOL patients or service users.

Missing Patient Sub Category	Insignificant	Minor	Moderate	Grand Total
Absconded/left without informing staff	76	78	4	158
Attempted to abscond/leave without informing staff	25	10		35
AWOL / Absconded (detained patients only)	2	1		3
Failed to return from authorized leave	1	1		2
Left with notice contrary to advice	1	1		2
Grand Total	105	91	4	200

⁶ 8 reported incidents of inappropriate behaviour by staff to patients further analysed, 5 incorrectly coded, 1 verbal assault, 1 safeguarding and PSNI investigation and 1 allegation.

2.6 Serious Adverse Incident Investigations submitted to HSCB (YTD 31st December 2021)



2.7 Trust Performance against Regionally Agreed Timescales

Timescales for the completion of Serious Adverse Incidents are set out by HSCB:

- ❖ Level 1 - 8 weeks
- ❖ Level 2 - 12 weeks
- ❖ Level 3 – timescales are agreed between the reporting organisation and the HSCB/PHA DRO

Table 14.0

	In Times	Outside Times	Total
Acute	13	14	27
CYP	2	6	8
MHD	7	38	45
OPPC	0	5	5
On Hold	n/a	n/a	1
Total	22	63	86
%	26	74	

SHSCT currently have:

86 SAI investigations in progress⁷. 1 of which have been paused due to ongoing investigations by external bodies (Safeguarding Board Northern Ireland and PSNI)

22 SAI investigations (26%)⁸ remain within the HSCB timescales for submission.

There are a number of contributory factors which influence the compliance of completion of SAI reports within the timescales identified in the HSCB Serious Adverse Incident Procedures.

- ❖ Appropriate team configuration to ensure appropriate level of clinical independence and expertise.

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 26% in the previous quarter.

Clinical and Social Care Governance Report – February 2021

- ❖ 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

Table 15.0 sets out the detailed position on the progress of the 87 SAI investigations currently on-going as at 26/01/2021 (1 SAI investigation currently paused).

SAI Level	ACUTE			CYPS			MHD			OPPC		
	Within HSCB Timescales	Outside HSCB Timescales week 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB Timescales weeks 26 <	Within HSCB Timescales	Outside HSCB Timescales weeks 26 >	Outside HSCB Timescales weeks 26 <
Level 1	2	1	7	2	1	2	0	4	7	0	3	1
Level 2	1	1	5	0	2	1	3	12	15	0	0	1
Level 3	10	0	0	0	0	0	4	0	0	0	0	0

2.8 Approval Status of Incidents⁹

Figs 5.0 & 6.0 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.

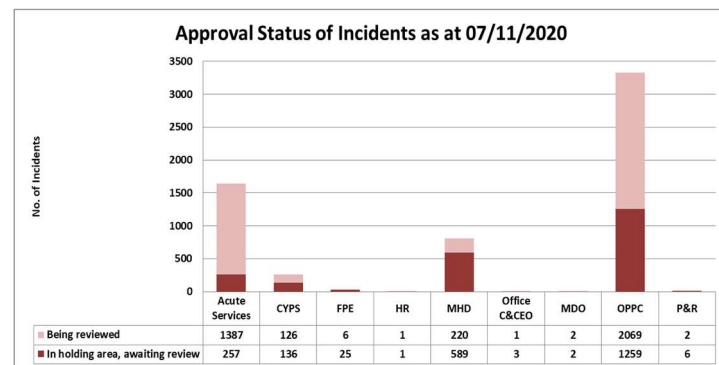
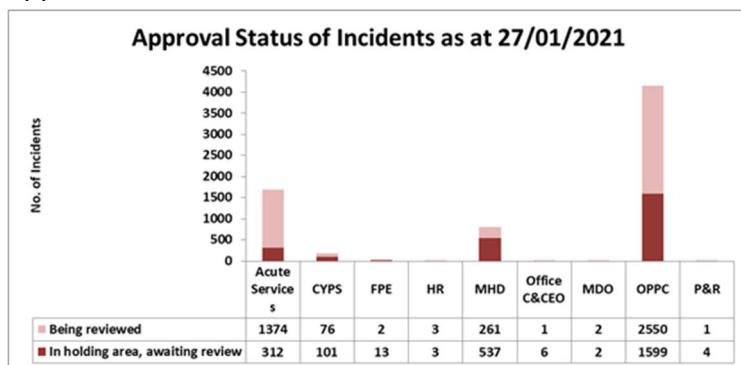


Fig. 7.0 Details the retrospective time frame for unapproved incidents.

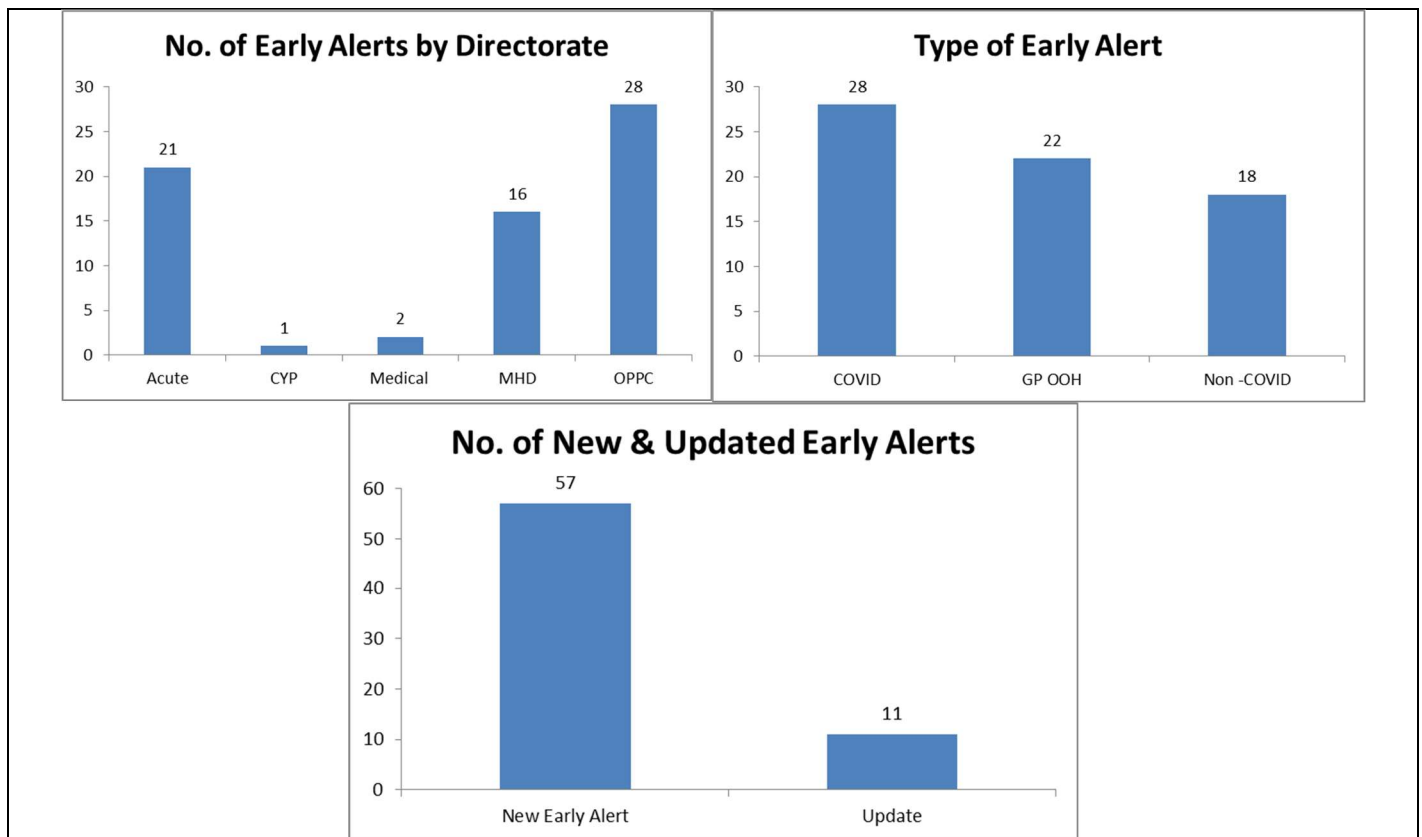
⁹ Approval status reporting is for all unapproved incidents (6089 @ 07/11/2020 5107 @ 14/08/2020, 4486 @ 27/04/202, 4532 @ 21/01/20, 4348 @ 15/11/19, 5107 @ 14/09/2020) on Datix Web pre governance committee report.

Clinical and Social Care Governance Report – February 2021

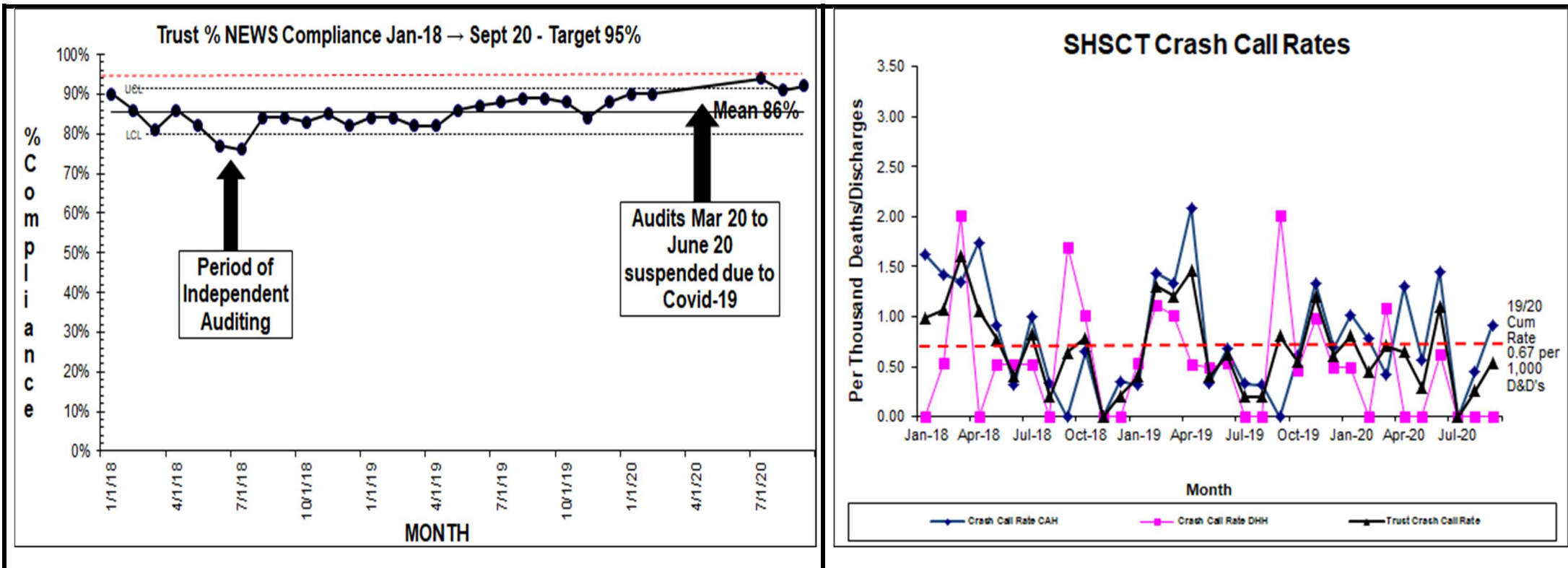
	2010	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Acute Services	1	0	0	2	3	11	36	198	1070	357	1678
Children and Young Peoples Services	0	0	0	0	0	0	21	26	103	30	180
Finance Procurement & Estates	0	0	0	0	0	0	1	1	12	1	15
Human Resources and Organisational Development	0	0	0	0	0	0	0	0	2	4	6
Mental Health and Disability	0	0	0	5	10	22	40	80	512	127	796
Office of the Chair and Chief Executive	0	0	1	0	0	0	0	0	6	0	7
Office of the Medical Director	0	0	0	0	0	0	0	3	1	0	4
Older People and Primary Care	0	0	0	0	17	42	171	797	2985	122	4134
Performance and Reform	0	1	0	0	0	0	1	0	3	0	5
Total	1	1	1	7	30	75	270	1105	4694	641	6825

2.9 Early Alerts Submitted by the Southern Health and Social Care Trust

Between 01st October 2020 – 31st December 2020 there has been 68 Early Alerts submitted to the DoH and the HSCB. These Early Alerts are either new alerts that the SHSCT would like to bring to the DoH's attention or an update on previously submitted Early Alerts. **Figure 8** below is a breakdown of the Early Alerts.



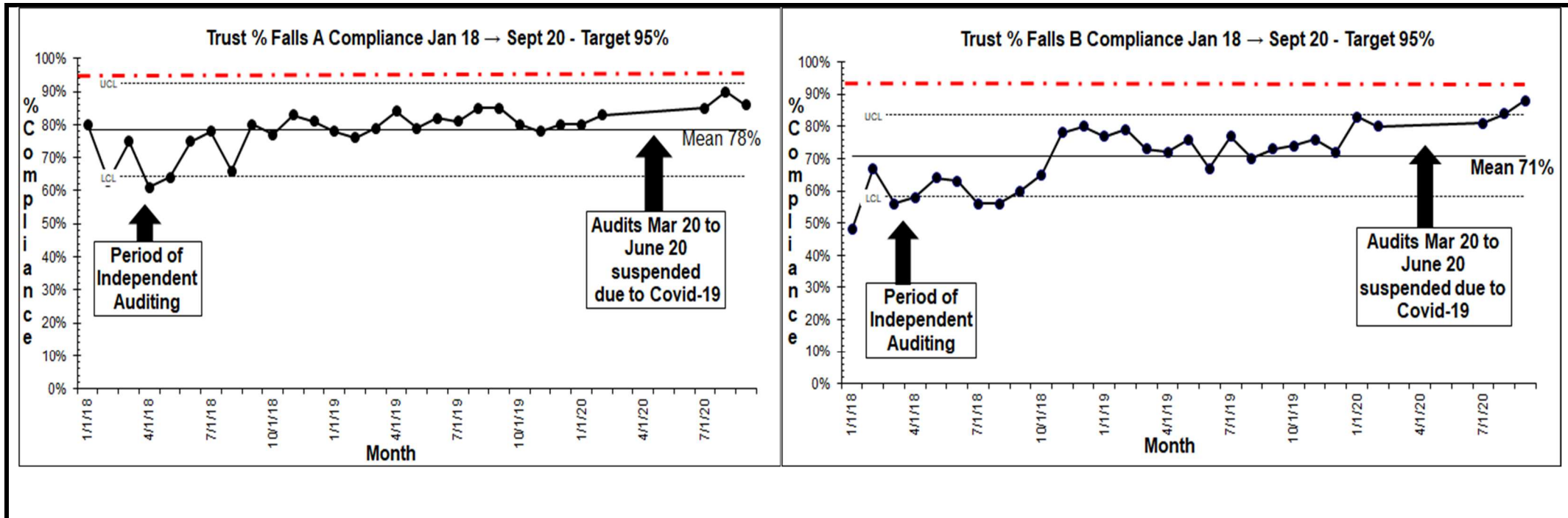
3.0 Patient Safety Measures Data – Quarter 2 July → Sept 2020

3.1. NEWS & Crash Calls¹⁰

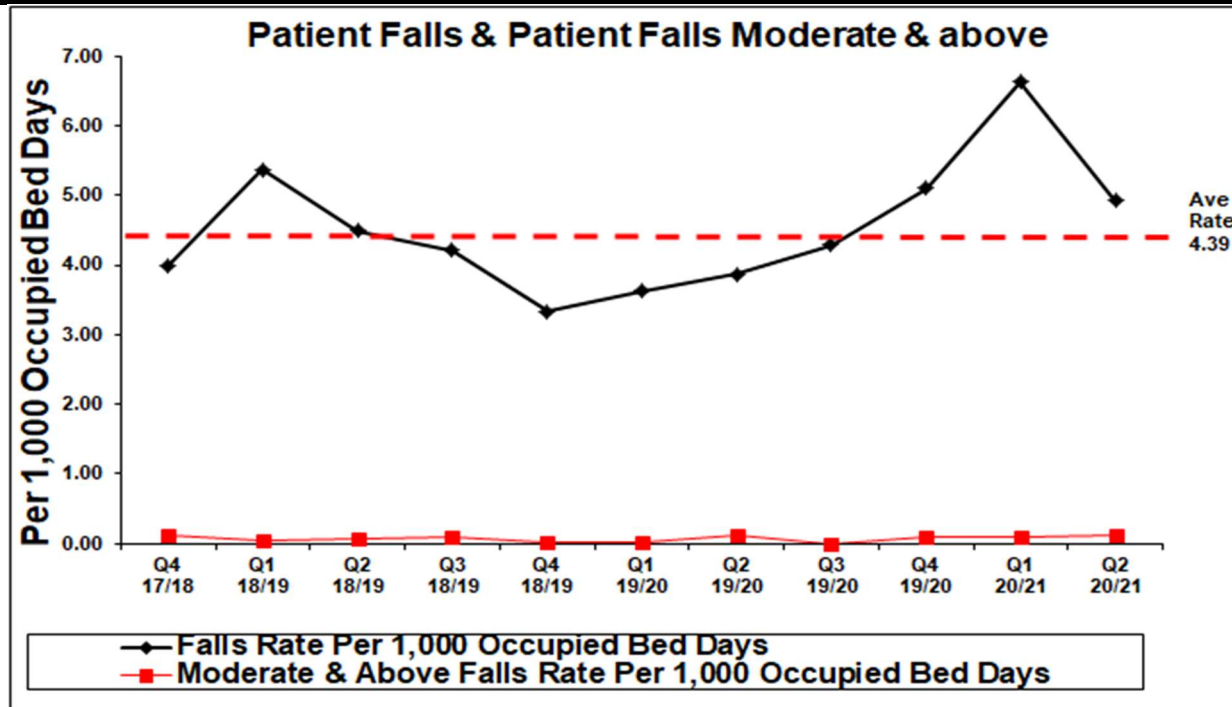
- NEWS – Q1 20/21 (Apr 20 → June 20) Audit was suspended by PHA due to Covid 19
- NEWS Compliance Q2 20/21 (July 20 → Sept 20) was **93%**
- Trust Crash Call Rate for 19/20 was **0.67** per 1,000 Deaths & Discharges (**39** Crash Calls) compared to **0.68** per 1,000 Deaths & Discharges (**38** Crash Calls) in 18/19
- Trust Crash Call Rate for 20/21 stands at **0.46** per 1,000 Deaths & Discharges (**10** Crash Calls)
- Based on the data there has been no significant change in crash call rates. NEWS compliance whilst not reaching the target has shown significant improvement of 2 of the 3 months of the reporting period where two upper limit breaches have occurred

¹⁰ The NEWS Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. March 20 Audit suspended due to Covid-19. Regional Improvement Work on Crash Calls began in 2008, since June 2008 the Trust's Crash Call Rate has fallen significantly from a Baseline of 1.89

3.2. Patient Falls¹¹

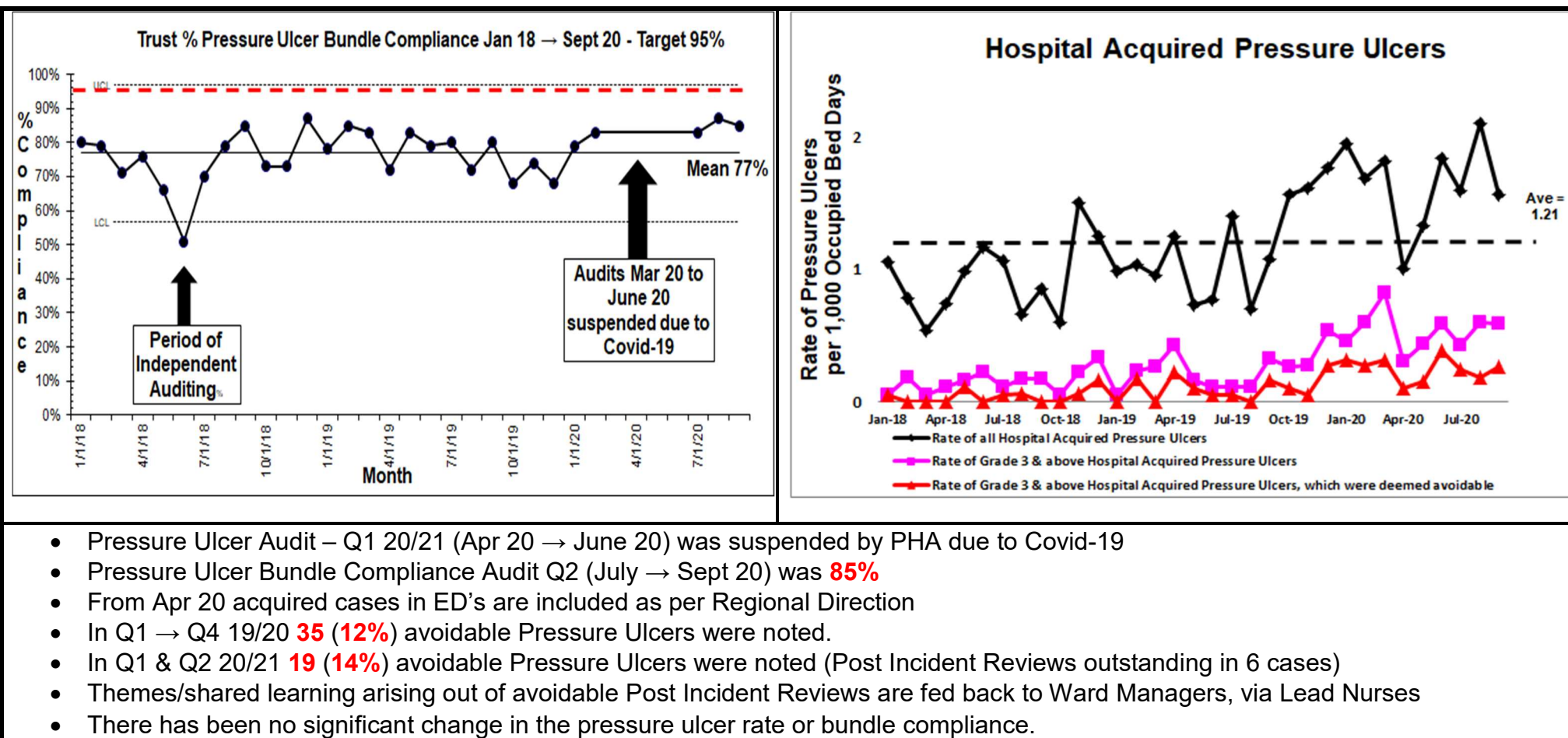


¹¹ The Falls Audits are a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Patient Falls began in 2011. In line with the Region since Apr 18 the Trust undertakes a Post Falls Review for all patient falls resulting in Moderate to Severe Harm.



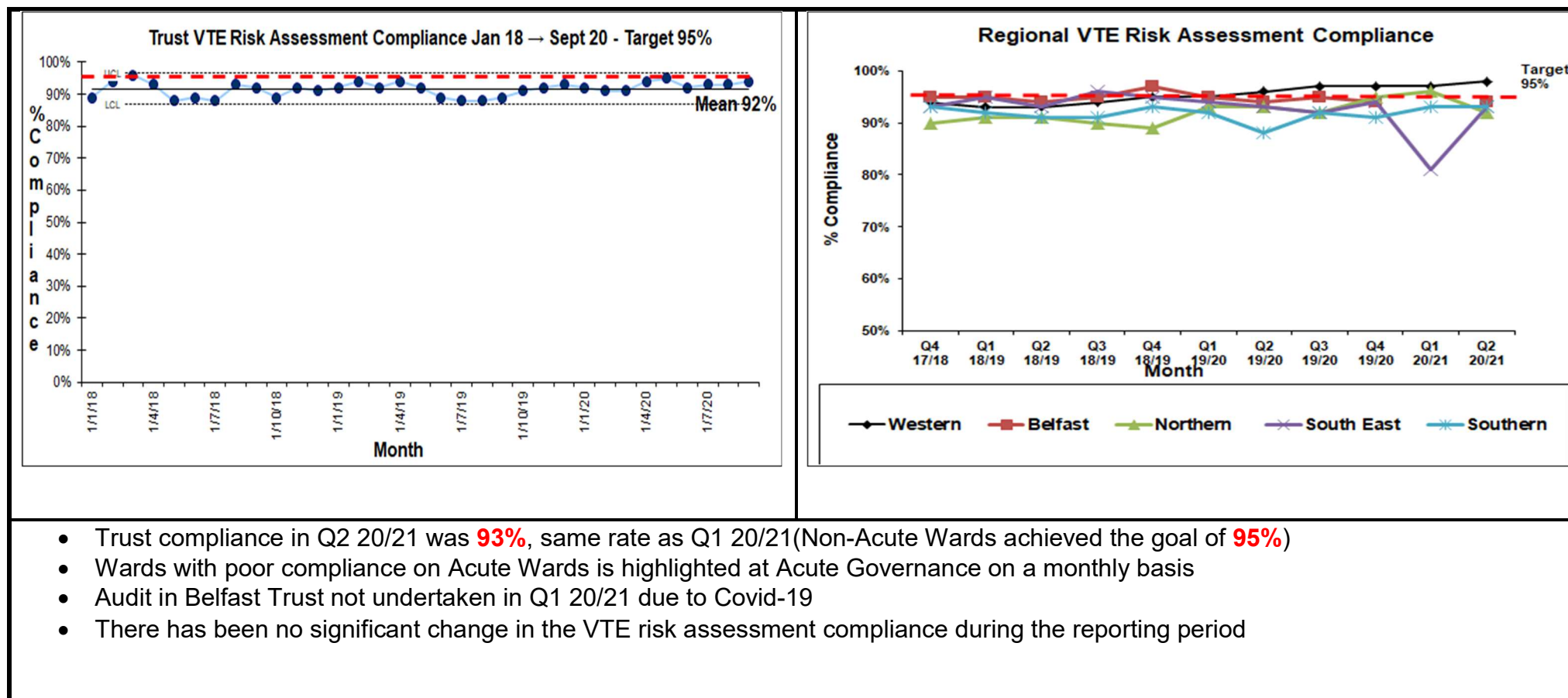
- FallSafe – Q1 20/21 (Apr 20 → June 20) Audits A & B were suspended by PHA due to Covid-19
- FallSafe Bundle A Compliance Audit Q2 (July → Sept 20) was **87%**
- FallSafe Bundle B Compliance Audit Q2 (July → Sept 20) was **84%**
- Patient Falls Rate Q2 20/21 was **4.93** per 1,000 Occupied Bed Days, compared to **6.64** in Q1 20/21
- Patient Moderate & Above Falls Rate Q2 20/21 was **0.11** per 1,000 Occupied Bed Days compared to **0.10** in Q1 20/21
- Of the 27 Wards monitoring their Patient Falls/Falls Rate using the Falls Walking Stick **19** wards (**70%**) saw an increase in Patient Falls Rates in Q1 & Q2 20/21 compared to the same period 19/20, while the number & rate of patient falls for the Trust has also seen an increase over the same period **634** (**5.69** per 1,000 Occupied Bed Days) compared to **493** (**3.40** per 1,000 Occupied Bed Days). The Rate of increase is more significant due to the decrease in Occupied Beds day in Q1& Q2 20/21 due to Covid-19.
- There has been no significant change in the falls rate however there have significant improvement in compliance in Falls Bundle B with two upper confidence limit breaches .

3.3. Hospital Acquired Pressure Ulcers¹²



¹² The Pressure Ulcer Audit is a combination of self-auditing by Ward Managers/Band 6's & Independent Auditing by Lead Nurses. Regional Improvement Work on Pressure Ulcers began 2011. A number of pro-active initiatives have subsequently taken place i.e. the implementation of the Regional SKIN Bundle, the use of the Pressure Ulcer Safety Cross by Wards to capture details of their Ward Acquired Pressure Ulcers & the development of the 24 Hour Pressure Ulcer Prevention & Management Plan. The focus of the Region has moved towards Grade 3 & 4 Ward Acquired Pressure Ulcers. Since April 16 an RCA is conducted on ward acquired pressure ulcers to determine those which were avoidable.

3.4. Venous Thromboembolism (VTE) Risk Assessment Compliance¹³



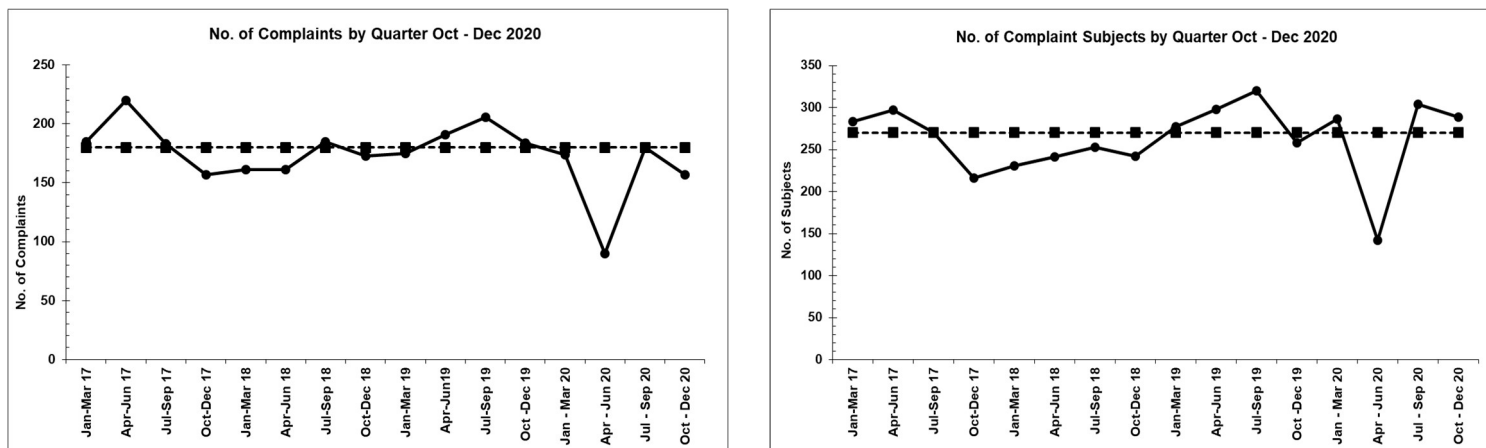
¹³ Regional Improvement Work on the introduction of a VTE Risk Assessment began 2009. All Trust's now use a Regional Risk Assessment Tool. For the past number of years VTE Risk Assessment compliance has been one of the Commissioning Plan Priorities, with the target for Trusts set at 95%. All Trusts have seen an increase in compliance since measurement began in April 2013.

4.0. Service User Formal Complaints

4.1 Complaints received

Regionally complaints are categorised and reported by the subject within the complaint. One complaint letter may have multiple complaints subjects. This period **157 complaints** were received (**13% decrease** on Jul - Sept 20). The 157 complaints contained **289 complaint subjects** (a decrease of 5% and a ratio of 1 complaint: 1.8 subjects).

Figures 9.0 & 10.0 below show complaint and complaint subject levels



4.2 Complaint Subjects

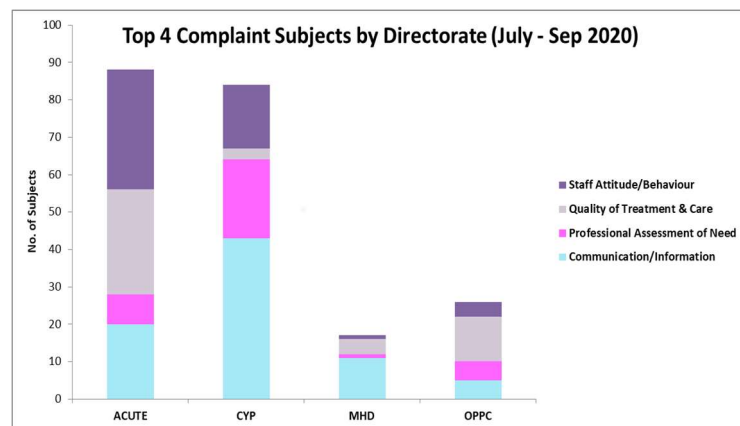
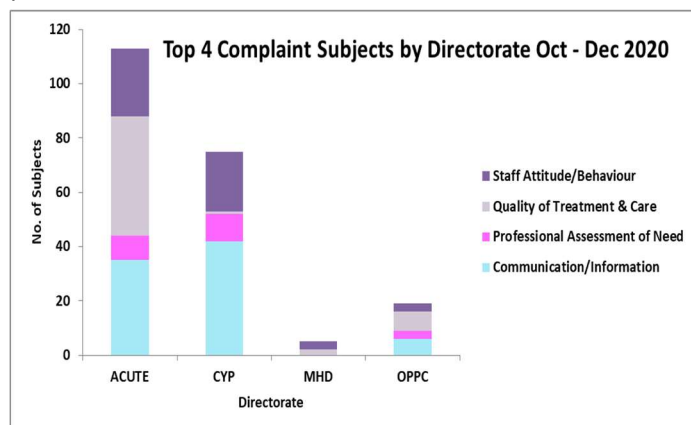
These have been ranked for the period Oct - Dec 2020, with previous quarter comparisons.

Table 16.0 below details the top 9¹⁴ complaint subjects by % share of the 289 subject total. It also compares the level of those complaint subjects against previous quarters.

Complaint Subject	Oct Dec 19	Jan Mar 2020	Apr Jun 2020	Jul Sep 2020	Oct Dec 2020	Subject %
Communication/Information	57	67	30	79	84	29%
Staff Attitude/Behaviour	47	49	29	54	54	19%
Quality of Treatment & Care	44	57	26	47	54	19%
Professional Assessment of Need	30	19	18	35	22	8%
Quantity of Treatment & Care	4	6	6	13	10	3%
Clinical Diagnosis	3	11	4	7	10	3%
Other	3	3	2	9	7	2%
Property/Expenses/Finances	3	2	5	4	6	2%
Hotel/Support/Security Services (Excludes Contracted Services)	3	2	0	4	5	2%
Subjects outside of the Top 9 < OR = 4					37	13%

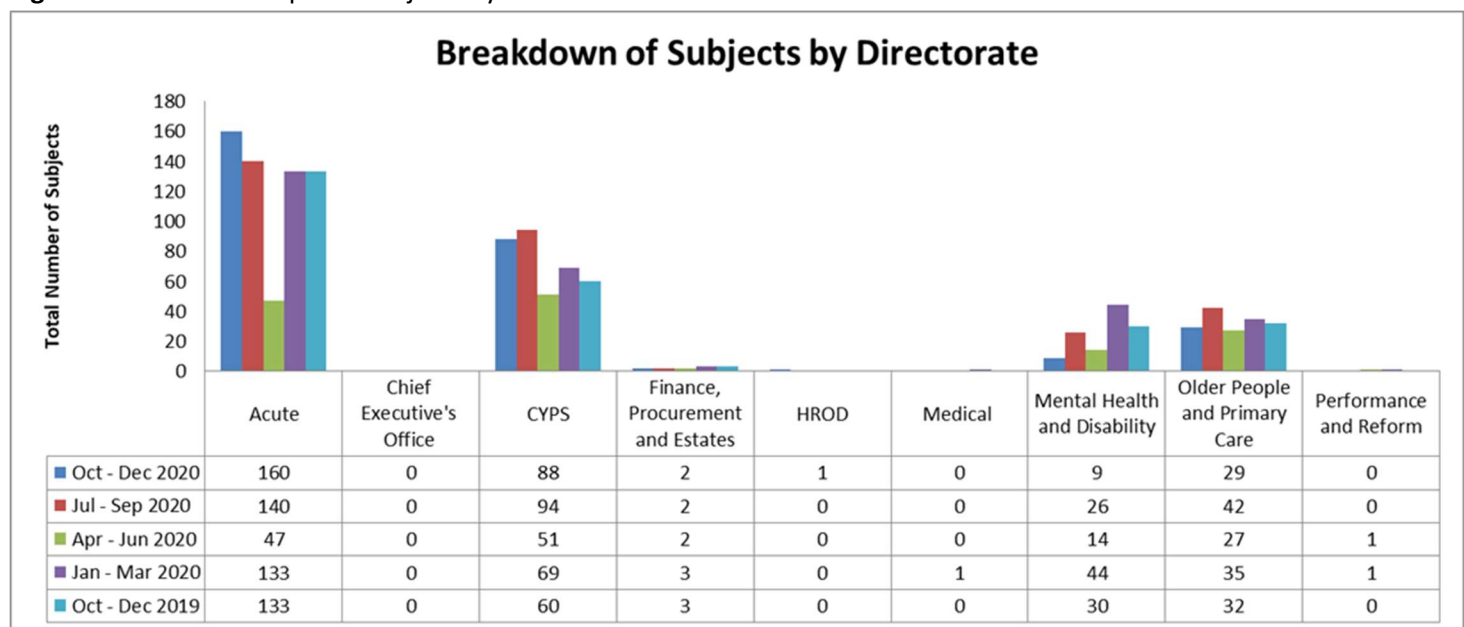
¹⁴ Cut off at 9 due to Discharge/Transfer Arrangements, Waiting List, Delay/Cancellation Community Based Appointments and Policy/Commercial Decisions all have 4 records assigned.

A further drill down of the ‘**top 4**’ areas shows they covered 73% of the quarter’s 289 complaint subjects. These 4 subject areas are split across the 4 operational service directorates as shown in **Figs 11.0 & 12.0**, compared to previous Qtr.



4.3 Complaints % by Directorate¹⁵

Figure 13.0 - Total Complaint Subjects by Directorate since October 2019.



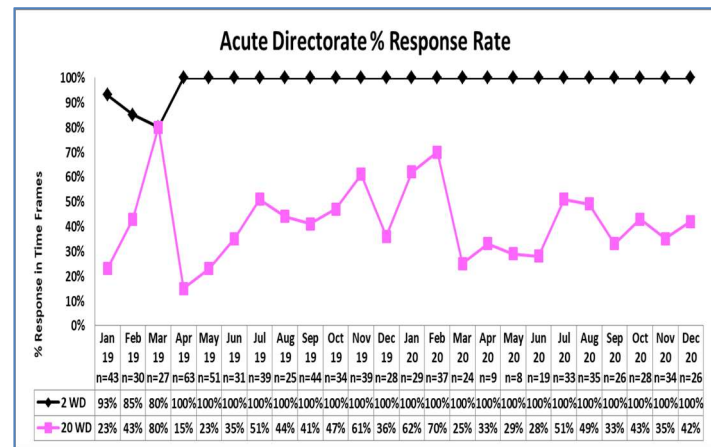
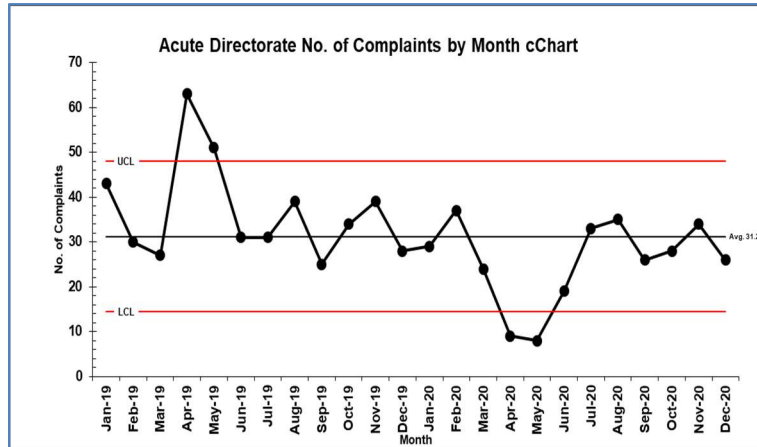
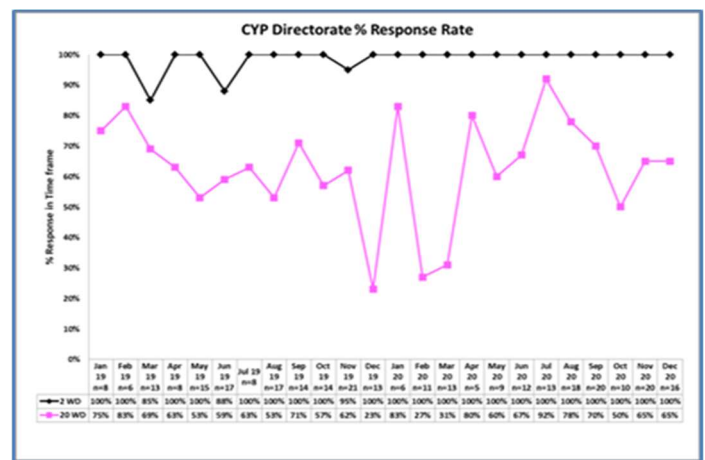
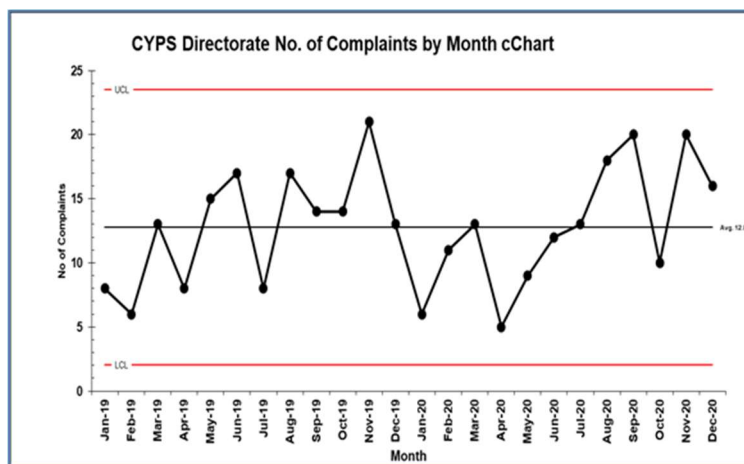
4.4 Complaint Response

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.

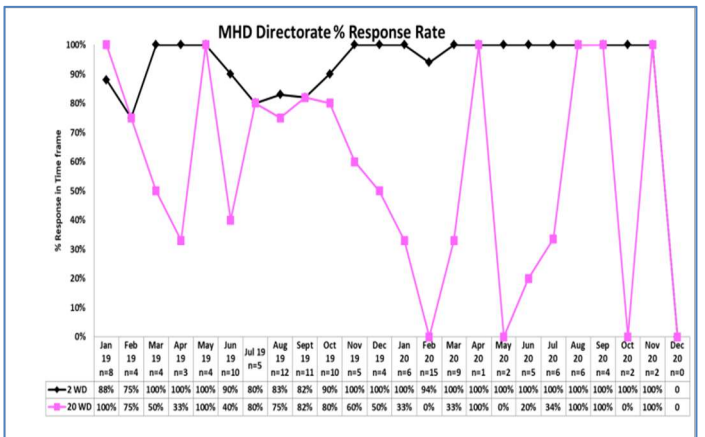
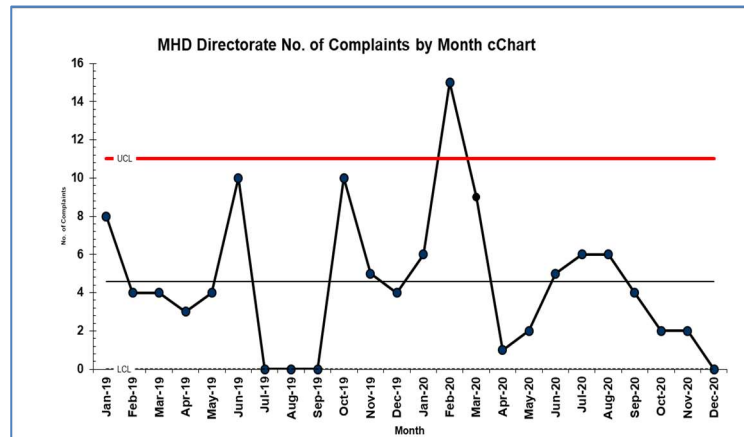
The information in the following charts (collectively **figure 14**) details the number of complaints by directorate, the 2 working day acknowledgement and 20 working day response rates.

¹⁵ A breakdown by Division is available through the relevant Directorate Governance Team

Acute Complaints and Response Times

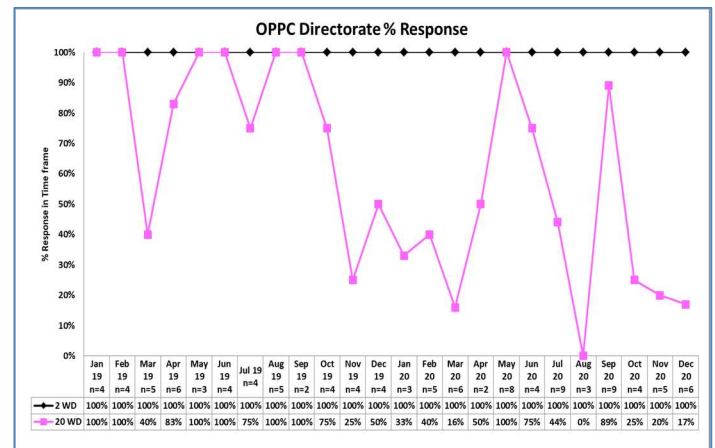
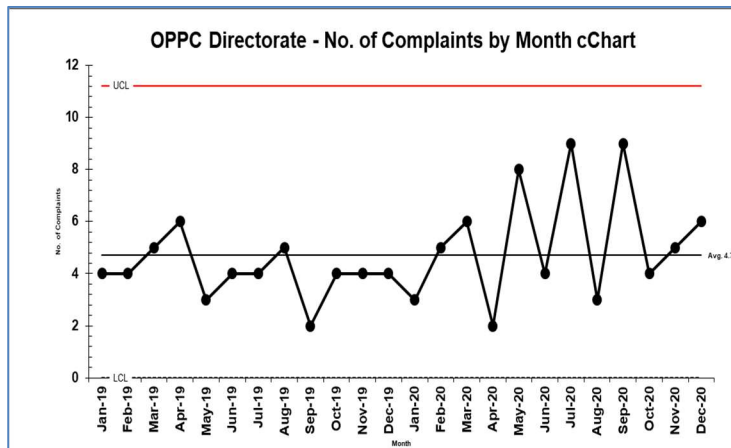
CYPs Complaints and Response Times¹⁶

MHD Complaints and Response Times



¹⁶ Unable to provide figure for 20 day response time because at the time of reporting, the response timescale had not passed.

OPPC Complaints and Response Times



4.5 Independent Sector Providers

The new guidance (2019) in relation to the HSC Complaints Procedure stipulates that complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated. In order to become compliant with this section of the guidance, the governance departments would require additional resources.

4.6 Informal/Enquiries and Local Resolution

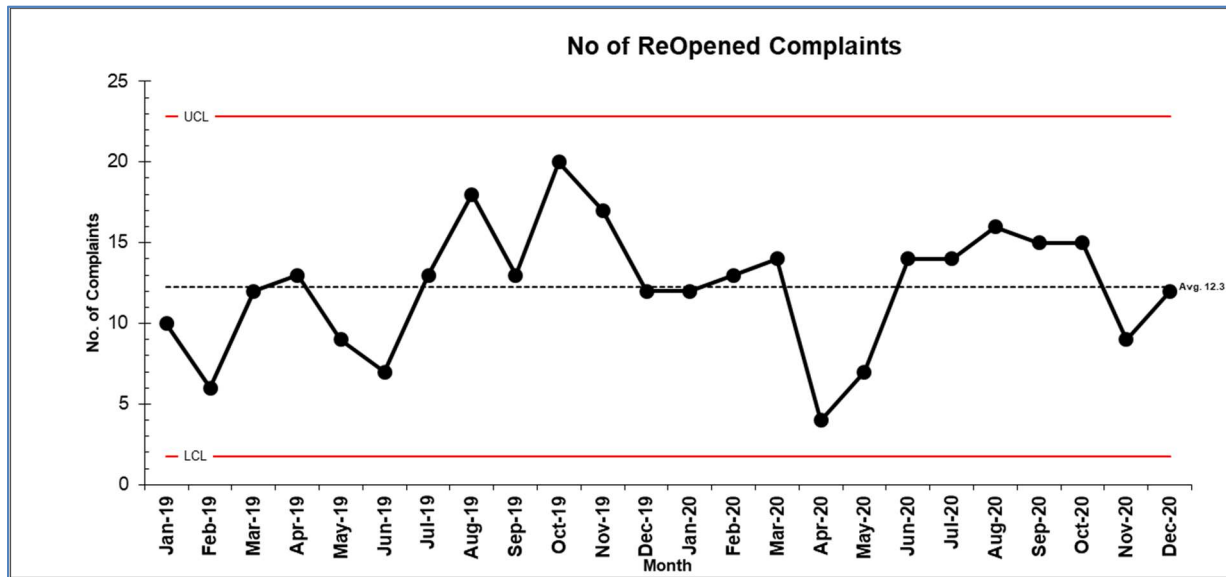
Table 17.0 below sets out the informal methods of complaints received for all directorates since July 2019.

Resolution Stage / Method	Total - All Directorates					
	July-Sep 19	Oct - Dec 19	Jan - Mar 20	Apr - Jun 20	Jul-Sep 20	Oct - Dec 20
Awaiting consent	12	33	12	10	15	4
Enquiry	148	66	98	63	143	132
Informal HSC Complaint	110	50	58	35	30	47
Resolved at Point of Service Delivery	16	2	7	3	7	3
Redirected	12	8	6	10	4	7
COVID 19 Enquiry			16	61	12	26
Totals	298	159	197	182	211	219

4.7 Complaints – Re-opened

Oct - Dec 2020 saw 36 complaints re-opened. The line graph below shows the number of Reopened complaints since January 2019.

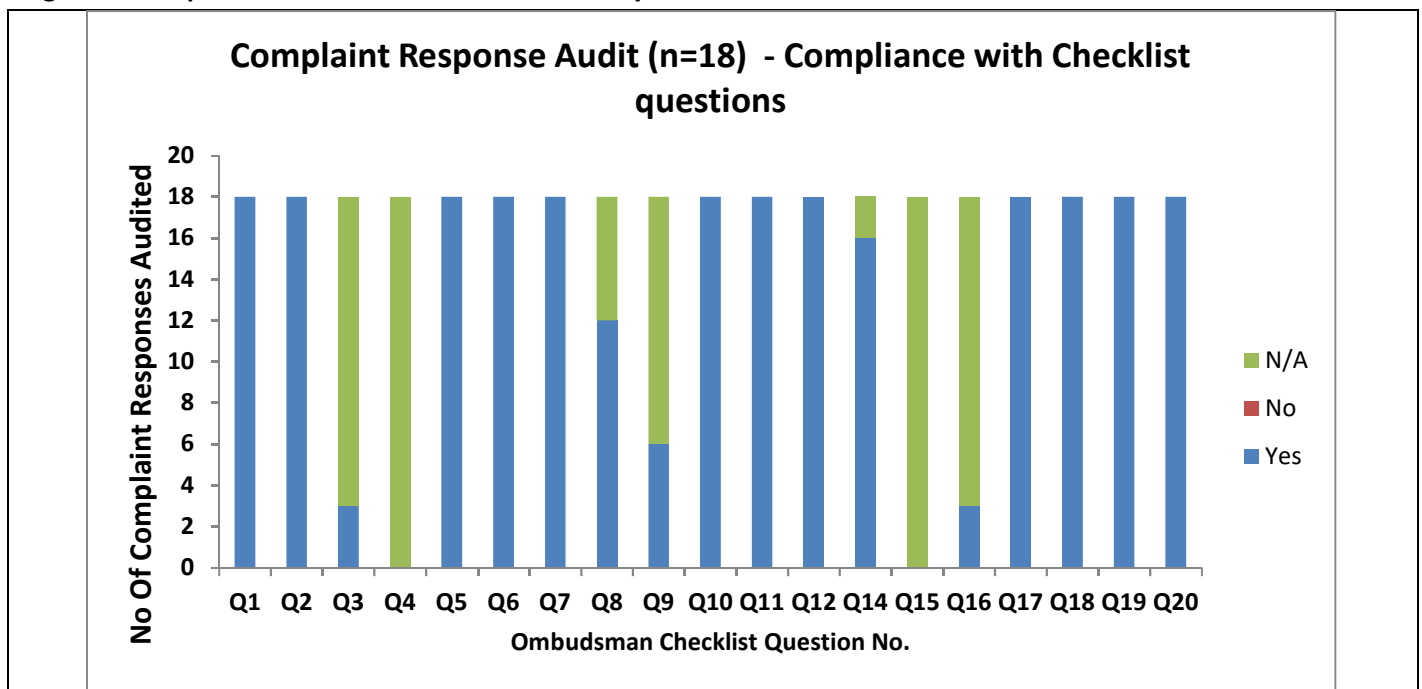
Figure 15



4.8 Complaints - Response Audit

A response audit was carried out on 18 complaints received in this period using the regionally agreed 'Checklist for Preparing Draft Responses to Complaints'. The checklist takes into consideration the Ombudsman's Principles of Good Complaint Handling¹⁷.

Fig 16.0 – Response Audit Results and Commentary



¹⁷ 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 was double checked.

Commentary:

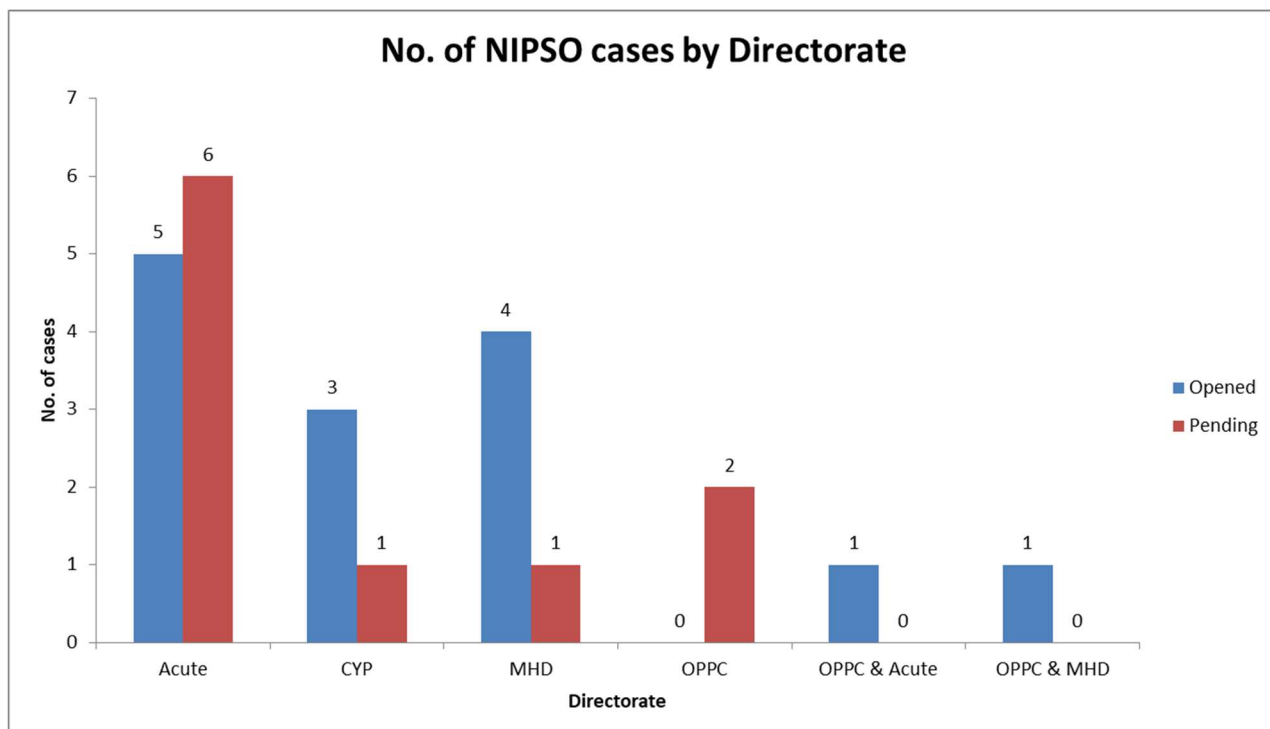
- Q1) All of the 18 responses appeared to have fully understood what the complainant was unhappy about prior to preparing the draft response.
- Q2) All of the 18 included a polite opening to the letter and thanks for raising the complaint.
- Q3) Three of the complaints were responded to outside of the 20 working day response time. They provided apologies for the delay.
- Q4) None of the complainants were in relation to a bereavement.
- Q5) All of the responses provided a short summary of the complaint issues.
- Q6) All of the responses addressed all of the issues.
- Q7) All responses only included necessary information.
- Q8) Any responses that identified an error apologized for this.
- Q9) Any responses that hadn't found something went wrong were answered in a customer friendly approach.
- Q10) All of the responses expressed regret for a misunderstanding, if applicable.
- Q11) Straightforward, simple language was used in all complaint responses. Where technical terms were used, the meaning of such terms was explained.
- Q12) Appropriate language was used in all of the responses audited.
- Q14) All of the responses (where applicable) advised the complainant of any changes/ improvements that had taken place as a result of their complaint.
- Q15) This was not applicable for these cases.
- Q16) A meeting to discuss the outcome of the complaint investigation was offered to three of the complainants.
- Q17) All of the responses reflected the Trust values and were very understandable.
- Q18) All of the responses could have been understood even if you did not work within that department.
- Q19) The auditor would have been happy for a loved one to have received all of the responses.
- Q20) All responses were signed by Director's (or on behalf of) prior to sending.

4.9 Ombudsman Cases

Oct - Dec 2020, SHSCT received six requests for further information from the Ombudsman's Office. Four of these cases are currently pending and 2 are closed.

At present there are 14 open Ombudsman cases and 10 pending cases.

Figure 17 below shows a breakdown across the Directorates.



Three reports were received and the Recommendations from these have been circulated within the relevant Directorate for action.

4.10 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 Corporate Complaints office from the 1st June 2020. The report for complaints received 1st October – 30th December 2020 can be found at Appendix 1.

As the data collection grows, greater in-depth analysis will facilitate learning for directorates to be able to focus upon and evidence any improvements to services they may make.

5.0 Service User Compliments

Business Services Organisation (BSO) is the HSC organisation that both hosts the compliments websites and servers, on which SHSCT compliment data is stored. BSO is now providing compliment information to HSCTs.

Table 18.0 below shows the compliments received into the Trust in the period. 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).

Table 18.0 – Compliments Received by Subject and Method Oct - Dec 2020 – Significant increase since previous quarter. This quarter the compliments are recorded which have been provided through Care Opinion.

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	253	21	3	17	8	0	53	355
Staff Attitude & Behaviour	239	29	6	22	4	0	45	345
Information & Communication	157	14	1	9	0	0	24	205
Environment	150	4	0	7	0	0	11	172
Other	6	1	0	1	0	0	0	8
Total Compliments	805	69	10	56	12	0	133	1085

Previous Quarter

Subject of Compliment	Card	Email	Feedback Form	Letter	Social Media*	Phone call**	Care Opinion	Total
Quality of Treatment and Care	172	32	3	14	1	1	78	301
Staff Attitude & Behaviour	10	4	4	4	0	0	74	96
Information & Communication	0	1	0	0	0	0	11	12
Environment	0	1	0	0	0	0	47	48
Other	1	1	0	0	0	0	0	2
Total Compliments	183	39	7	18	1	1	210	459

Healthcare Complaints Analysis Tool

October - December 2020

Contents

1. Executive Summary	1
2. Benchmark Data.....	2
3. Structure of Report.....	2
4. Introduction to HCAT	2
5. Method	3
6. Results of October – December 2020 Data Collection.....	4
Severity by Harm	4
Stages of Care.....	5
Near-Miss by Stage	5
Categories of Harm.....	7
Harm According to Directorate.....	8
Exit-Entry Problems	9
Type of Complainant by Harm	10
Complaints with Multiple Problems.....	11
Omission and Commission Errors.....	12
Problem Categories	13
6. Summary	14
7. Conclusion.....	14
8. Next Steps.....	14
Appendices.....	16
Appendix 1: Key HCAT definitions	16

The Healthcare Complaints Analysis Tool (HCAT) was used to analyse 3 month's (October, November and December 2020) of complaints received by the Southern Trust. Prior to this a report was compiled for June, July, August and September 2020 as a starting point for HCAT within the Trust.

HCATs purpose is to support organisational learning by analysing complaints in an aggregate and objective way, rather than individually. Each complaint is coded from the complainant's perspective and therefore the issues which could seem minor to a health and social care worker, could feel major to the complainant.

As a relatively new concept of learning from our service user feedback, the data analysis will develop and evolve as processes around the system develops, implements and embeds. It is the ambition that the Trust can increase learning from reviewing complaints made, from a different perspective, to gain greater insight, better understanding and strive to provide an improved and more effective service to all. It should be noted that the HCAT system was developed for a hospital setting and therefore, has been adapted to take into account the unique structure of the Health and Social Care setting in Northern Ireland.

2. Benchmark Data

The data for June – September 2020 is used as a benchmark against October – December 2020.

Indicator	October to December 2020	June to Sept 2020
% high and catastrophic harm	11.9%	19.7%
% entry-exit problems	18.9%	9.4%
% systemic problems	81.1%	71.4%
% omission problems	51.6%	52.2%

It should be noted that the complaints are coded from the complainants' perspective as opposed to a health and social care perspective, with one complaint having a multitude of "problems", severity and stages within the one complaint. This should allow learning to be developed with the service user's perspective and journey at the centre.

3. Structure of Report

This report provides the Trust with insights on the profile and nature of their service user complaints, evaluated using the Healthcare Complaints Analysis Tool (HCAT) developed by the London School of Economics (LSE). The report begins with an introduction to HCAT and its approach.

4. Introduction to HCAT

Organisations usually analyse complaints in relation to the number received. However, this only provides part of the story. If a Trust receives a high number of complaints, this could signal that poor care is being provided, or conversely it could simply be a product of the complaints process being easier to navigate than in other Trusts.

Rather than looking at number of complaints, HCAT facilitates an analysis of complaints by severity, which helps to provide a richer picture. A Trust/ Directorate may have a large number of overall complaints, but if the majority are low severity, this is a positive thing; indeed it can be illustrative of a healthy complaints system where patients and their families feel able to complain about a diverse set of issues because they trust that they will be listened to.

Further to this, the tool is innovative since it:

- is based on a systematic review of the complaints literature, has established high reliability, and a systematic procedure for analysis;
- provides both high-level analytics on Directorate/Trust complaint profiles, and insight on specific areas for local-level learning and improvement;
- facilitates benchmarking (e.g. comparing the profiles of Trusts in terms of complaint severity, identifying outliers).

HCAT can be used as an early warning system and a means to support organisational learning since it allows complaints to be analysed in an aggregate and objective way, rather than individually

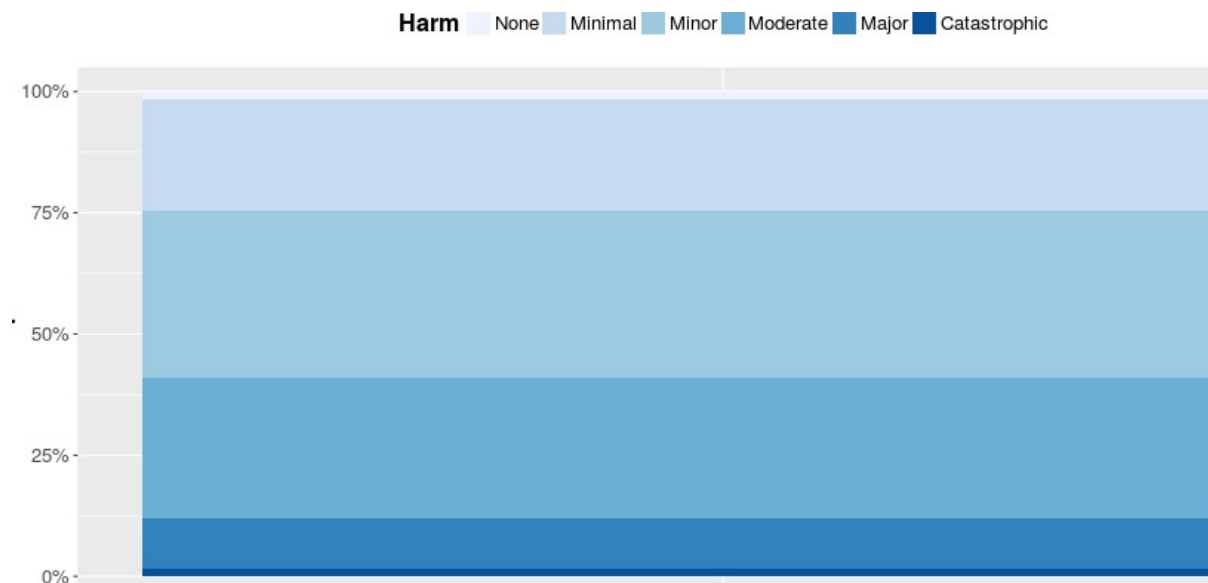
Usable formal complaints were analysed from the Southern Trust over a period of 3 months October, November and December 2020. It was envisaged that this would provide a sufficient starting point in data to commence using HCAT as a significant learning tool within the Southern Trust, as well as utilising the data as evidence to identify areas of improvements and their successes.

The complaints were preliminarily analysed by one coder and used a coding form developed for the Southern Trust for efficiency and ease of reference as part of a testing process of the development and implementation of the Tool. Moving forward the vision to offer greater assurances to the system, a clear oversight process will be put in place with agreed representation from directorates to review and audit coding. This will serve to create improved knowledge and understanding of the system within the teams, as well as give consistency and assurance to the potential learning outcomes highlighted.

More information on how complaints were analysed, the different components of HCAT (e.g. severity and how this interacts with patient harm) can be found in Appendix 1. It should be noted that in line with HCAT, one complaint can have multiple problems, stages and severity. To assist with theming the complaints, there are also 'sub problems' which are categorised by key words.

Severity by Harm

A high severity complaint is a complaint letter that has at least one ‘high severity’ problem reported within it. High severity problems reflect the most extreme types of issues relating to each problem category (please see Appendix 1 for further details).

Chart 1 – Severity by Harm

A small proportion of low severity complaints may indicate that patients and their representatives are simply not observing these types of problems. Alternatively, it may instead indicate that patients have a higher threshold for complaining (i.e. things have to be serious in order for them to act upon), or that they do not feel it worthwhile to report smaller issues. Over the period of October - December 2020 there is a significant number of lower severity (none, minimal, minor and moderate harm) complaints which evidences that complainants were able to access the service user feedback system easily and more readily, reinforcing an organisational approach to learning outcomes from our service users. There is a marked low rate of “major” and “catastrophic” harm level which is positive, particularly as complaints within HCAT are coded from the service user perspective.

Within the Southern Trust coding form, “Care on Ward” was changed to “Care” to reflect the different settings in which a complainant could receive care and therefore, feel the need to provide feedback about the same.

This bar chart shows the stages at which problems occur, including the amount of harm reported at each stage. This is useful for identifying the stages of care where patients are reporting the most harm. The October – December 2020 complaints reporting high and catastrophic harm is relatively low, which reflects positively for the Trust.

Coding is based on the complainant’s perception and judgement of problem/s. It would appear that when a complaint has a made a complaint about multiple stages of care, the Trust should to focus its improvements on the patient pathway to ensure consistent, high quality care throughout their journey.

Chart 2 – Harm by Stage

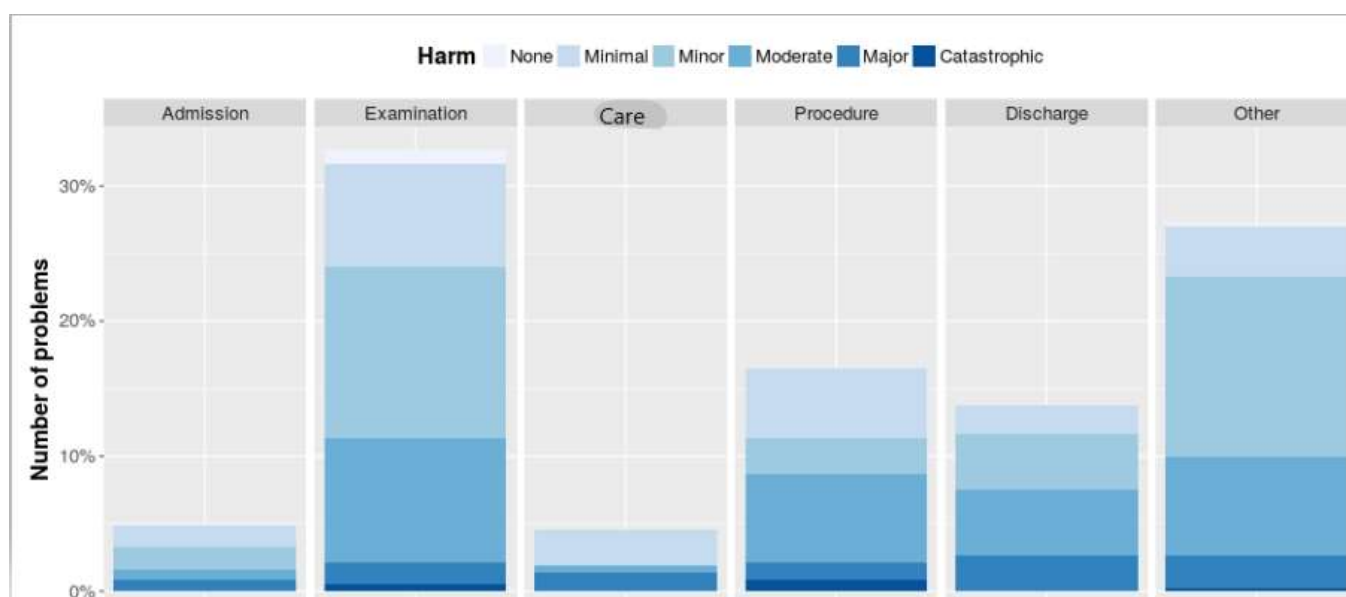
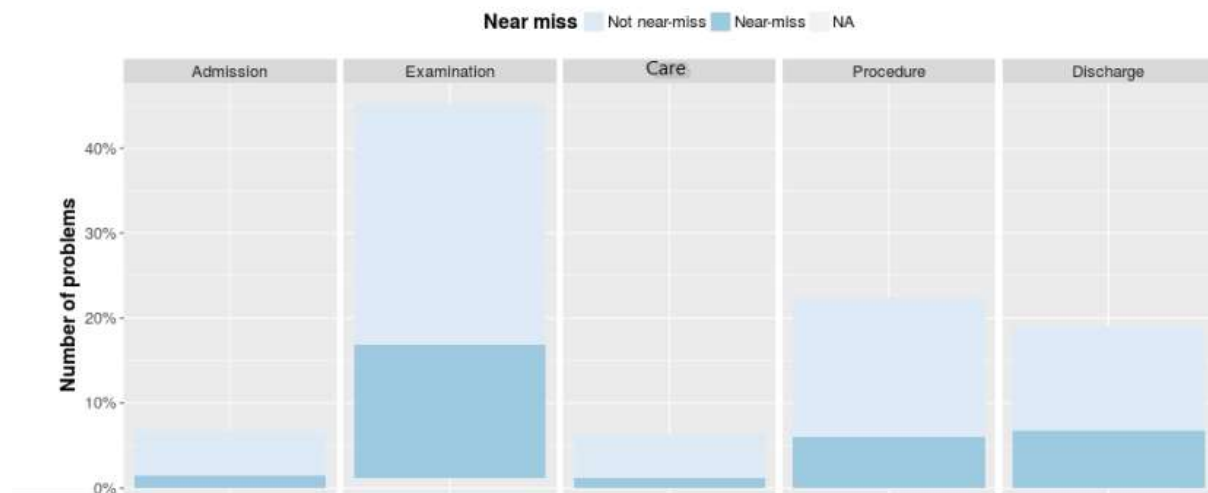


Chart 2 highlights that there is minimal harm being reported with regards to the admission and discharge stages within the Trust, however, there is significant levels of harm concerning the examination of service users, although these levels are on the majority within the lower levels of harm. The ‘Examination’ category includes service user assessments and often are inclusive of the outcomes of the assessments. ‘Other’ can be in relation to environment (e.g) issues with disabled parking access.

Near-Miss by Stage

Near-misses are important for identifying potential future problems and processes of error recovery. Moving forward additional data will allow for trends to be identified and learnt from assisting with identifying areas for improvement and where there have been improvements made.



The evidence provided for October - December 2020 suggests that Trust improvements are needed within the patient's examination/ assessment to prevent further "near misses", however, future data collection will enable clear identification of areas in need of improvements. Once again, it should be considered that not all service users will be satisfied with the outcomes of their examinations/ assessments and an area of improvement which could be considered is how the Trust communicates and explains the process and outcomes of the examinations/ assessments to increase service user understanding of the same.

Chart 4 – Harm Categories

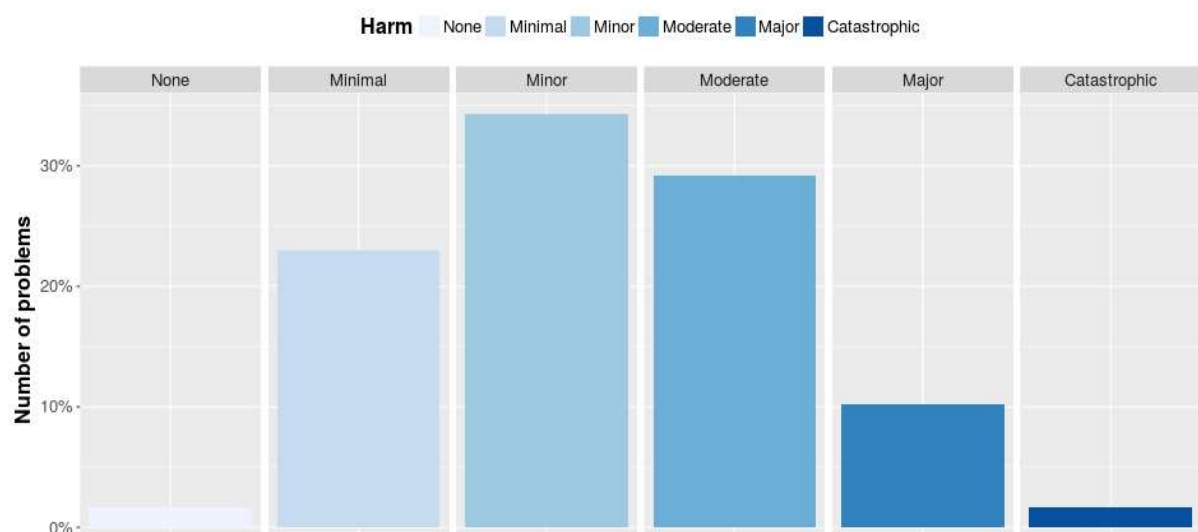
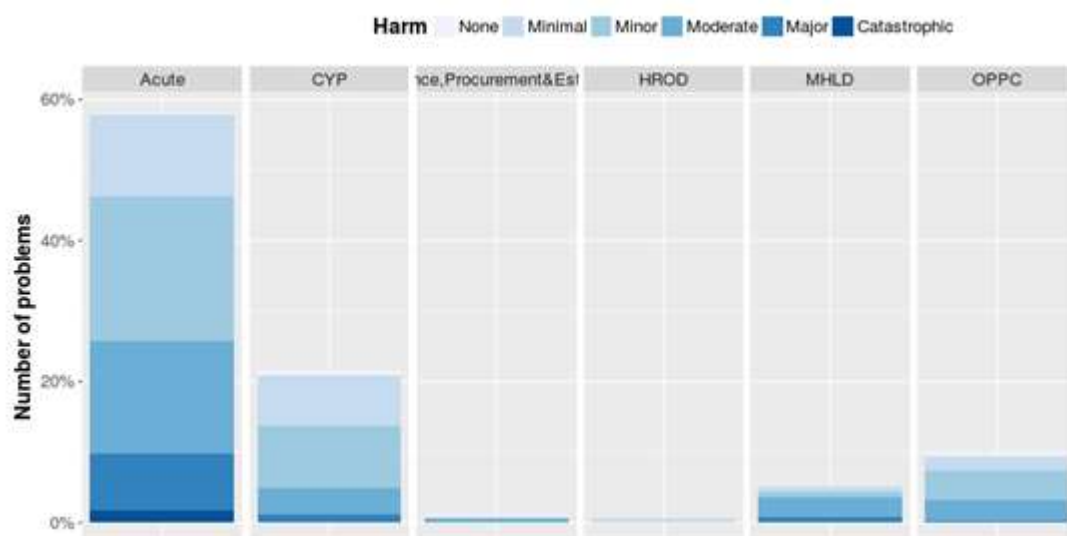


Chart 4 above shows that most feedback was categorised as having caused minor or moderate harm, with smaller numbers having none or catastrophic harm. Complaints of this severity demonstrate that the Trust service user feedback is recognised as being accessible by service users, carers, families and others.

Chart 5 conveys that the majority of complaints were within Acute Directorate, followed by Children's Services, OPPC and Mental Health and Learning Disability. Smaller numbers were received with regards to the lesser "front facing" directorates such as Performance, Finance, Procurement and Estates.

It should be noted that the timeframe reviewed was only for three months, in which less secondary care services were being provided and only prioritised service delivery given due to the ongoing Pandemic. Acute receiving the greatest volume of the complaints is to be expected as the care provision has continued throughout and includes Emergency Departments across two sites. It should also be noted that the months reviewed are those which fall within the "winter pressures" and accompanied by pandemic pressures, demands on Acute services has been at its greatest.

Chart 5 – Harm Categorised by Directorate

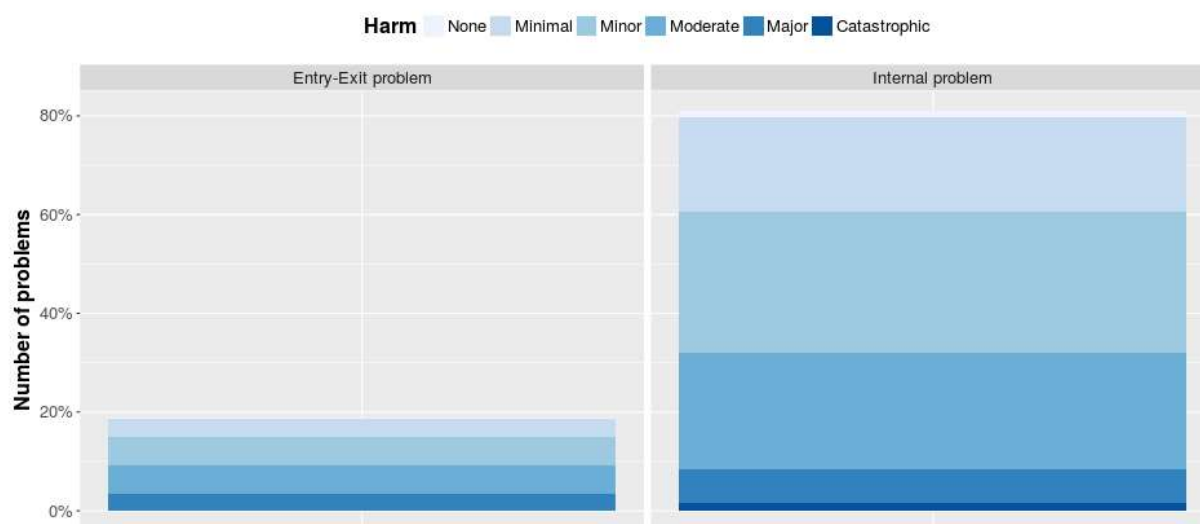


Exit-Entry Problems

WIT-79314

Chart 6 below shows the number of problems that occurred while entering and exiting the healthcare institution, compared to the number of problems that occurred within the institution. The number and type of entry-exit problems can provide information on problems that might be difficult to identify via internal monitoring systems. The October- December 2020 data has 18.9% problems reported being entry-exit problems. The Chart below displays the level of harm for the Entry- Exit problems, noting that the vast majority of complaints received were in regards to 'internal' issues such as the care and examination/ assessments.

Chart 6 – Entry-Exit problems



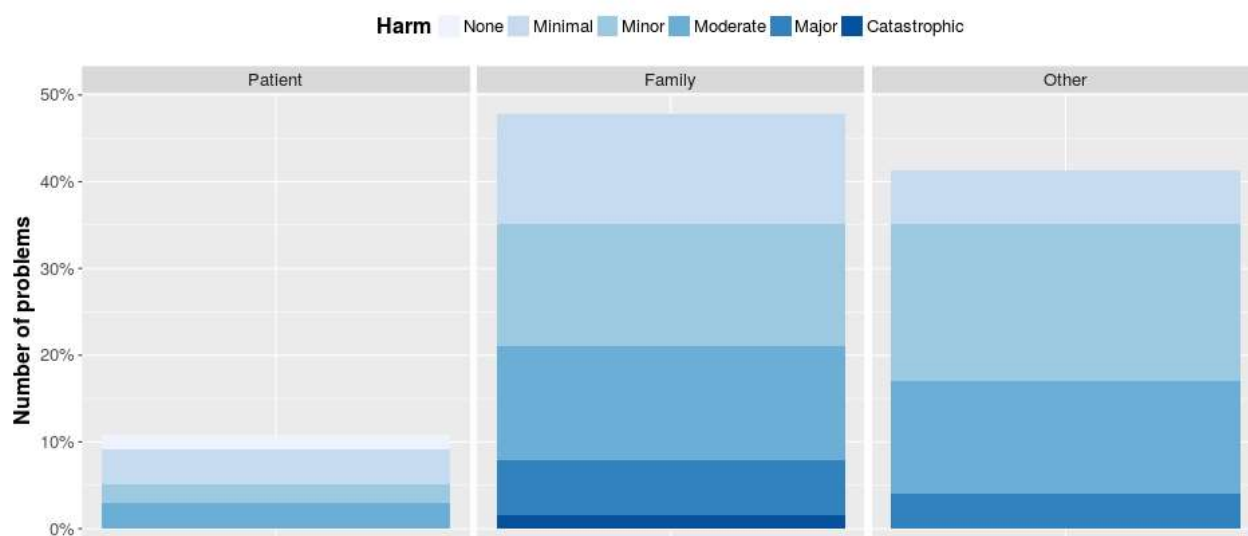
Type of Complainant by Harm

WIT-79315

HCAT categorises the type of complainant into three areas, “Family”, “Patient” and “Other”. “Patient” within the Southern Trust analysis is inclusive of all service users. “Other” mostly includes MLA’s and councillors acting on behalf of service users/families.

The high number of “family” complainants is positive as this may indicate our complaints system is working well and is accessible, as opposed to their being barriers to giving feedback. High number of complaints made by “other” would reinforce this and suggest that the local representatives in the Southern Trust area feel that they are able to communicate and engage with the Trust in a meaningful way using the service user feedback mechanism.

Chart 7 – Type of Complainant



Complaints with Multiple Problems

Chart 8 below shows how many complaints have one or more problems. A high number of complaints with multiple problems indicates that the complaints reported are more complex and systemic issues are prevalent. In October - December 2020 data 81.1% of problems are systemic which given current waiting times and access to services being limited is to be expected in the current circumstances. Across these problems there are a range of levels of harm, albeit within the lower range, which conveys the complexity of the issues being presented.

Chart 8 – Systemic Problems

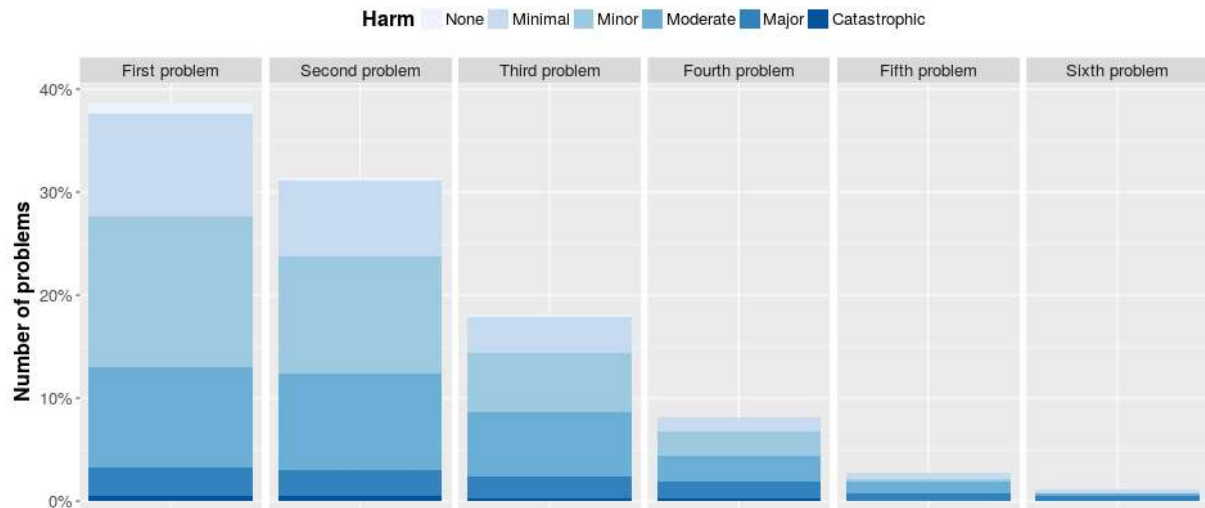
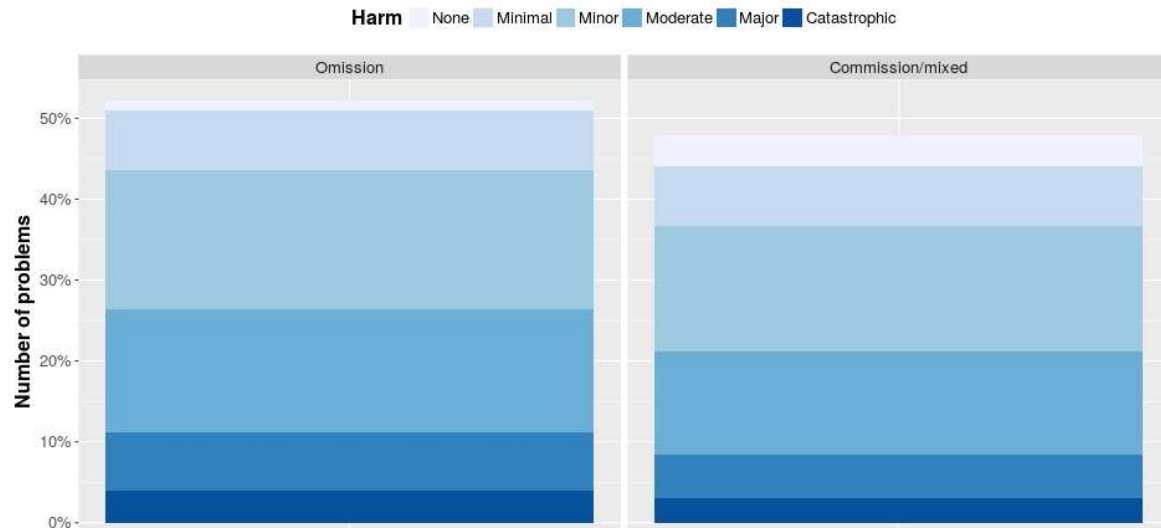


Chart 9 provides an indication of the number of problems that are errors of omission and commission. Errors of commission occur when something is done incorrectly. Errors of omission tend to be more difficult to identify because they refer to things not being done. The 'October to December 2020' data has 51.6% problems reporting omission problems, with just under half being commission errors.

Chart 9 – Omission Problems



The complaints reviewed identified 4 domains in which there could be learning from, which is further broken down into 8 categories of Quality, Safety, Communication, Listening, Rights, Environment, Institution and other.

The domains include the following categories

- Clinical: Quality and Safety
- Relationship: Listening, Communication and Rights
- Management: Environment and Institutional problems
- Other: Finance and other issues highlighted that do not fall into other domains

Chart 10 – Harm within each Domain

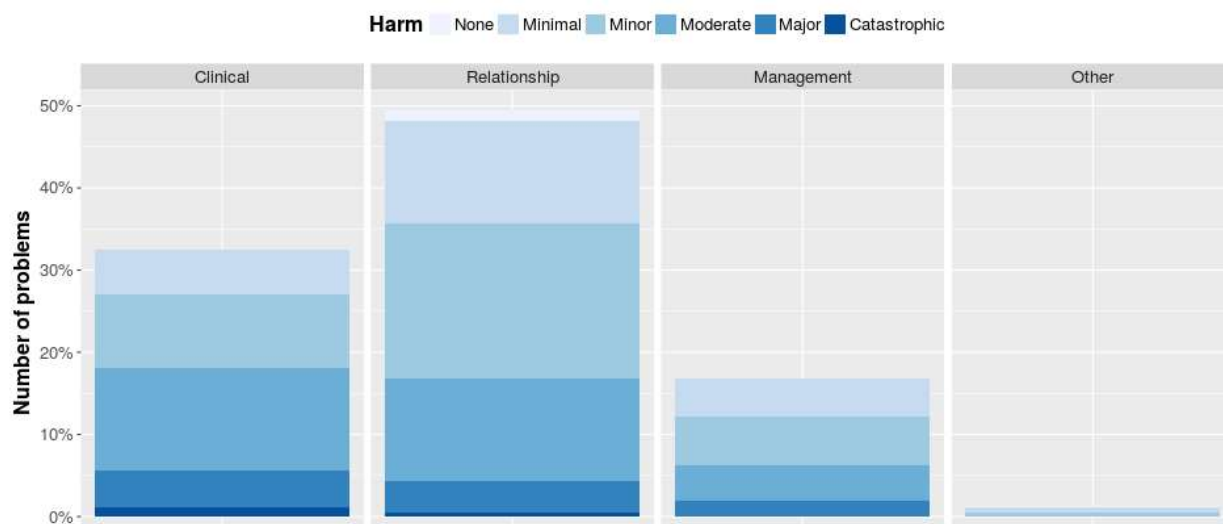
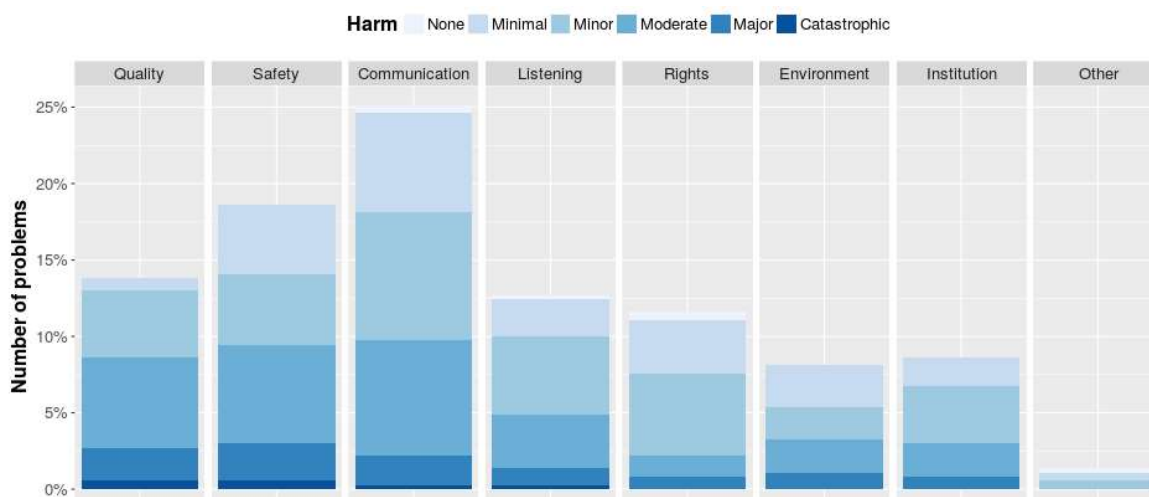


Chart 11– Categories of Problem



There are less environment issues and institution issues. Some feedback highlighted was around better signage and cleanliness of areas and the Chart would suggest that this has improved. Institution (problem in bureaucracy, waiting times and accessing care) category is the third lowest, which given the volume of services stood down and therefore a backlog created, would suggest that service users are understanding of the current situation within the Health and Social Care setting. Quality and Communication are the two highest categories of complaints for the Trust through October to December 2020.

6. Summary

Overall, HCAT analysis indicates that the Southern Trust has strengths in some areas, and potential for improvement in others. Positively, there are a low number of catastrophic incidents reported across the Trust, however, there is a need for improvements with the care delivered to service users and the communication delivered to them and their families. These two areas are prevalent throughout the timeframe and could suggest that there is work needing focused on how we manage expectations, how we present to service users and their families and how we deliver the care they need and deserve.

7. Conclusion

The report demonstrates how HCAT can assist with the identification of areas of improvement within a Health and Social Care setting, it also conveys the challenge of presenting meaningful analysis with limited data. Ongoing use of the HCAT tool will allow Directorates to gain greater understanding and knowledge from service user feedback which can be adapted for better identification of improvement areas. The long term data collation will also provide the Trust with the opportunity to have its own benchmarking using previous quarters or/ and annual reviews as well as being able to clearly identify themes which continue or are addressed.

HCAT data can also be a clear quality improvement tool if services choose to use the information as an indicator of areas needing improved, evidencing where improvements have been made and testing of the effectiveness of those improvements with the vision to further review if needed. This would require directorates to focus in on their service user feedback and possibly try to target areas to improve to sustain the improvements.

8. Next Steps

This report is an illustration of how HCAT could be used by the Trust to analyse and learn from their complaints. The report has been limited by the relatively limited timeframe and small number of complaints which has been used. With more extensive data, the report could include:

- *Trend analysis* – illustrating how Directorate's complaint profiles changes over time using longitudinal data, which would allow any improvements to be evaluated.
- *Tailored benchmarking* – in time you could choose a subset of Trusts to be compared against that are more similar to the Trust. Trusts with similar HCAT profiles could also potentially be paired in order to share insights on service improvement and share the learning. Directorates could choose year-on-year comparison to review any improvements made and identify areas which need further explored. At this early stage the process moving forward has many opportunities which need to be tested and reviewed to gauge value and purpose.
- *Further granularity* – providing insights on particular directorates, departments or units and in relation to high severity complaints only (the sample size here did not allow for this).
- *Direct quotes linked to trends* – the tool facilitates the extraction of specific quotes from a complaint, that are representative of a trend, and which could

be used to inform patient stories, for example this data as highlighted institutional issues as being high, having linked in with our Performance Indicators, the Trust has had a rise in waiting times for patients, many of which are likely to have increased as a direct result of COVID-19, which is increasing frustration of those who would have already been waiting for some time. Refocus on supporting services through winter pressures, as well as through the pandemic is ongoing and managing expectations continues to be prevalent.

Appendix 1: Key HCAT definitions

Complaint: service-user dissatisfaction about healthcare provision that is communicated to the institution and documented within the institution. A complaint can report multiple problems.

Healthcare Complaints Analysis Tool (HCAT): HCAT is a theoretically based and reliable method for coding the subject and severity of problems reported within healthcare complaints. The tool allows for a single complaint to report multiple problems within three domains and seven associated problem categories: clinical (safety and quality), management (environment and institutional), and relationship (communication, listening and patient respect & rights). Within each of these domains, and associated categories, problems are graded on a severity scale from not present (0) to high severity (3). The most severe problems reported within each category, domain and letter are used to provide severity scores for each category, domain and letter. HCAT is free and can be accessed [here](#). There is also a free online training tool that can be accessed [here](#).

Severity ratings: This relates to how severe problems are within a given category. For example, in the problem category of “Quality”, a low severity problem would be: *Delay in changing bedding*; a medium severity problem: *patient dressed in dirty clothes*; and a high severity problem: *patient left in own waste*. Severity ratings were developed through analysing a sample of 1000 complaints, and identifying the range of problem types within each problem category. Published research by the LSE shows the severity ratings to be highly reliable. It is notable that severe problems in some categories (e.g. safety, institutional processes) have clear implications for patient outcomes. Severity problems in other categories (e.g. communication) relate more to unexpected or unpleasant experiences that might not have directly caused patient harm, but are highly problematic (from the perspective of patients) nonetheless, and provide insight for learning.

Harm: This relates to the actual harm experienced by patients as a consequence of their complaint. The NHS 2008 “Risk matrix for managers” was used to calculate this, with the following categories being evaluated: N/A. No information on harm is reported; 1. Minimal harm: minimal intervention or treatment required; 2. Minor harm: minor intervention required to ameliorate harm; 3. Moderate harm: significant intervention required to ameliorate harm; 4. Major harm: patient experienced, or faces, long-term incapacity; 5. Catastrophic harm: death or multiple/permanent injuries.

In terms of the incidences of harm reported in complaints received by SAMPLE HOSPITAL, 10% of complaints described an outcome of major or catastrophic harm (below the average of 14%). 32% of complaints described an outcome of minor or moderate harm. The remainder reported near misses, or issues around management and relationships. Problems that have high severity but do not result in harm include: malfunction of key medical equipment, inability to access care, mix-up of patient notes, ignoring patient in distress, breaching confidentiality, patient provided with wrong test results, not obtaining consent, disrespect for deceased patient, and patient humiliation.

Harm and severity have a moderate association (Cramer’s $V = .341$, $p < .001$). This association is driven mainly by Clinical Severity (Cramer’s $V = .351$), and weaker for Management Severity (Cramer’s $V = .22$) and Relationship Severity (Cramer’s $V = .219$).

Hospital profiles: Hospital profiles for complaint severity were calculated by considering the severity of all the complaints reported within the given hospital's sample of complaints, and calculating the proportion of complaints that were i) low severity, ii) medium severity, and iii) high severity. This was also done for complaints referring to different types of problems (e.g. safety), stages of care, and staff groups. We focus on proportions, and not raw numbers of complaints (or complaints per admissions), because receiving a high number of complaints can indicate either i) systemic problems in patient care, or ii) a healthy complaint system where patients and their families raise a diverse set of issues (e.g. low severity) because they know they will be listened to. Analysing the severity of complaints (and what they refer to) allows for a more precise analyse in terms of capturing clear and problematic trends, and opportunities/priorities for learning.

Benchmarking data: The benchmarking data is based on 969 complaints from 44 acute NHS hospital Trusts in England. The study cohort had on average 108 (range 63 to 235) thousand admissions per year and received on average 624 (range 73-2451) complaints annually. The sample included 11 teaching hospitals.

Coding: Trained coders used HCAT to codify 100 complaints from 5 pilot Trusts. Complaints were masked (to the coders) in terms of the Trust they referred to. Data were then qualitatively analysed in order to identify common trends across complaints within a Trust. Reliability has been found to be substantial for the problem categories (0.69-0.91), largely moderate for stages of care (0.38-0.66), substantial for staff group (0.62-0.64), and substantial for harm (0.68).References:

Weekly Governance Meeting – Terms of Reference

Approved 28th October 2021

Background

The Trust is committed to delivering high quality, safe and effective services. To achieve this there must be a fast and responsive mechanism to:

- (i) de-brief on newly emerging issues e.g. SAIs, Never Events, Complaints, Adult Safeguarding referrals, complex Adult Protection cases where the risk is high to the individual or the organisation, Medicines management, Litigation etc;
- (ii) brief staff on newly issued Standards & Guidelines, Safety alerts etc; and
- (iii) report the above to Trust SMT, as part of the integrated governance arrangements of the Trust's assurance and accountability framework.

The Weekly Governance meeting, Chaired by the Medical Director, is a multi-disciplinary, cross Directorate vehicle through which this is achieved.

Purpose / Role of the Group

- To promote incident reporting safety culture across the organisation in order to reduce avoidable harm
- To review Directorate patient safety concerns which emerged in the week prior to the meeting of the group
- To identify learning from the events surrounding these concerns
- To identify opportunities for improvement based on a thorough understanding of the issue which caused the concern; ensuring the application of systematic quality improvement tools and methods
- To provide a Weekly Governance paper to SMT detailing the issues/concerns of the previous week.

Membership

- Medical Director (Chair)
- Executive Director of Nursing
- Head of Nursing , Patient Safety and Quality
- Deputy Medical Director Governance, Safety and Quality (Alternate Chair)
- Deputy Medical Director of Education and Workforce
- Assistant Director Clinical and Social Care Governance and Infection Prevention & Control

- Assistant Director Clinical and Social Care Governance
- Corporate Clinical and Social Care Governance Coordinator
- Operational Directorate Governance Coordinators
- Governance Officer, Corporate Clinical and Social Care Governance
- Complaints Manager
- Datix Risk Manager
- Head of Patient Safety Data and Improvement
- Senior Manager of Standards, Risk & Learning
- Litigation Manager
- Medicines Governance Pharmacist
- Head of Service – Adult Safeguarding
- Head of Information Governance
- Liaison Officers
- Assistant Director Quality Improvement / Head of Quality Improvement
- Corporate CSCG Admin staff member

When a member of the meeting group is unable to attend, an alternative nominee from his/her service area is required to attend. In cases where this is not possible, a comprehensive narrative report is required to be submitted clearly describing any issues which ought to be brought to the attention of the group.

Meeting Format

- Meetings held on a weekly basis
- Chaired by Medical Director or Deputy Medical Director
- Papers will be circulated the day before the meeting via email
- Additional members or presenters will be invited as agreed with the Chair

Review

- Terms of reference for the group will be reviewed on a 6 monthly basis

Confidentiality

- Information included in meeting papers will be anonymised and the discussions of the meeting will be treated as strictly confidential

Reporting

- The Weekly Governance Meeting will report weekly to the Trust SMT

Quality care – for you, with you

GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	12 th May 2022	
Agenda item	Quarterly Mortality Report July 2020 – June 2021	
Accountable Director	Dr Maria O’Kane, Medical Director	
Report Author	Name	Suzanne Barr
	Contact details	Personal Information redacted by USI
This paper is presented for: Assurance		
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>	

1. Detailed summary of paper contents:

There are three different sources of information contained within the report:

- CHKS Data: July 2020 – June 2021
- CAH ICU ICNARC: 1st April 2021 – 31st December 2021
- SHMI & VLADs: SHMI: July 2020 – June 2021
- Data Quality Assurance: July 2020 – June 2021
- For the reporting period of July 2020 – June 2021, there were 1,183 deaths within the Southern Trust.
- **A red alert has been generated by the Crude Mortality rate compared to both regional and national peers for the Southern Trust, however, these are inclusive of the COVID-19 deaths. The Trust Risk Adjusted Mortality rate indicators, has not generated any alerts and compare favourably with regional and national peers. These exclude COVID-19 deaths. The Risk Adjusted Mortality Indicators offer clear assurance to the Trust.**
- It should also be noted that risk adjusted measures such as RAMI are not designed for pandemic activity such as that observed during 2020. It is anticipated that at least 12 months full year activity will be required for sufficient data to be available to begin considering the development of risk adjusted mortality relating to Covid-19. As a result, the present RAMI measure cannot accurately calculate an expected deaths figure for records with Covid-19 coding using the present methodology. Risk adjusted reporting in this report therefore excludes any activity with Covid-19 diagnoses codes, specifically ICD-10 codes Confirmed Covid-19 U07.1 & Suspected Covid-19 U07.2. *No exclusions are applied to crude mortality indicators*

2. Areas of improvement/achievement:

- The Trust crude mortality rate was 1.50% compared to 1.12% for the 2019/20 period. In comparison with the UK peer, the mortality rate is similar (UK peer 1.48%) whilst the trust RAMI is lower (UK peer 93.39).
There was a significant increase in mortality for April 2020 before reducing in May and returning to within control limits for June 2020. The Mortality rate increased again in November/December 2020 above control limits (Chart 1 & chart 2, pages 12 & 13) and both episodes reflected deaths from COVID 19. These have been reflected and presented within previous Mortality Reports for the relevant timeframe.
- The RAMI 2019 score for the 2020/21 period was 79.03 compared to 78.83 2019/20. In comparison with the UK peer, the mortality rate is similar (UK peer 1.48%) whilst the trust RAMI is lower (UK peer 93.39). RAMI is rebased each year to address changes in data capture and it is worth noting that the RAMI used in this report is RAMI 2019.

- The RAMI Risk Adjusted mortality between April and November 2019 notes there were 7 consecutive points below the mean which were noted with special cause variation indicating a significant decrease. This trend has not been maintained and has returned to normal variation.
- The trust monthly RAMI is within the control limits for the period under review; May 2020 reports as highest index score by monthly value (117.53). The lowest RAMI score is observed in March 2020 (64.5). The overall RAMI index score for the trust over the period April 2018 to March 2021 is 81.81. For the 12 month reporting period April 2020 to March 2021 the overall RAMI index score is 79.03. (Chart 3)
- For specialist mortality indicators, there was no statistically significant alerts generated during the analysis period. Note that as numbers of deaths are at low confidence intervals they tend to be wide. Small changes in absolute numbers may lead to large percentage annual change causing some to be presented as a red alert
- The performance in the trust relating to the rate of deaths within 30 days of an emergency admission with a myocardial infarction is lower than peer (trust 0.38%, peer 3.3%) presented in Table 4.
- The performance relating to the rate of deaths in hospital within 30 days of an emergency admission with a stroke was better than peer, (trust 8.5%, peer 11.6%). The overall rate has decreased for this indicator in comparison with the same period last year (9.8% 2019/20) presented in Table 5.
- The rate of deaths for non-elective surgical patients within 30 days of surgery performance is similar in comparison to the previous 12 month period (0.50% 2019/20 to 0.52% 2020/21). There were 38 deaths associated with this indicator. Trust performance compares favourably with the peer (1.6% peer). (Table 6)
- The rate of deaths for elective surgical patients within 30 days of surgery is similar to the previous 12 month period (0.08% 2019/20 to 0.06% 2020/21). There was 1 death associated with this indicator. Trust performance compares favourably with the peer (0.18% peer). (Table 7)
- The rate of deaths in low mortality CCS groups is similar in comparison to the previous 12 month period (0.087% 2019/20 to 0.082% 2020/21). There were 9 deaths associated with this indicator. Trust performance compares positively to peer (0.14% peer) for the analysis period. (Table 8)
- ICNARC outcomes for the period 1st April 2021 to 31st December 2021 indicate that the Trust is performing on par in relation to all other NHS general critical care units peer and all similar peer units (Pages 17 -22). There were no alerts, with the Trust observed percentage lying within the predicted range (95%)

- The overall data quality index score for the trust for the July 2020 – June 2021 period was 95.70. This compared favourably to the NI peer (peer 93.29; note: the data quality index is a composite score made up of a series of data quality indicators including depth and completeness of coding. A score of 100 is the maximum score and is the most favourable position).
- Using both the regional methodology for mortality (SHMI pages 22 – 24) and the national CHKS methodology, the Southern Trust SHMI was “lower than expected” with Daisy Hill Hospital in the “lower than expected group”.

3. Areas of concern/risk/challenge:

- As previously noted there was a red alert has been generated by the *Crude Mortality rate* compared to both regional and national peers for the Southern Trust, however, these are *inclusive of the COVID-19 deaths*. The Trust *Risk Adjusted Mortality rate* indicators, has not generated any alerts and compare favourably with regional and national peers. *These exclude COVID-19 deaths*. The Risk Adjusted Mortality Indicators offer clear assurance to the Trust.
- There were no significant areas of concern, risk or challenge noted from this quarter.

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

Corporate Risk Register	no
Board Assurance Framework	no
Equality and Human Rights	no



The Southern Health and Social Care Trust

Quarterly Mortality Review: July 2020 to June 2021

Report to the Governance Committee, 12th May 2022

- CHKS Data: July 2020 – June 2021
- CAH ICU ICNARC: 1st April 2021 – 31st December 2021
- SHMI & VLADs: SHMI: July 2020 – June 2021
- Data Quality Assurance: July 2020 – June 2021

Where HES data has been used, it is
with the permission of NHS Digital.
All rights reserved.

© Copyright CHKS Limited 2022.

Confidential and contains
commercially sensitive information.

1	Contents.....	6
2	About CHKS.....	7
3	Introduction	8
3.1	Background.....	8
3.2	Interpretation of mortality measures	8
3.3	Analysis and Reporting	9
3.4	Trigger points	10
4	Findings	11
4.1	Mortality measures.....	11
4.2	Mortality analysis.....	11
4.3	Specialist mortality indicators	15
4.4	Intensive Support Unit, Craigavon Area Hospital (1 st April 2021 – 31 st December 2021)	18
4.5	Summary Mortality Hospital Information (July 2020 – June 2021)	23
4.6	Variable Life Adjusted Displays (VLADS)	27
4.7	Data quality assurance	29
5	Appendices	31
	Appendix 1. Trust trigger point protocol	31
	Appendix 2. Funnel Plots & Statistical Process Control Charts	33
	Appendix 3. CHKS Top Hospital Peer	34
	Appendix 4. Definitions for the condition specific indicators	36
	Appendix 5. Trust specialist mortality indicators process	38
	Appendix 6. SHMI Interpretation Guidance.....	39
	Appendix 7 ICNARC Guidance.....	41

2 About CHKS

CHKS is a leading provider of healthcare intelligence and quality improvement products and services. Over the last 32 years our team of NHS data experts, clinicians and quality managers have worked with more than 400 healthcare organisations around the world to improve population health.

We enable providers and commissioners to make better decisions at patient, service, organisation and population level and deliver sustainable improvements in care quality, patient outcomes and service efficiency along the entire patient pathway.

Our services include:

- **Healthcare benchmarking and analytics** – we identify what to improve and model the impact of change at patient, organisation and population level;
- **Clinical coding, data quality and costing services** – we ensure data used for payment and decision making accurately reflect the care delivered;
- **Care quality, assurance and accreditation** – we work to the latest international standards of best practice within a proven framework of continuous improvement.

Head office:

6190 Knights Court
Solihull Parkway
Birmingham Business Park
Birmingham
B37 7YB
T: 0333 241 2323

www.chks.co.uk

3 Introduction

3.1 Background

The SHSCT Mortality Report is at the core of the trust's clinical and quality indicator suite. The trust continues to develop, refine and validate mortality reporting mechanisms.

The Directorate of Performance and Reform and the Medical Directorate have established a number of matrices which draw upon CHKS benchmarked data in the analysis and review of the raw statistics of hospital deaths.

Death in hospital can be both an accepted fact of medical care delivery and a cause for organizational reflection and continuous assessment. Some unexpected deaths might be prevented if all the factors that contribute to them are better understood.

Hospital death rates, appropriately adjusted for variables such as population characteristics and diagnoses can serve as important quality indicators, and are an essential starting point in a journey to improve care and reduce mortality.

Good governance requires that trust managers and clinicians work together to distinguish between preventable deaths and deaths from other causes.

The mortality review has been designed in response to stakeholder comments which indicated that previous quarterly mortality reports were too detailed but did not provide an easily understandable picture of mortality.

3.2 Interpretation of mortality measures

Hospital Standardised Mortality Ratios (SMRs) are indicators of healthcare quality that measure whether the number of deaths at a hospital are higher or lower than expected based on the risk derived from case mix, given the type of patients admitted to the hospital.

A high SMR does not necessarily mean that there is a quality of care issue, or that unsafe services are being provided. It is not always possible to distinguish between deaths which could potentially have been preventable and those which were not. Therefore, a high SMR is regarded as a trigger for further investigation.

SMRs and mortality rates vary between trusts and fluctuate over time. This is especially true if SMRs or mortality rates are monitored frequently over short periods of time. The degree of fluctuation will be higher with smaller numbers of deaths in shorter time periods, simply because the effect of change is greater when the numbers are smaller. Equally, a single figure cannot be looked at in isolation and

must be examined in the context of a trend, and other sources of information on quality and safety. The two main mortality indicators used by CHKS in this report are as follows:

- Crude mortality – this is the proportion of patients treated in a hospital/site who died. It is calculated as $\frac{\text{Total deaths} \times 100}{\text{Total discharges} + \text{deaths}}$ and
- Risk-Adjusted Mortality Index (RAMI) – this indicator uses the characteristics of the patients treated in hospital to calculate a number of expected deaths and then compares this to the number of actual (observed) deaths. RAMI is then calculated as $\frac{\text{Observed deaths} \times 100}{\text{Expected deaths}}$ and expressed as an index, base 100 e.g. 210 observed deaths vs 200 expected = RAMI 105. If the number of observed deaths is higher than the number of expected deaths, RAMI will be greater than 100; if observed deaths are lower than expected, RAMI will be below 100.

The methodology behind the RAMI is limited to just six factors, each of which is known to have a significant and demonstrable impact on risk of death. They are:

- Age - six groups;
- Admission type - elective or non-elective;
- Primary clinical classification - 260 CCS groups;
- Sex - defaults to female if not known;
- Length of stay - specific groups only; and
- Most significant secondary diagnosis - list covers 90% of all diagnoses mentioned in patients who died.

The first five of these are defined as primary factors. Each is known with greater certainty and recorded with greater consistency than secondary diagnoses. For this reason the methodology uses these factors first. Secondary diagnoses which most significantly and consistently increase risk of death are then also used in the model.

RAMI is rebased each year to address changes in data capture. The RAMI used in this report is RAMI 2019.

3.3 Analysis and Reporting

The analysis completed in this report uses the CHKS benchmarking tool (iCompare) using data supplied by the trust, other NI trusts and NHS Digital. This review covers mortality for all admissions in SHSCT for the period July 2020 – June 2021 (inclusive) based on the data extract submitted by the trust in January 2022.

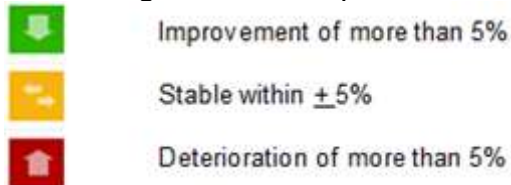
The peer groups used in this review for the purposes of benchmarking trust performance are the NHS England HES Acute Trusts peer and Northern Ireland Health and Social Care Trusts, (see Appendix 3).

Reporting includes funnel plot and statistical process control charts. Funnel plot charts show the volume of activity being analysed (along the x-axis) and the performance against the indicator (along the y-axis) for the trust and comparative peer group sites. The curved lines show the control limits, i.e. which data points are within the expected range of natural variation. Smaller datasets are more prone to the effect of natural variation, so that the control limits narrow as the volume of activity increases.

Statistical process control charts show variation over time. Upper and lower control limits have been included at ± 3 standard deviations. These show which data points are within the expected range of natural variation. It should be noted that the number of deaths in any given month is small and as such, it is important not to over-interpret fluctuations in the data month on month. In charts, the trust is identified in blue and peers are identified in green.

The benchmark report scorecards included in this report set out the performance of the trust for the reporting period. There are two sets of information to review:

- The change in the trust performance between the two years under review-



- Comparison in performance to the peer (HES acute peer). The peer value is the average and the 25th and 75th percentiles are shown. The performance key is:
 - Diamond represents Trust
 - Whiskers either side of Trust represent 95% confidence intervals
 - Vertical dotted line is peer mean
 - Horizontal grey box is peer percentile range from lower quartile to upper quartile
 - Low scores always on left/high scores on right.

All analysis is based on discharge attribution.

It should also be noted that risk adjusted measures such as RAMI are not designed for pandemic activity such as that observed during 2020/21. This is because this activity is not recorded in the reference data to which RAMI makes its adjustments. It is anticipated that at over 12 months full year coded activity will be required for sufficient data to be available to begin considering the development of risk adjusted mortality relating to Covid-19. As a result, the present RAMI measure cannot accurately calculate an expected deaths figure for records with Covid-19 coding using the present methodology. Risk adjusted reporting in this report therefore excludes any activity with Covid-19 diagnoses codes, specifically ICD-10 codes Confirmed Covid-19 U07.1 & Suspected Covid-19 U07.2. No exclusions are applied to crude mortality indicators.

3.4 Trigger points

In applying this analysis the following trigger points for further investigation have been agreed (incorporating agreed trigger points with the HSC Board).

- A value higher than the upper confidence limit on a single or multiple occasions;
- A risk adjusted score / index higher than 100 on six or more successive occasions;
- Six or more consecutive increases, regardless of the starting level (a rising trend) across any indicator.

The trust trigger point activation protocol is detailed in Appendix 1.

4 Findings

4.1 Mortality measures

The findings in this section of the report focus on the following measures of mortality:

- Crude mortality including trended in a SPC (statistical process control chart) against the trust's own upper and lower confidence limits;
- CHKS Risk Adjusted Mortality Index (RAMI 2019) including trended in a SPC (statistical process control chart) against the trust's own upper and lower confidence limits;
- The rate of deaths within 30 days of an emergency admission with a myocardial infarction (age 35 to 74);
- The rate of deaths within 30 days of an emergency admission with a stroke;
- The incidence of mortality for non-elective surgical patients within 30 days of surgery;
- The incidence of mortality for elective surgical patients within 30 days of surgery; and
- Rate of deaths in low mortality clinical classification groups.

4.2 Mortality analysis

The following charts, graphs and tables are taken from the CHKS iCompare system, using the trust's own data. This allows the organisation to review key components of its performance either over time in trend analysis or comparatively against peer hospitals.

The SHSCT Mortality Table – UK Peer (Table 1) and the SHSCT Mortality Table – NI Peer (Table 2) show the trust RAMI and mortality rate performance for the trust for the July 2020 – June 2021 reporting period and the same period the previous year. For the reporting period, there were 1,183 deaths; the trust crude mortality rate was 1.50% compared to 1.12% for the 2019/20 period. The RAMI 2019 score for the 2020/21 period was 79.03 compared to 78.83 2019/20.

In comparison with the UK peer, the mortality rate is similar (UK peer 1.48%) whilst the trust RAMI is also lower (UK peer 93.39).

Table 1: SHSCT Mortality, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Mortality Rate	1183	78704	1.5031%	1.1241%	33.72%	1.4803%		1.3439%	1.8145%	-
RAMI (Risk adjusted mortality index) 2019	816	1033	79.03	78.83	0.24649%	93.39		85.10	101.23	-

The trust crude mortality rate is higher than the NI peer of 1.42%. While this change creates a 'red' alert, it is in line with UK peers. The crude mortality rate includes Covid 19 deaths. The trust RAMI is lower than the NI peer of 91.37 which excludes Covid 19 deaths.

Table 2: SHSCT Mortality, NI Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Mortality Rate	1183	78704	1.5031%	1.1241%	33.72%	1.4210%		1.2226%	1.3641%	Red
RAMI (Risk adjusted mortality index) 2019	816	1033	79.03	78.83	0.24649%	91.37		84.95	93.41	-

Table 3 shows that there were 351 recorded deaths with a confirmed Covid-19 diagnosis and 16 with a suspected Covid-19 diagnosis. The SHSCT has had more Covid related deaths in this period than the NI peer.

Table 3: SHSCT Mortality, NI Peer, July 2020 – June 2021

Description	Local Numerator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Alert
Total Deaths with Covid-19	351	351	54	550%	275	-
Total Deaths with Suspected Covid-19	16	16	16	0%	17.8	-
Total Deaths without Confirmed or Suspected Covid-19	816	816	989	-17.5%	1177	-

Chart 1 illustrates the trended monthly average mortality (crude) for the trust for the period July 2018 to June 2021 and shows that performance for the trust falls within the upper and lower control limits up to April 2020 before reducing in May and returning to within control limits for June 2020; mortality rate performance also increases above the upper control limit from November 2020 through to February 2021. The range for the period is between 0.75% (August 2018) and 3.3% (January 2021). *The chart shows significant findings as an upper confidence breach and 'special cause variation' (decrease from April 2019 to November 2019 which was previously reported on), the upper confidence breaches are most likely to be the Covid-19 fatalities previously noted.*

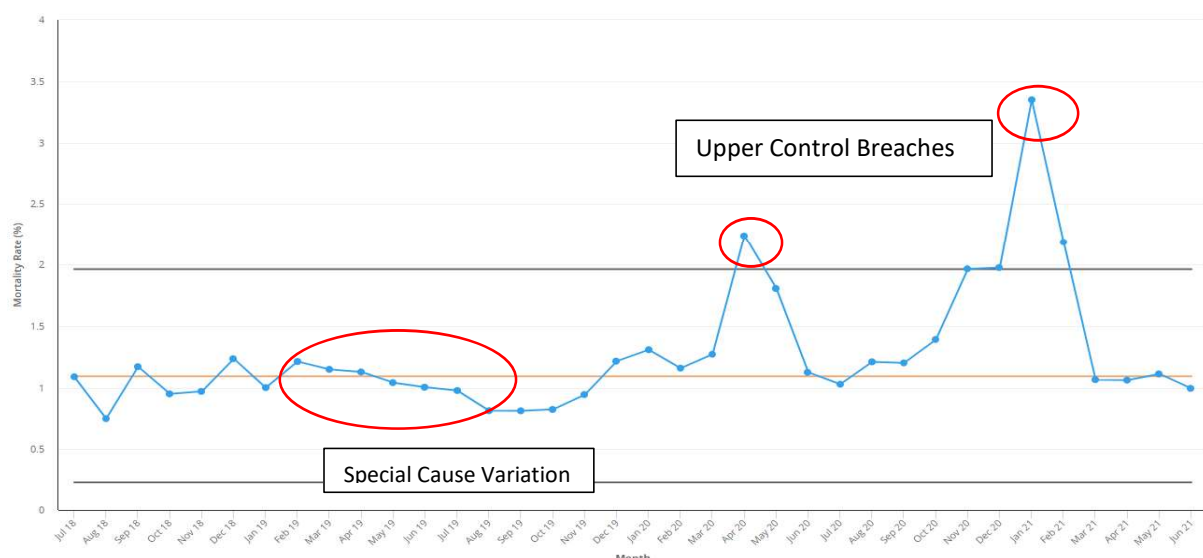
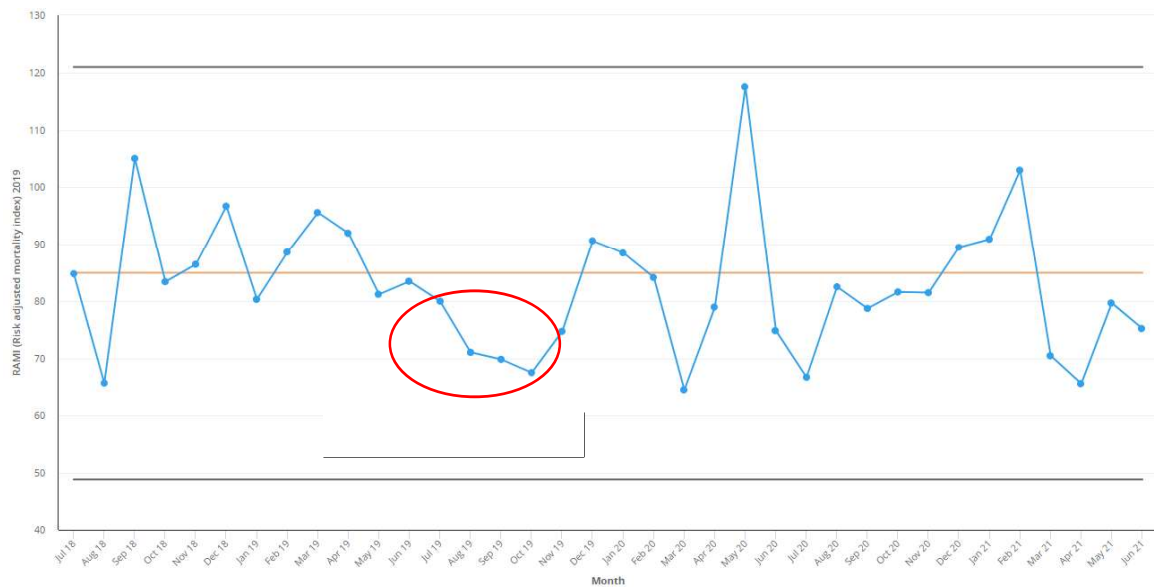
Chart 1: Average Monthly Mortality (Crude) SPC, July 2018 – June 2021

Chart 2 (below) illustrates the trended position for RAMI over the July 2018 to June 2021 period.

Chart 2: Monthly Risk Adjusted Mortality (RAMI) SPC, July 2018 – June 2021

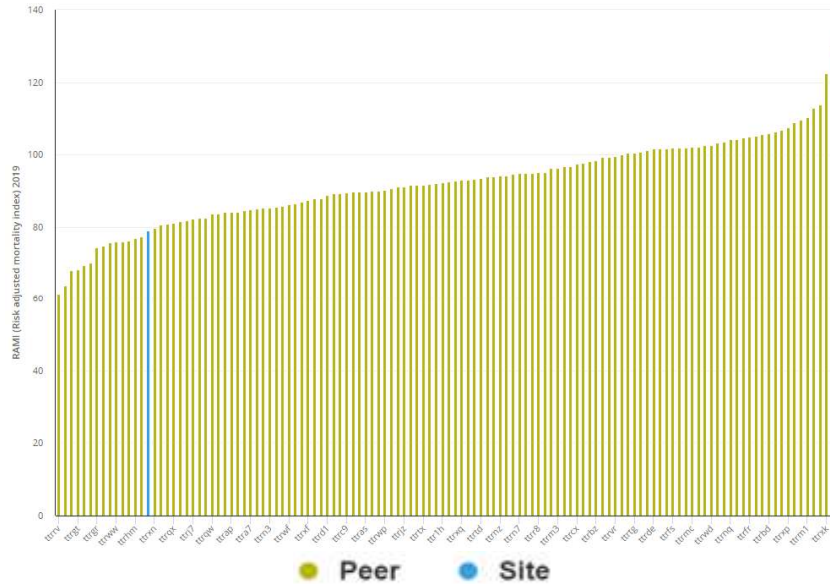


The trust monthly RAMI is within the control limits for the period under review; May 2020 reports as highest index score by monthly value (117.53). The lowest RAMI score is observed in March 2020 (64.5).

The overall RAMI index score for the trust over the period April 2018 to March 2021 is 81.81. For the 12 month reporting period April 2020 to March 2021 the overall RAMI index score is 79.03.

The trust's position relative to the UK HES Acute peer for the July 2020 to June 2021 period is represented by the blue bar in Chart 3 below.

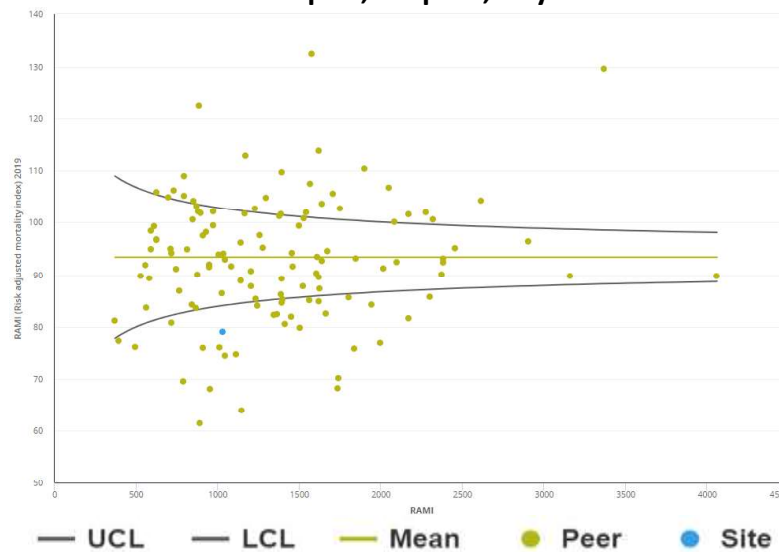
Chart 3: RAMI compared to UK peer, July 2020 – June 2021



In comparison with the UK peer, the trust RAMI score of 79.03 falls into the lower range of the peer.

Funnel plot analysis (see Chart 4 below) shows the trust position relative to individual UK peer sites. HSCB guidelines indicate that a position above the upper confidence limit in a funnel plot would require further investigation; this is not the case for the trust as it is sitting below the peer mean average and lower confidence limit. This means that the Trust has a statistically lower than expected mortality rate.

Chart 4: RAMI funnel plot, UK peer, July 2020 – June 2021



4.3 Specialist mortality indicators

The following section sets out a number of key areas where the incidence of mortality may be exceptional and as such a review of these cases could identify areas of concern and learning for the trust where the rate of mortality is greater than expected. Definitions for these indicators can be found in Appendix 4.

The trust has developed a specialist mortality indicators assurance process which was ratified by the SHSCT Mortality and Morbidity Monitoring Group – see Appendix 5 for further details.

The following tables show trust performance in relation to the peer average (HES Acute peer) for the period July 2020 to June 2021. No statistically significant alerts are generated relating to trust performance for these indicators during the analysis period.

Table 4. Rate of deaths within 30 days of an emergency admission with a myocardial infarction, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	1	260	0.3846%	2.0478%	-1.6632%	3.3266%		1.9553%	3.781%	-

The performance in the trust relating to the rate of deaths within 30 days of an emergency admission with a myocardial infarction is lower than peer (trust 0.38%, peer 3.3%).

1 death was recorded against this indicator. This case was subject to the Trust M&M screening process, however was not selected for detailed review.

This represented a rate decrease for the trust in comparison with the same period last year (2.0% 2019/20).

Table 5. Rate of deaths in hospital within 30 days of an emergency admission with a stroke, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Rates of mortality in hospital within 30 days of emergency admission with a stroke	47	553	8.499%	9.790%	-1.291%	11.598%		10.374%	13.732%	-

The performance relating to the rate of deaths in hospital within 30 days of an emergency admission with a stroke was better than peer, (trust 8.5%, peer 11.6%). 47 deaths were recorded against this indicator. The overall rate has decreased for this indicator in comparison with the same period last year (9.8% 2019/20).

There were 47 deaths recorded against this indicator of June 2020 – July 2021, all of these deaths were subject to Trust M&M screening processes, with 10 cases being discussed in detail at a Trust M&M Meetings. For this report there was 18 cases not previously reported on within the last quarterly report - 2 of these cases have Covid-19 noted and therefore learning from these cases is awaited. There was no learning outcomes noted from the other cases reviewed.

Table 6. Rate of deaths for non-elective surgical patients within 30 days of surgery, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Rate of Mortality in hospital within 30 days of Non elective surgery	38	7246	0.5244%	0.5037%	4.106%	1.6050%		1.2095%	1.8761%	-

The rate of deaths for non-elective surgical patients within 30 days of surgery performance has increased in comparison to the previous 12 month period (0.50% 2019/20 to 0.52% 2020/21).

There were 38 deaths associated with this indicator. Trust performance compares favourably with the peer (1.6% peer).

Of the 38 deaths associated with this indicator, all were subject to Trust M&M screening processes, with 4 waiting to be signed off by an M&M Chair (2 cases with Urology Consultant to review, 1 case with General Surgery and 1 outstanding due to no Gynae M&M Chair however this has been escalated to Divisional AMD).

24 of these cases were discussed in detail at Trust M&M Review Meetings. Following detailed reviews, 18 cases were deemed to have no learning outcomes and care provision was determined to be appropriate. One case is being reviewed as an SAI and at point of writing, remains ongoing.

There was no learning outcomes noted from the **new** cases reviewed at Trust M&M meetings.

Table 7. Rate of deaths for elective surgical patients within 30 days of surgery, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Rate of Mortality in hospital within 30 days of elective surgery	1	1967	0.05084%	0.06614%	-24.134%	0.16476%		0.06983%	0.20859%	-

The rate of deaths for elective surgical patients within 30 days of surgery has decreased in comparison to the previous 12 month period (0.07% 2019/20 to 0.05% 2020/21).

There was 1 death associated with this indicator. Trust performance compares favourably with the peer (0.16% peer). This case was previously commented on within the last quarterly report.

Table 8. Rate of deaths in low mortality CCS Groups, UK Peer, July 2020 – June 2021

Description	Local Numerator	Local Denominator	Jul 20 - Jun 21	Jul 19 - Jun 20	Change	Peer Value	Performance	25th Percentile	75th Percentile	Alert
Deaths In Low Mortality CCS Groups	9	10989	0.08190%	0.08660%	-0.0047%	0.13907%		0.09039%	0.17232%	

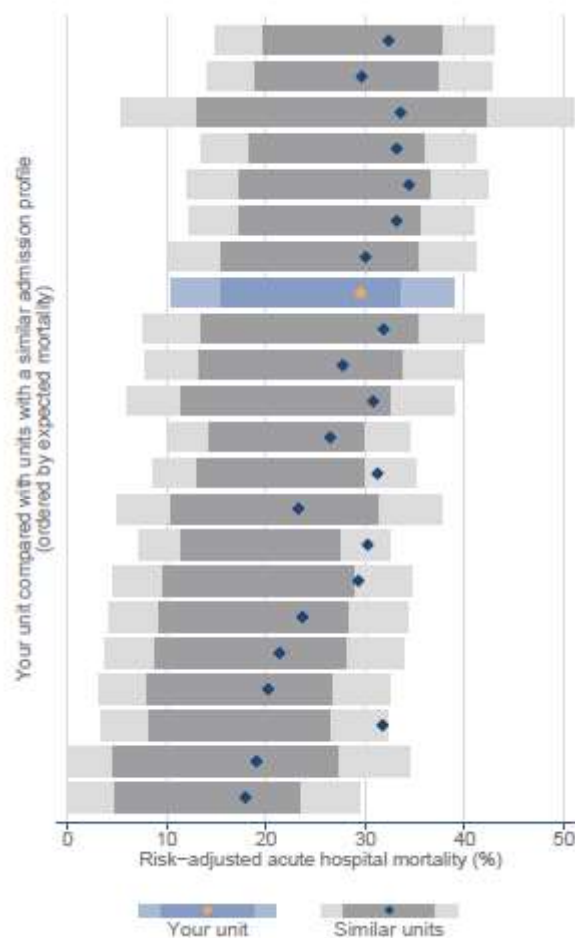
The rate of deaths in low mortality CCS groups is similar in comparison to the previous 12 month period (0.087% 2019/20 to 0.082% 2020/21).

There were 9 deaths associated with this indicator. Trust performance compares positively to peer (0.14% peer) for the analysis period. None of these cases are new cases and have been previously commented on within previous quarterly Mortality reports.

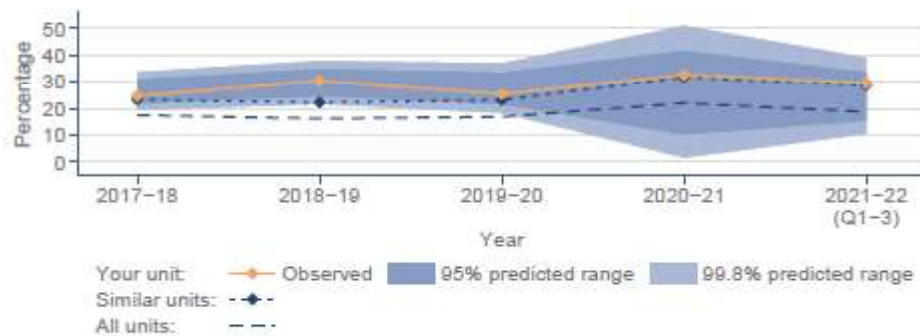
4.4 Intensive Support Unit, Craigavon Area Hospital (1st April 2021 – 31st December 2021)

The Trust participates in a UK wide audit of Intensive Care Outcomes - ICNARC Case Mix Programme (CMP). ICNARC is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland. [Appendix 7]. This information will also feature in the Trust National Audit Assurance Report.

Chart 5: Chart of Risk Adjusted Acute Hospital Mortality – ICNARC 2018 Model [All and Similar Units] Compared with all other NHS general critical care units (1st April – 31st December 2021)



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	113	112	21.4	19.7	(12.1, 26.8)	(8.4, 31.5)	●
Quarter 2	138	133	27.8	23.8	(10.5, 36.3)	(3.8, 44.4)	●
Quarter 3	122	114	39.5	30.5	(12.9, 47.0)	(3.8, 57.4)	●
Quarter 4							
Year to date	373	359	29.5	24.6	(15.4, 33.5)	(10.5, 39.0)	●

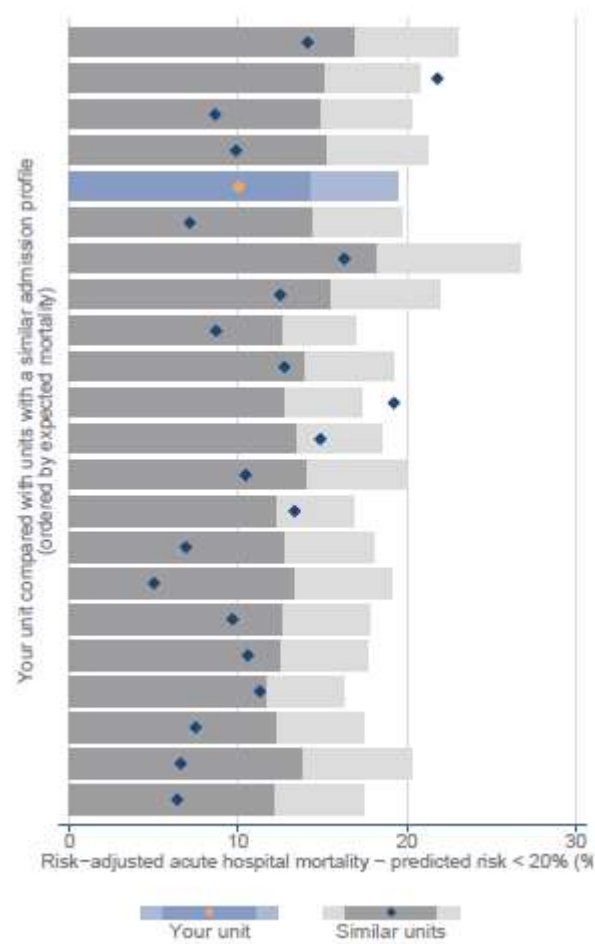


Definition

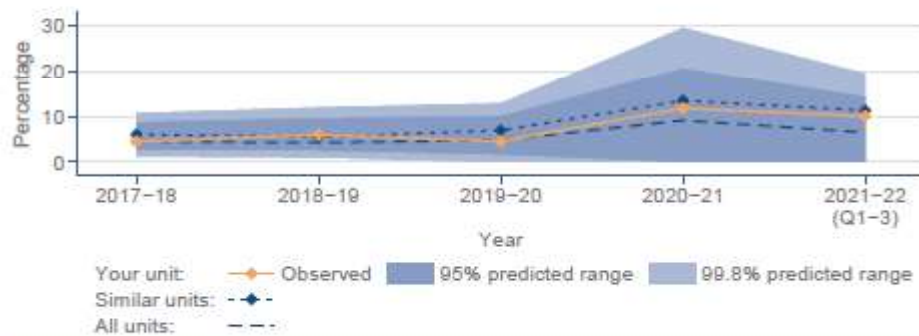
- Eligible: All critical care unit admissions, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- Observed percentage: The percentage of eligible admissions that died before ultimate discharge from acute hospital
- Expected percentage: The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC_{HT-2018} model for eligible admissions to your unit
- Predicted range: We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Chart 5 and the charts above illustrate the CAH ICU ICNARC 1st April – 31st December 2021 score on a plot compared to all other ICNARC participating units. The position of the Southern Trust is indicated by the orange marker and compares on par to peer sites. The Trust observed percentage lies within the 95% predicted range.

Chart 6 – Chart of Risk Adjusted Acute Hospital Mortality [Predicted Risk <20%] – ICNARC 2018 Model [All and Similar Units] Compared with all other NHS general critical care units. 1st April – 31st December 2021



	N	Eligible	Observed percentage	Expected percentage	95% predicted range	99.8% predicted range	
Quarter 1	113	80	6.3	5.5	(0.4, 10.5)	(0.0, 14.3)	●
Quarter 2	138	79	10.1	6.3	(0.0, 16.8)	(0.0, 24.9)	●
Quarter 3	122	60	15.0	8.5	(0.0, 24.9)	(0.0, 37.5)	●
Quarter 4							
Year to date	373	219	10.0	6.6	(0.0, 14.2)	(0.0, 19.5)	●

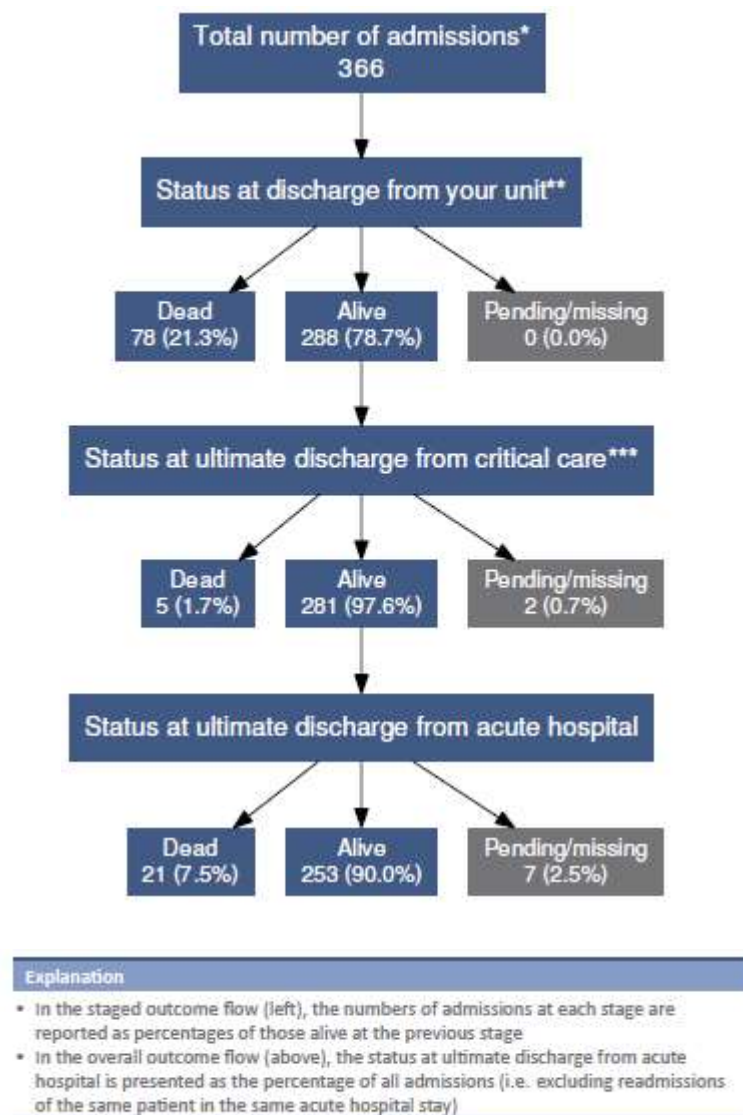


Definition

- **Eligible:** All critical care unit admissions with a predicted risk of death < 20% on the ICNARC₁₁₋₂₀₁₈ model, excluding readmissions, patients dead on admission and those admitted to facilitate organ donation
- **Observed percentage:** The percentage of eligible admissions that died before ultimate discharge from acute hospital
- **Expected percentage:** The expected percentage of acute hospital deaths among eligible admissions, calculated as the mean predicted risk of death from the ICNARC₁₁₋₂₀₁₈ model for eligible admissions to your unit
- **Predicted range:** We expect a unit's observed percentage to lie within the 95% predicted range 19 times out of 20 and within the 99.8% predicted range 998 times out of 1000

Chart 6 and the charts above illustrate the CAH ICU ICNARC April 2021 – December 2021 score on a plot compared to other similar ICNARC participating units. The position of the Southern Trust is indicated by the orange marker. This shows that the Trust lies within the 95% predicted range.

Chart 7 – below provides detailed outcomes for admission into ICU from 1st April – 31st December 2021



The above chart gives comprehensive and detailed data on the admissions and outcomes of those in the Southern Trust ICU throughout 1st April – 31st December 2021.

4.5 Summary Mortality Hospital Information (July 2020 – June 2021)

The Summary Hospital-level Mortality Indicator (SHMI) compares the actual number of patients who die following hospitalisation at a Trust, with the number that would be expected to die on the basis of average Northern Ireland figures, given the characteristics of the patients treated there. SHMI analysis is provided to all HSCTs by the Department of Health Information Analysis Directorate.

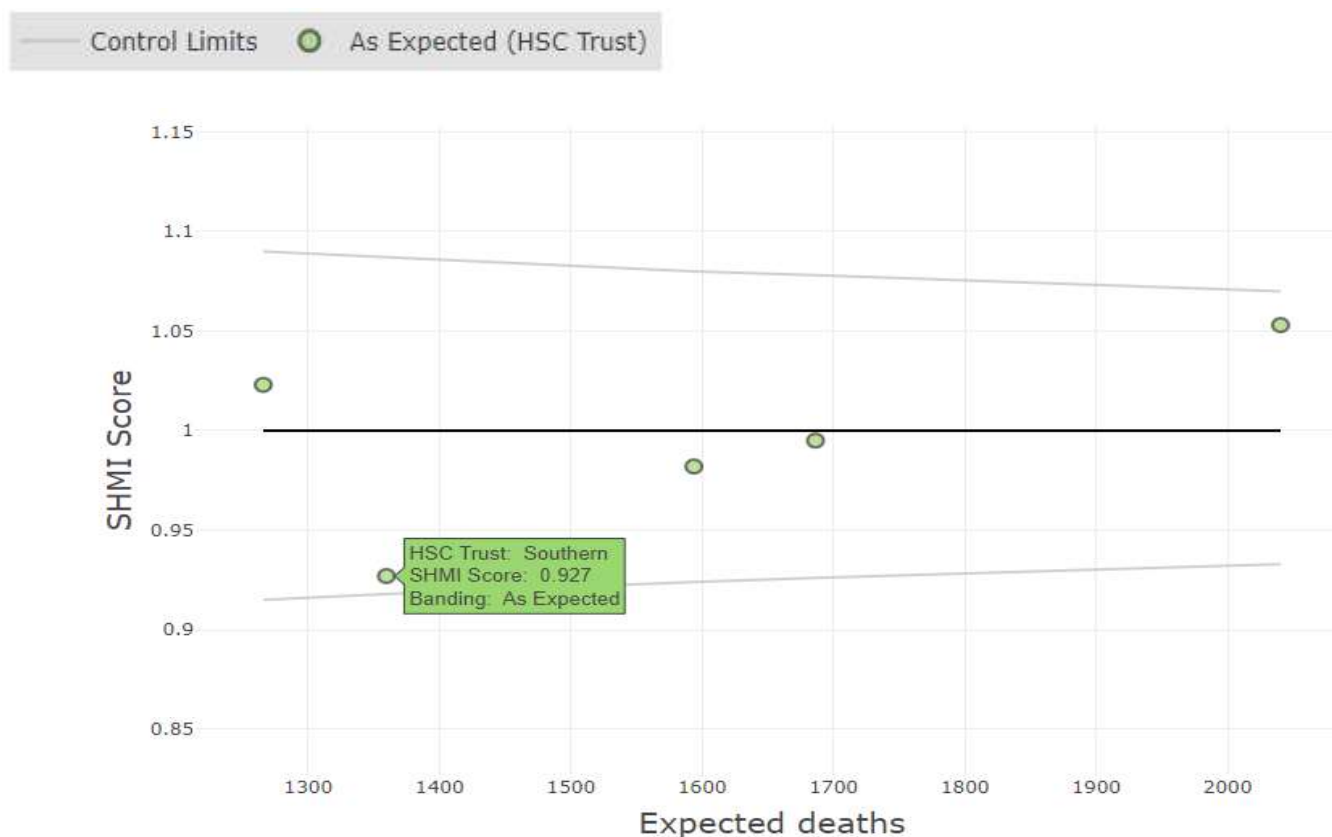
For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the Trust in question is considered to have a higher or lower SHMI than expected.

The SHMI includes deaths which occur in hospital or within 30 days of discharge and is calculated using Patient Administration System (PAS) data linked to General Registry Office (GRO) death registrations data.

The expected number of deaths is estimated using the characteristics of the patients treated; age, sex, method of admission, current and underlying medical condition(s). It covers patients admitted to hospitals in Northern Ireland who died either while in hospital or within 30 days of being discharged.

Scatter plots showing results at Trust and Hospital Level are included below. As shown on the chart, the Southern Trust overall has a risk adjusted mortality rate that significantly lies below the expected range.

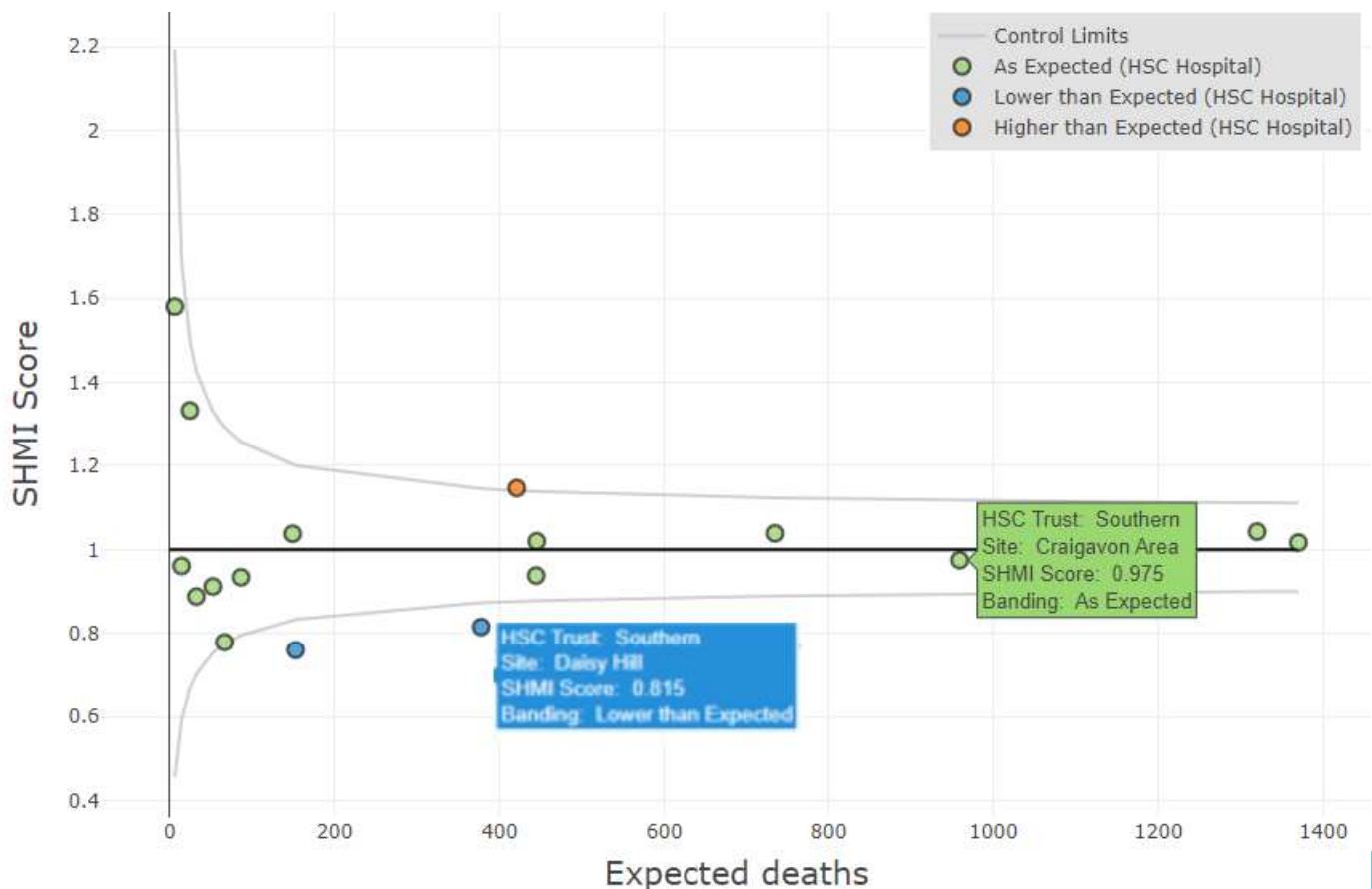
Chart 8 – Funnel Plot of Summary Hospital Level Mortality Indicator [Trust Level] July 2020 – June 2021



HSC Trust	Deaths	Risk	SHMI Score	Admissions	SHMI Banding
Belfast	2,148	2,040	1.053	60,233	As Expected
Northern	1,678	1,686	0.995	42,693	As Expected
South Eastern	1,565	1,593	0.982	41,419	As Expected
Southern	1,260	1,359	0.927	43,324	As Expected
Western	1,295	1,265	1.023	36,992	As Expected

The funnel plot and table above illustrates the Trust score compared to all other NI Health and Social Care Trusts. The position of the Southern Trust is labelled on the funnel plot with all Trusts presenting as expected.

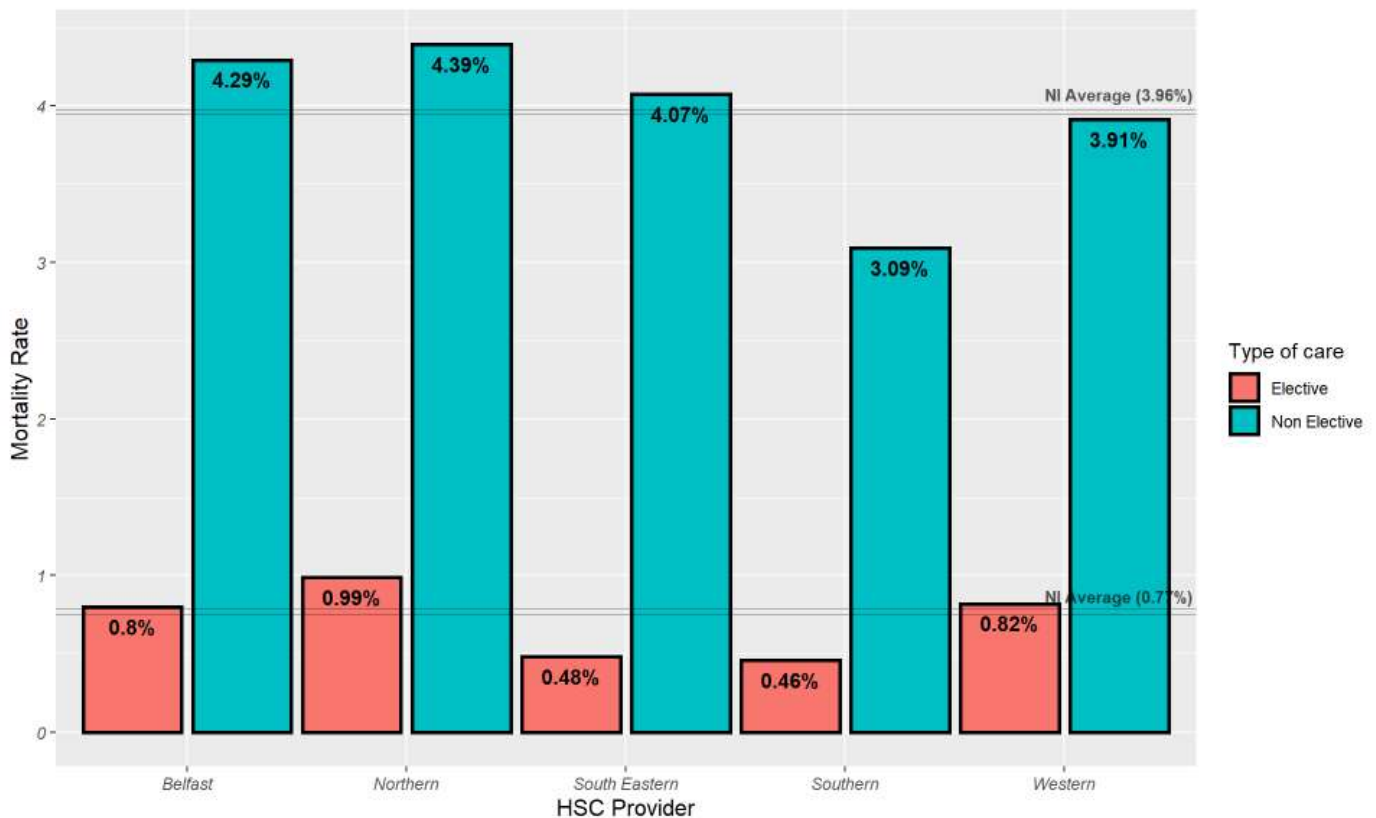
Chart 9 – Funnel Plot of Summary Hospital Level Mortality Indicator [Hospital Level] July 2020 – June 2021



Southern	Craigavon Area	935	959	0.975	27,993	As Expected
Southern	Daisy Hill	308	377	0.815	14,404	Lower than Expected

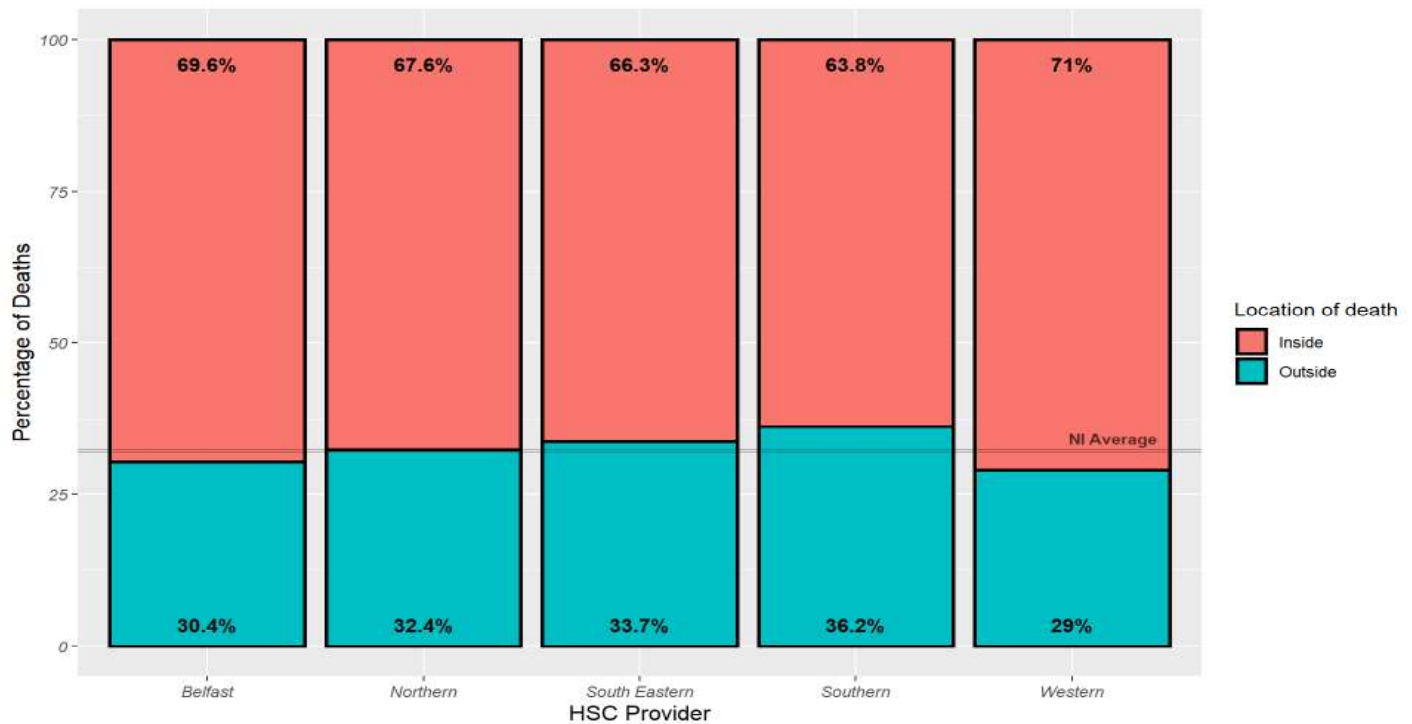
Chart 9 illustrates the Trust Hospitals score on a funnel plot. The position of two Hospitals in the Southern Trust are labelled, with Craigavon Area Hospital 'as expected' compared to peer organisations, with Daisy Hill Hospital SHMI score 'lower than expected' as also presented on the table above.

Chart 10 –Summary Hospital Level Mortality Indicator – Percentage of Deaths Elective / Non-Elective Care July 2020 – June 2021



The chart above indicates Southern Trust performance compared with other NI Trusts with regards elective and non-elective deaths. The Southern Trust ranks lower than average for both elective and non-elective deaths for the period. Trust non-elective (3.09%) and elective (0.46%) deaths are the lowest for the region.

Chart 11 –Summary Hospital Level Mortality Indicator – Location of Patient Deaths July 2020 – June 2021



The chart above indicates the Southern Trust's position regarding the location of patient deaths (i.e. inside and outside of hospital). This chart shows the percentage of deaths in each category. The rate of deaths occurring outside of hospital is higher in the Southern Trust than in the other NI HSC Trusts (Southern Trust 36.2%). The Southern Trust has the least number of deaths inside hospital (63.8%) in comparison with its peers. Several factors will influence the Trust's ratio of in-hospital and outside hospital deaths, including support for palliative care services at home and Acute Care at Home services which are embedded within the Trust.

Chart 12 –Summary Hospital Level Mortality Indicator – Percentage of total deaths coded as Palliative July 2020 – June 2021

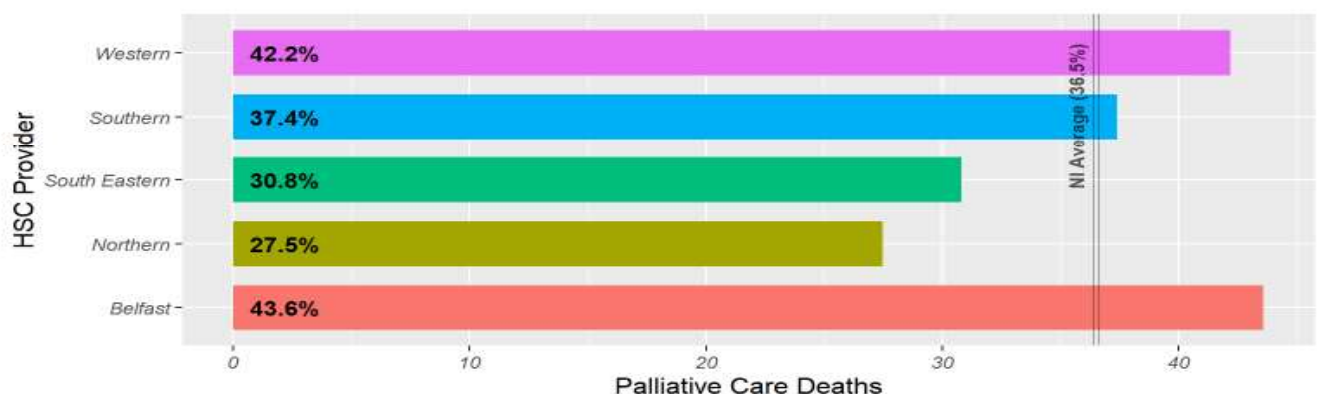


Chart 12 highlights the total percentage of deaths coded as Palliative; this considers deaths that occurred **both** in and outside of hospital settings. The Southern Trust percentage (37.4%) is higher than the regional average (36.5%).

4.6 Variable Life Adjusted Displays (VLADS)

A VLAD is a visual representation of treatment outcomes for selected diagnosis groups which itself is a subset of the SHMI methodology. It displays trends over time within a hospital and identifies unexpected runs of outcomes. Each plotted point on the line represents an episode of care. The outcome (0 = Survived, 1 = Died) of that episode is subtracted from the expected score for that episode (Risk). If a patient survives, the line moves up, if a patient dies, the line moves down. The extent of movement up or down is dependent on the difference between the expected and the observed outcomes. If any chronological run of outcomes is greater than is deemed statistically probable, the line will move above or below its control limit and the chart will flag this as a control limit breach. These charts can be created for any of the 140 SHMI diagnosis groups but currently are created for 11 SHMI Diagnosis groups which show high levels of activity and SHMI Model stability by the Department of Health Information Analysis Directorate. The 11 groups are listed below:

- Septicaemia
- Cancer of Bronchus
- Secondary Malignancies
- Fluid and Electrolyte Disorders
- Acute Myocardial Infarction
- Pneumonia
- Acute Bronchitis
- Gastrointestinal Hemorrhage
- Acute and Unspecified Renal Failure
- Urinary Tract Infection
- Fractured Neck of Femur (Hip)

The below table indicates the VLAD that experienced control limit breaches for SHMI group during this reporting period. None of the remaining VLADs experienced any breaches during the reporting period July 2020 – June 2021

SHMI Group	SHMI Description	Upper Limit Breaches	Lower Limit Breaches
73	Pneumonia (excluding TB/STD)	1	0

Chart 14 – Variable Life Adjusted Display Control Limit Pneumonia (excluding TB/STD) – June 2020 – July 2021

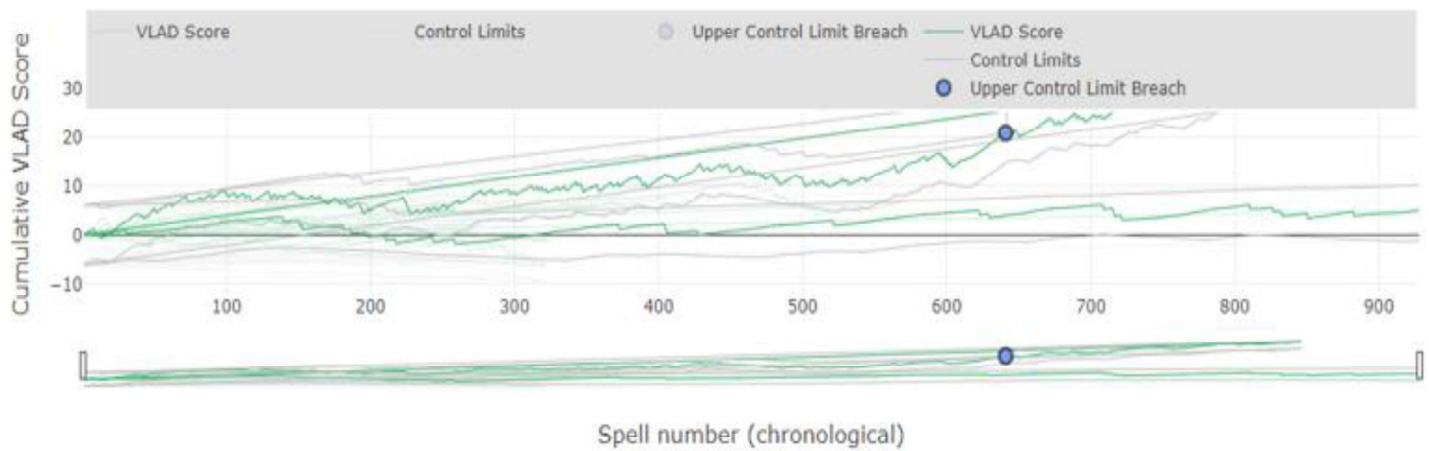


Chart 14 above details the upper limit breach regarding Pneumonia (excluding TB/STD) which occurred in the case of one patient within this reporting period.

4.7 Data quality assurance

The analysis of any case mix / risk adjusted scoring relies heavily on the accuracy and completeness of the coded data. The data quality index within iCompare is derived from a number of indicators including the volume of un-coded activity and the depth of coding as more codes can give a more comprehensive view of the individual patient's condition and treatment.

A number of indicators are monitored against the peer in relation to coding quality; these are:

- Trust data quality index score;
- Blank (un-coded) diagnosis rate;
- Depth of coding, (the average number of diagnoses recorded against each episode of care);
- Use of palliative care diagnosis code Z51.5

The overall data quality index score for the trust for the July 2020 – June 2021 period was 95.70. This compared favourably to the NI peer (peer 93.29; note: the data quality index is a composite score made up of a series of data quality indicators including depth and completeness of coding. A score of 100 is the maximum score and is the most favourable position).

Chart 5a. Trust data quality index by month compared to NI peer, July 2020 – June 2021



Chart 5b. Trust % blank diagnosis codes (Finished Consultant Episode), NI peer comparison, July 2020 – June 2021

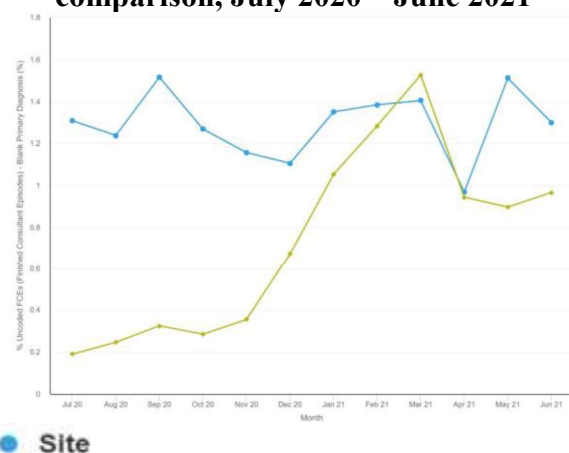
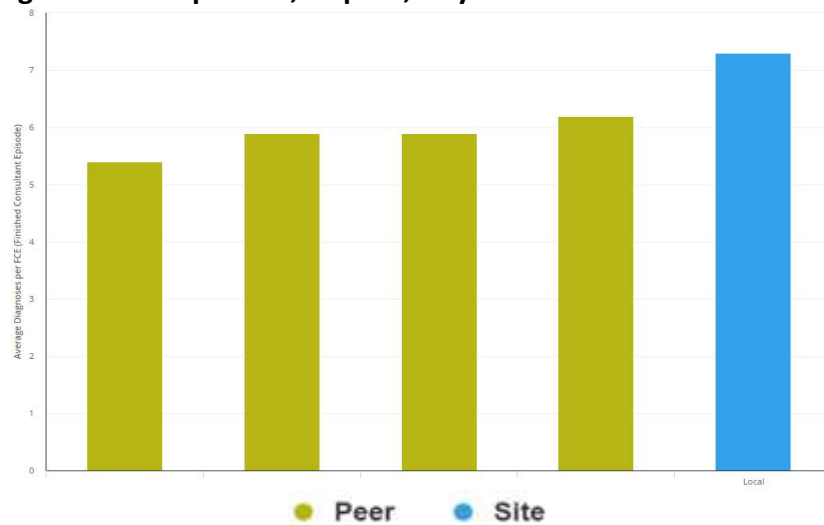


Chart 5a shows that the trust data quality index score is higher over the analysis period in comparison with peer. Chart 5b shows higher levels of % blank diagnosis codes to peer throughout reporting period with the exception of March 2021.

In relation to depth of coding, Chart 6 shows the trust average diagnosis codes are highest compared to NI peers for the analysis period (trust depth of coding is 7.3 for the July 2020 – June 2021 period, peer 5.8).

Chart 6. Average diagnosis codes per FCE, NI peer, July 2020 – June 2021



The final data indicator reviewed relates to the level of palliative care codes associated with the caseload of the trust. Consistent and appropriate use of palliative care codes are important to ensure that differences in performance to the peer are not due to variation in recording practices. The following table highlights the trust position is higher than the NI peer for the percentage of episodes with a palliative care code and the percentage of deaths with a palliative care code.

Table 8. Palliative care coding, July 2020 – June 2021

Indicator	Southern Trust	Benchmark NI Peer
Number of FCEs with palliative care code Z51.5	2734	N/A
% of all episodes with palliative care code	2.3%	1.2%
FCE deaths in hospital with palliative care code	455	N/A
FCE deaths with palliative care code	38.72%	34.52%

5 Appendices

Appendix 1. Trust trigger point protocol

The HSCB have defined the following trigger points which would suggest that there is a high possibility that the pattern of data has not arisen by chance alone.

- The Risk Adjusted HSMR score is higher than the upper control limit on a single occasion
- The Risk Adjusted HSMR score is higher than 100 on six or more successive occasions
- The trend of Risk Adjusted HSMR scores shows six or more consecutive increases, regardless of the start level.

Trigger Point Escalation

For HSCB Board Regional Mortality Report the following process will be followed by the Trust Medical Director/Director of Public Health:

- Inform HSCB/Trust Chief Executive and relevant members of HSCB/Trust SMT
- Liaise with Trust Medical Director to establish a HSCB SMR Incident Team
- Inform Chief Medical Officer and the DHSSPS through the early alert system
- Report progress to the HSCB and Trust SMT, Governance Committee and Board
- Escalate immediate concerns to Chief Executive Level as and when required.

For Internal Patient Safety Mortality Review/ Clinical Specialty Mortality Review the following process will be followed by the Trust Medical Director.

- Inform Trust Chief Executive and relevant members of Trust SMT
- Escalate immediate concerns to Chief Executive Level as and when required.

Review Structure

For HSCB Board Regional Mortality Report a SMT Incident Team will be established.

For internal Reports the Trust M&M Oversight Group will establish a SMR Response team.

Actions to be undertaken

Step 1 Check for data analysis errors

- Was raw data from the correct data period used?
- Is any raw data missing?
- Was additional data included in error?
- Were the correct expected death rates applied?
- Was the right peer group used as the comparator?

Step 2 Check for artefacts, specifically

- Did the data quality change significantly compared to the previous period or compared to other Trusts in NI/peer?
- Did the Trust change other aspects of its coding practice?
- Did any new specialised units open or close in the Trust since the last reporting period?
- Did the denominator change significantly since the last reporting period?

Step 3 Check the source of the trigger, specifically

- Is it a generalised increase in deaths, or limited to 1 or 2 specialties?
- If limited, have there been any special features or changes in those areas that might explain the change in SMR?

Step 4 Check other measures of quality and safety of care in the areas affected, specifically:

- What do other assurance systems show, e.g. M and M meetings, clinical audits, nutritional audits, environmental cleanliness audits, Confidential Enquiry reports or Sentinel audits?
- Has there been any notable change in adverse events or complaints?
- Has there been any increase in HCAs [as a proxy for good care]?
- Have there been any concerns about the performance of individual medical, nursing or other staff?
- Have there been any qualitative concerns raised about safety/quality?

Step 5 Instigate more detailed analysis and monitoring, including, but not limited to:

- Senior doctors, nurses/other relevant staff review a substantial sample of deaths including coding of these details. Widen the size of the review if the first phase identified cause for concern [This may be done by staff external to the Trust]
- Conduct short, immediate specific audits to examine any areas of concern in more detail
- Monitor SMRs more frequently or at a more detailed level where valid

Step 6 Address any issues identified, specifically

- The Trust SMR Response Team will develop and implement an action plan to ensure that all identified issues are addressed. They will report to the Safety Monitoring Committee and HSCB Incident Team [where appropriate].

Step 7 Next Steps

- If SMRs do not improve, or further analysis identified other substantive issues of concern, the situation will be escalated to Chief Executive level.

Appendix 2. Funnel Plots & Statistical Process Control Charts

The funnel plot shows the distribution of RAMI scores of the peer group, and includes confidence limits at 99.8%. A RAMI score outside the confidence limits is unlikely to have arisen due to normal variation or fluctuation. Instead, it is considered to be a 'special cause' variation which requires further investigation.

A rising trend associated with trended values, or persistently higher RAMI or other score that is still within confidence limits, is also considered to be unlikely to have arisen by chance, and therefore would require further investigation.

SPC charts compare performance of a single Trust over time. They therefore do not provide any assurance of performance relative to other sites. They need an absolute minimum of 1 years' worth of data. The control limits are centred around the Trust mean and set to 3 standard deviation above and below.

Appendix 3. CHKS Top Hospital Peer

The 'CHKS Top Hospital Peer' is based on the evaluation of 22 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. Peer hospitals included are:

West Suffolk NHS Foundation Trust

Shrewsbury And Telford Hospital NHS Trust

Surrey And Sussex Healthcare NHS Trust

East Cheshire NHS Trust

Homerton University Hospital NHS Foundation Trust

Royal Surrey County Hospital NHS Foundation Trust

Kingston Hospital NHS Foundation Trust

Western Sussex Hospitals NHS Foundation Trust

Ashford And St Peter's Hospitals NHS Foundation Trust

Airedale NHS Foundation Trust

South Warwickshire NHS Foundation Trust

Norfolk And Norwich University Hospitals NHS Foundation Trust

Taunton And Somerset NHS Foundation Trust

Wrightington, Wigan And Leigh NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust

Weston Area Health NHS Trust

Harrogate And District NHS Foundation Trust

Southern Health and Social Care Trust (*Note: excluded as a peer in analysis*)

Chelsea And Westminster Hospital NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust

Wirral University Teaching Hospital NHS Foundation Trust

Bedford Hospital NHS Trust

The Hillingdon Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Poole Hospital NHS Foundation Trust

Imperial College Healthcare NHS Trust

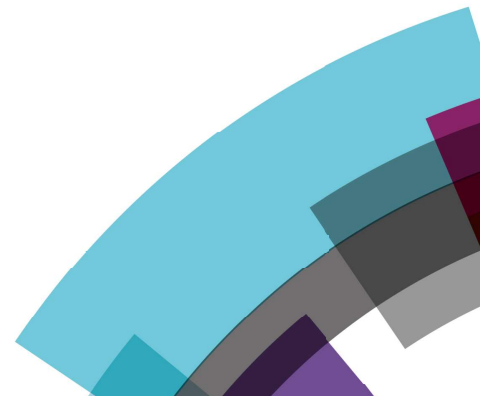
Yeovil District Hospital NHS Foundation Trust

The Dudley Group NHS Foundation Trust

The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust



Gateshead Health NHS Foundation Trust
Countess Of Chester Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
The Whittington Hospital NHS Trust
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
Burton Hospitals NHS Foundation Trust
Derby Teaching Hospitals NHS Foundation Trust
George Eliot Hospital NHS Trust
Barking, Havering And Redbridge University Hospitals NHS Trust
Salford Royal NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust



Appendix 4. Definitions for the condition specific indicators

1. Rates of deaths in hospital within 30 days of emergency admission with a heart attack (myocardial infarction) for patients aged 35 to 74

Numerator: Number of spells where a patient aged 35 to 74 died in hospital within 30 days of an emergency admission with a primary diagnosis of myocardial infarction ICD10 I21, I22. When looking for the qualifying condition look at primary diagnosis in episode 1 OR where primary diagnosis in episode 1 = R071, R072, R073 or R074 and episode 1 LoS is <2 days, look at episode 2 (only episode 2) primary diagnosis for MI (I21 or I22)

Denominator: Total number of complete (i.e. discharged) spells where a patient aged 35 to 74 with a primary diagnosis of myocardial infarction ICD10 I21, I22. When looking for the qualifying condition look at primary diagnosis in episode 1 OR where primary diagnosis in episode 1 = R071, R072, R073 or R074 and episode 1 LoS is <2 days, look at episode 2 (only episode 2) primary diagnosis, following an emergency admission.

2. Rates of deaths in hospital within 30 days of emergency admission with stroke

Numerator: Number of spells where a patient died in the hospital within 30 days of an emergency admissions with a primary diagnosis of stroke ICD10 I61, I63, I64 when looking for the qualifying condition look at primary diagnosis in episode 1 or where condition not primary diagnosis in episode 1 and episode 1 LoS is <2 days, look at episode 2 (only ep 2) primary diagnosis.

Denominator: Total number of completed (i.e. discharged) spells where a patient with a primary diagnosis of stroke ICD10 I61, I63, I64 when looking for the qualifying condition look at primary diagnosis in episode 1 or where condition no primary diagnosis in episode 1 and episode 1 LoS is <2 days, look at episode 2 (only ep 2) primary diagnosis, following an emergency admission.

3. Rates of deaths in hospital within 30 days of surgery: Non-elective admissions

Numerator: The number of non-elective admission spells where a patient died in hospital within 30 days of a surgical procedure

Denominator: The total number of complete (i.e. discharged) non-elective admission spells involving a surgical procedure.

Exclusions: A cancer diagnosis in any position within the spell (ICD 10 codes C00-C97, D37-D48, Z51.1) Day cases (zero length of stay), Spells with no surgical procedures

4. Rates of deaths in hospital within 30 days of surgery: Elective admissions

Numerator: The number of elective admission spells where a patient died in hospital within 30 days of a surgical procedure

Denominator: The total number of complete (i.e. discharged) elective admission spells involving a surgical procedure.

Exclusions: A cancer diagnosis in any position within the spell (ICD 10 codes C00-C97, D37-D48, Z51.1)

Table 4. Rate of deaths in low mortality CCS Groups Rates

5. Rates of death in low CCS Groups

Numerator: Total number spells and discharge method = patient died and age >17 and low mortality CCS Group.

Denominator: Total spells and age >17 and low mortality CCS group.

Exclusions: Low mortality CCS groups only or regular attender or day case or emergency admission and spell LoS = 0, AND not death.

Appendix 5. Trust specialist mortality indicators process

1. The Trust CHKS Specialist Mortality Indicator report sets out a number of key areas where the incidence of mortality may be exceptional. It is recommended that review of these cases could identify areas of concern and learning for the Trust. This review will provide assurance to the Trust Board via the Trust Governance Committee that a second level of scrutiny is being undertaken.
2. The following assurance process will be followed by the Trust Medical Director.
3. Currently the following specialist indicators are reviewed
 - Deaths within 30 days for admissions with Myocardial Infarction
 - Deaths in hospital within 30 days of emergency admission with stroke
 - Non Elective Deaths within 30 days of Surgery
 - Elective Deaths within 30 days of Surgery
4. Patient level data for each of the cases is provided by CHKS.
5. The Medical Director requests an assurance from clinical audit team that these deaths have been subject to M & M scrutiny [Screening and/or case presentation]. This will be reviewed by the relevant Associate Medical Director and Medical Director.
6. Medical Director tables the CHKS Annual Mortality Review to Governance Committee.
7. The relevant Associate Medical Director and Medical Director will identify cases for review by the Outcome Review Group. A key aim of this group is to 'identify issues from the M and M process which require further investigation or audit'.
8. Consultants in charge of care of patient will be expected to complete a detailed SBAR proforma for the identified case.
9. The SBAR proforma will be reviewed by the Medical Director/Assistant Director CSCG and Associate Medical Director.
10. Key themes, actions and learning points will be presented by the MD and AD CSCG to the Trust M&M Oversight Group.
11. The Medical Director as Chair of the Trust M&M Oversight Group & the Assistant Director of Clinical & Social Care Governance will ensure learning and/or action points from the case presentations are integrated into the wider governance structures.

Appendix 6. SHMI Interpretation Guidance

What is the Summary Hospital-level Mortality Indicator?

The Summary Hospital-level Mortality Indicator (SHMI) compares the actual number of patients who die following hospitalisation at a Trust with the number that would be expected to die on the basis of average Northern Ireland figures, given the characteristics of the patients treated there.

For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the Trust in question is considered to have a higher or lower SHMI than expected.

The SHMI includes deaths which occur in hospital or within 30 days of discharge and is calculated using Patient Administration System (PAS) data linked to General Registry Office (GRO) death registrations data.

Interpretation of the SHMI

The SHMI can be used by Trusts to compare their mortality outcomes to the national baseline, with some caveats

Where a Trust or hospital has an 'as expected' SHMI, it is inappropriate to conclude that their SHMI is lower or higher than the national baseline, even if the number of observed deaths is smaller or larger than the number of expected deaths.

This is because the Trust or hospital has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant.

The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths for the Trust or hospital

Whether or not a death could have been prevented can only be investigated by a detailed case-note review. The SHMI is not a direct measure of quality of care.

The expected number of deaths for each Trust or hospital is not an actual count of patients, but is a statistical construct which estimates the number of deaths that may be expected at the Trust or hospital on the basis of average NI figures and the characteristics of the patients treated there.

A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance

Instead, it should be viewed as a 'smoke alarm' which requires further investigation by the Trust. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance.

The methodology used to calculate the expected number of deaths for a particular Trust or hospital takes into account the number of patients treated and their characteristics (including the condition the patient is in hospital for, other underlying conditions the patient suffers from, age, gender, method of admission to hospital and for maternity models, the birth weight) and so these factors should not influence a Trust's SHMI.

There are many other factors which have the potential to affect a Trust or hospital's SHMI including (but not limited to) the quality of the data upon which the SHMI is based, other patient characteristics not listed above, the organisation of services and availability of resources e.g. staff, and quality of care.

The SHMI includes admitted patients for all clinical areas within a Trust or hospital and it is possible that mortality rates differ across these areas. For this reason, Trusts should investigate their SHMI data in detail using the data broken down by diagnosis group, regardless of whether their SHMI is categorised as 'higher than expected', 'as expected' or 'lower than expected'.

The SHMI requires careful interpretation and should be used in conjunction with other indicators and information from other sources (e.g. patient feedback, staff surveys and other similar material) that together form a holistic view of Trust outcomes.

The SHMI cannot be used to directly compare mortality outcomes between Trusts and hospitals and, in particular, it is inappropriate to rank Trusts and hospitals according to their SHMI

Instead, the SHMI banding can be used to compare mortality outcomes to the national baseline. If two Trusts or hospitals have the same SHMI banding, it cannot be concluded that the Trust or hospital with the lower SHMI value has better mortality outcomes.

A correlation between the SHMI and other variables of interest does not imply causation

Even if a correlation suggests that there is a relationship between the SHMI and another variable, it does not necessarily imply that one is causing the other. For example, other factors may be influencing both the SHMI and other variables, suggesting a direct relationship where there is none.



Appendix 7 ICNARC Guidance

ICNARC exists as a result of the success of the ICS UK APACHE II Study; a large research study, conducted in the late 80s/early 90s, on patient outcomes from intensive care units (ICUs).

In 1991, Dr Kathy Rowan, on behalf of the Intensive Care Society (ICS), submitted a proposal to set up a national centre for comparative audit and research in intensive care, to the Department of Health.

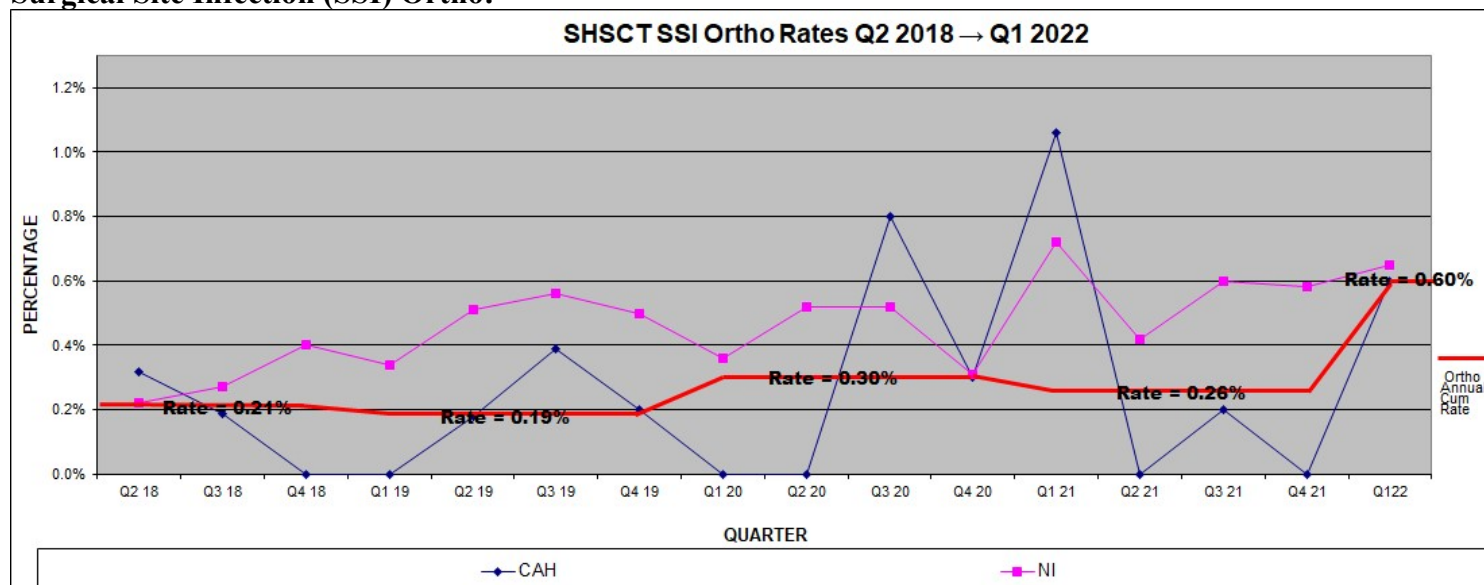
As a result of the study, and in response to the lack of information available on intensive care, in 1993 financial support was obtained from the Department of Health and the Welsh Health Common Services Authority for two years – to pump-prime the establishment of ICNARC.

ICNARC was set up in 1994, separate from the ICS, to provide an independent, national resource for the monitoring and evaluation of intensive care. Intensive care practitioners had (and still have) little or no data as to what is, or is not, effective with regard to how intensive care is organised or to the therapies employed

Southern Trust Intensive Care Unit participates in the Case Mix Programme (CMP). Which is an audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland.



Surgical Site Infection (SSI) Ortho:



- Q1 2022 SSI Rates have been released by the PHA. CAH Rate was **0.60%** (2/333 procedures). NI Rate was **0.65%** (13/1,985 procedures). CAH Rate (last 16 quarters i.e. Q2 2018 → Q1 2022) was **0.24%** (17/7,071). NI Rate (last 16 quarters i.e. Q2 2018 → Q1 2022) was **0.45%** (170/37,913).
- The Cumulative Rate for 2022 stands at **0.60%**, up from **0.26%** in 2021

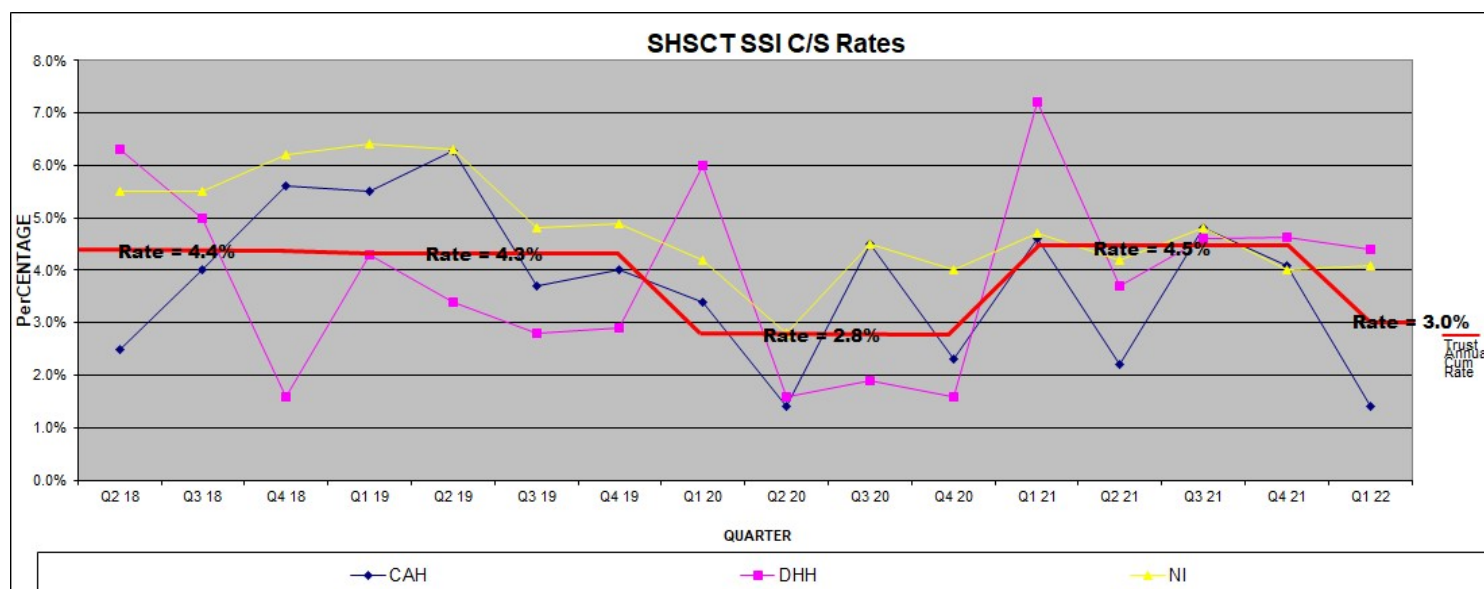
Surgical Site Infection (SSI) C/Section:

- Q1 2022 SSI rates have been released by the PHA. A summary of the data is as follows:

SSI Rates:

CAH **1.41%** (3) down from **4.15%** (9) in Q421 - Rate below the NI Average, having been above it in Q4
DHH **4.44%** (10) down from **4.57%** (9) in Q421 – 2nd successive quarter Rate has been above NI average
TRUST **2.97%** (13) down from **4.35%** (18) in Q421 - Rate below the NI Average having been above it in Q4
NI Average **4.08%** (64) up from **3.99%** (65) in Q421

- The Cumulative Trust Rate for 2022 stands at **2.97%**, down from **4.50%** in 2021



- The quarterly SSI C/Section Audits took place in June 2022

Overall Bundle Compliance at CAH **85%** (17/20 patients audited), up from **80%** in Mar 22

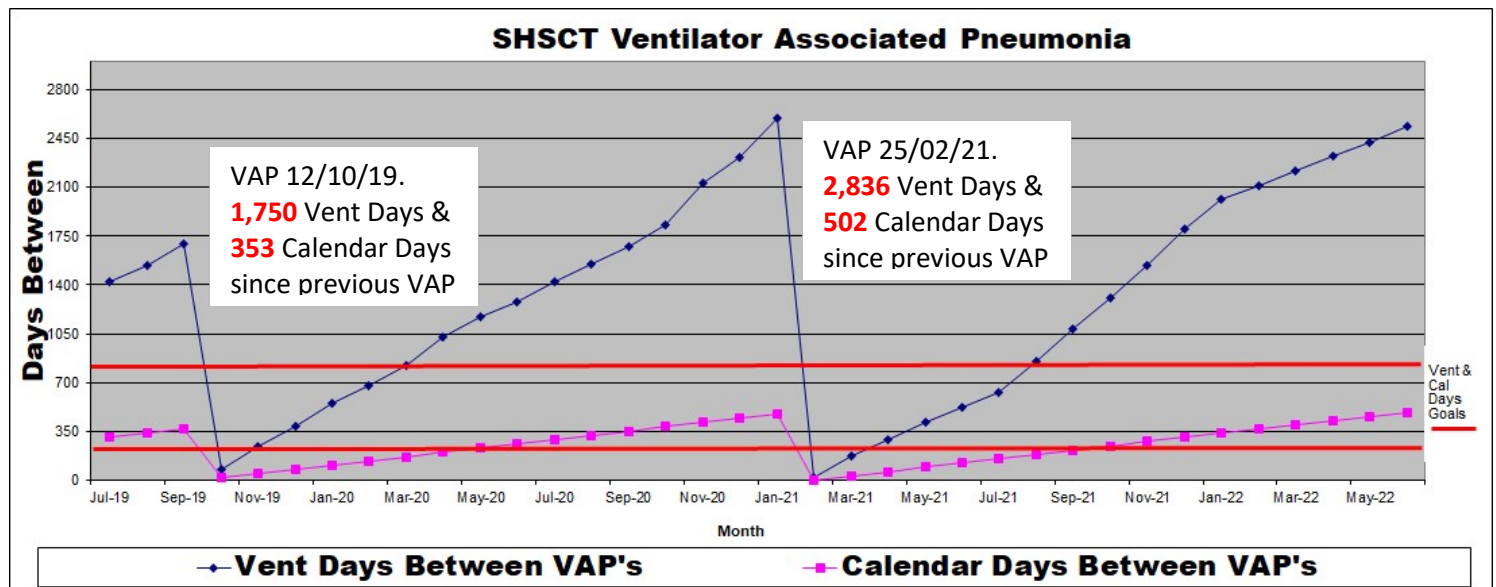
Non-compliant element:

Glucose Control (Diabetic patients only) – In 3 of 5 cases audited the mother's Serum Glucose Level was not measured/recorded/monitored Day 1 &/or Day 2 post C/Section.

Overall Bundle Compliance at DHH **100%** (20/20 patients audited), same as Mar 22

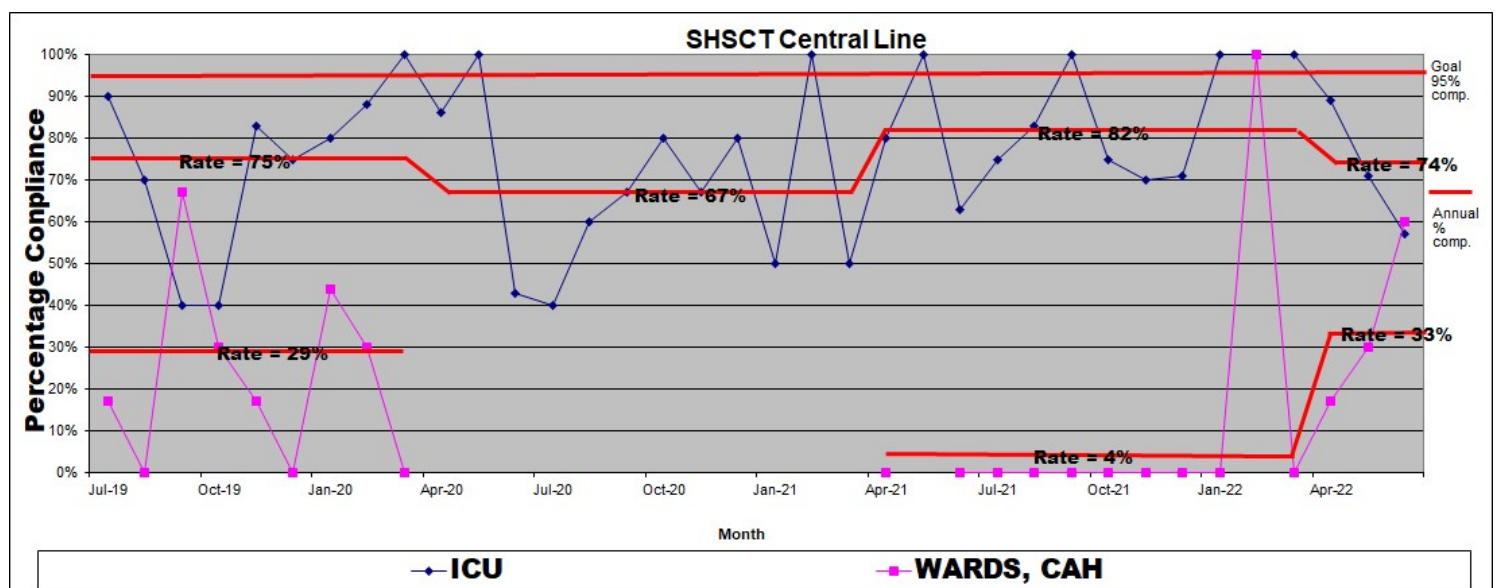
- The next quarterly Audits will take place in Sept 2022

Ventilator Associated Pneumonia (VAP):



- Vent Days Between VAP's **2,539** (26th February 21 → 30th June 22)
- Calendar Days Between VAP's **490** (26th February 21 → 30th June 22)

Central Line:



- Overall Bundle Compliance June 22, ICU **57%** (4/7 cases audited), down from **71%** (5/7 cases audited) in May 22
- Non-Compliant Cases:
 - In 2 of 7 cases audited the Central Line Insertion Form was not completed therefore there was no record of method of Hand Hygiene, Skin Prep., & Size of Drape used
 - In 1 of 7 cases audited Natural Detergent was used as the method of Hand Hygiene
- Cumulative Compliance 22/23 stands at **74%**, down from **82%** in 21/22
- Overall Bundle Compliance June 22, Wards, CAH **60%** (3/5 cases audited), up from **30%** (3/10 cases audited) in May 22
- Non-Compliant Cases:
 - In 1 of 5 cases audited Natural Detergent was used as the method of Hand Hygiene
 - In 1 of 5 cases audited there were gaps in the monitoring of the Daily Review of the Line (1 day missed on 1 occasion – 4 South)
- Cumulative Compliance 22/23 stands at **33%**, up from **4%** in 21/22
- Results shared with Lead Clinician, Lead Nurse & Wards for this QI work to address areas of non-compliance. Dr. Chris Clarke has also agreed to review the evidence in respect of the use of the Subclavian in preference to the Jugular

NEWS/NEWS2:

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

Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
ACUTE	71% (484/680)	93% (326/352)	93% (332/358)	92% (509/554)
TRUST	71% (594/832)	93% (461/494)	92% (480/520)	91% (637/700)

- Significant reduction in compliance due to the introduction of a revised Audit Tool

MUST (Malnutrition Universal Screening Tool):

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

Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
ACUTE	92% (562/614)	89% (294/329)	86% (277/321)	88% (436/496)
TRUST	93% (756/816)	92% (458/500)	88% (455/517)	88% (615/695)

Critical Medicines Omitted:

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

Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
ACUTE	1 (615)	0 (329)	0 (320)	0 (494)
TRUST	1 (942)	0 (655)	1 (610)	1 (806)

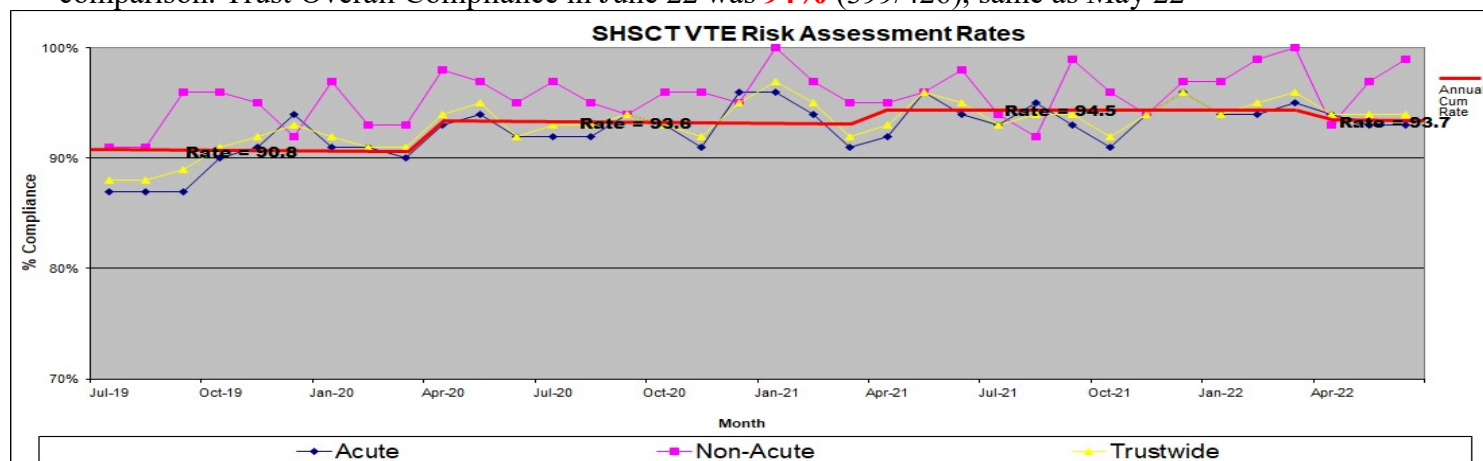
June 22 (Week Commencing 06/06/22 → Week Commencing 27/06/22)							
Division	Site	Ward	Number of Weekly Audits not done	Charts with Fully Completed VTE Risk Assessment	Number of Charts Audited	Monthly Percentage Compliance	Quarter 1 22/23 Percentage Compliance
S&EC	CAH	3 South	2	7	10	70% ↓	84% ↓
		4 North CESW	0	16	19	84% ↓	90% ↓
		4 South	0	19	19	100% ↑	97% ↑
		Elective Adm.	0	17	18	94% ↓	94% ↑
		Orthopaedic	0	19	19	100% ↔	100% ↔
		Trauma	1	13	13	100% ↔	100% ↔
	DHH	F/male Surg.	0	16	19	84% ↓	94% ↓
		HDU	0	20	20	100% ↔	97% ↑
M&UC	CAH	1 South	0	18	20	90% ↓	97% ↑
		1 North	0	20	20	100% ↑	94% ↑
		2 North Resp.	1	12	12	100% ↔	100% ↔
		Haematology	0	7	7	100% ↑	96% ↓
		2 South	0	18	20	90% ↑	75% ↓
		2 North Med	1	13	13	100% ↔	100% ↔
		AMU	0	19	20	95% ↑	92% ↑
		Ramone 1	0	17	17	100% ↔	100% ↔
	DHH	F/male Med.	0	14	18	78% ↓	85% ↓
		CCC/MMW	0	18	18	100% ↑	91% ↑
		Stroke/Rehab	0	13	19	68% ↓	89% ↓
		Respiratory L3	0	16	17	94% ↑	94% ↓
IMWH	CAH	Gynae	0	15	15	100% ↔	100% ↑
TOTAL			5 ↑ (4)	327	353	92.6% ↓	93.2% ↓

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

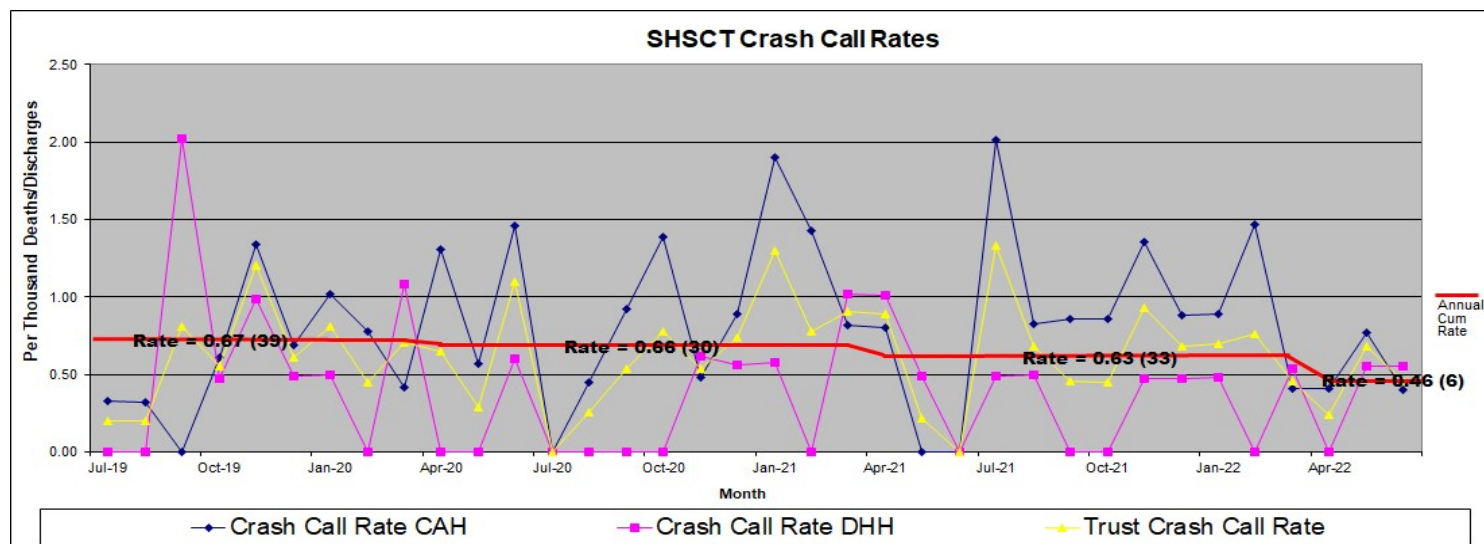
- In summary Overall Compliance with fully completed Risk Assessment on the Acute Wards was **92.6%** (327/353 charts audited) down from **93.3%** (417/447 charts audited) in May 22

- Total number of weekly audits not completed in June 22 was **5** up from **4** in May 22

The Run Chart below shows compliance against the Commissioning Plan target of **95%** compliance. The Trust Compliance includes the Non-Acute Wards & therefore their compliance has been included also for comparison. Trust Overall Compliance in June 22 was **94%** (399/426), same as May 22



- Cumulative Compliance 22/23 stands at **93.7%**, down from **94.5%** in 20/21

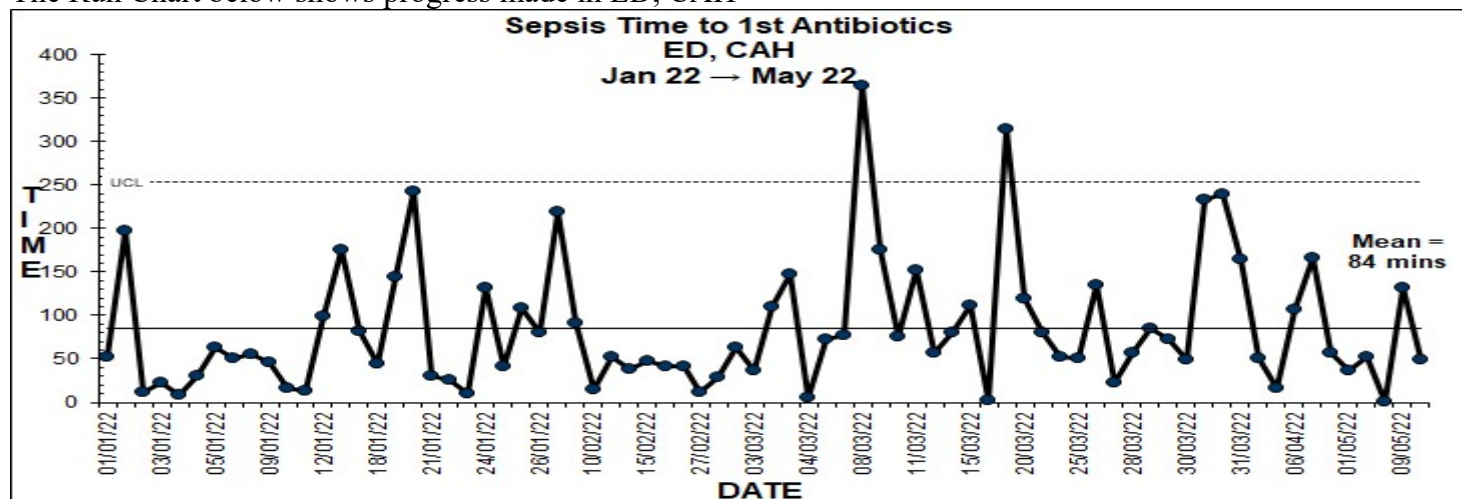


- CAH Rate **0.40** per 1,000 deaths/discharges (**1 – 2 North**) down from **0.77 (2 Crash Calls)** in May 22
- DHH Rate **0.55** per 1,000 deaths/discharges (**1 – Female Medical**) same as May 22
- Trust Rate **0.46** per 1,000 deaths/discharges (**2 Crash Calls**) down from **0.68 (3 Crash Calls)** in May 22
- Trust cumulative Crash Call Rate for 22/23 stands at **0.46 (6)** per 1,000 deaths/discharges, down from **0.63 (33)** in 21/22

Emergency Care QI Work: Sepsis 6 CAH & DHH:

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

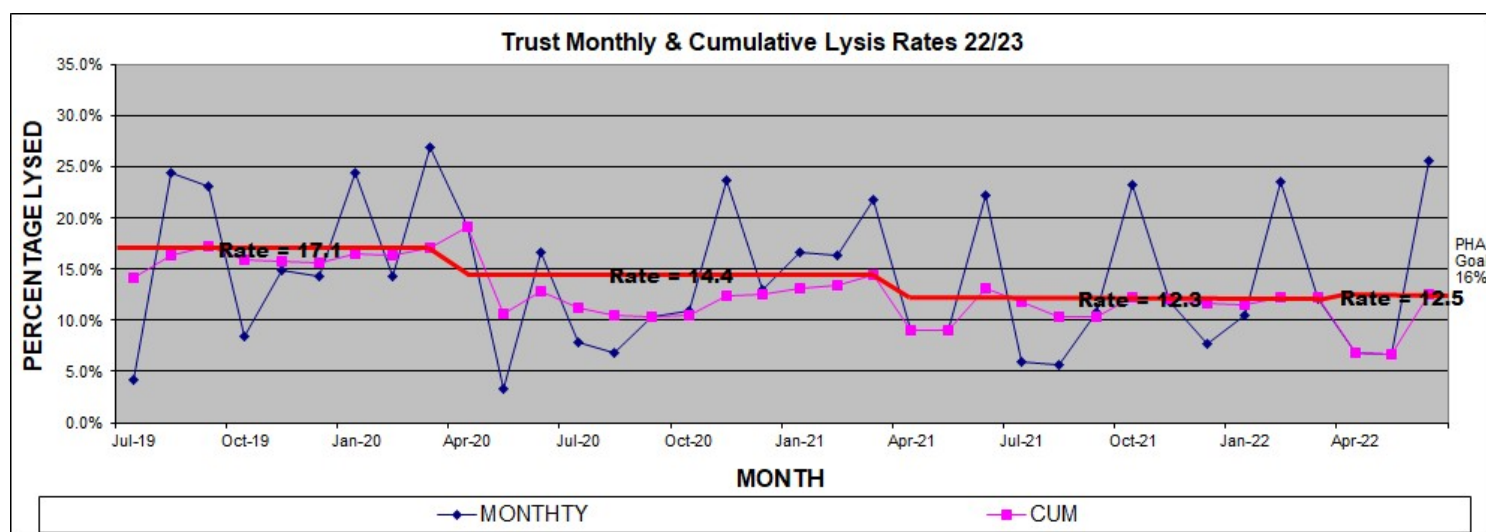
The Run Chart below shows progress made in ED, CAH



- May 22 data - compliance in-hours stands at **50%** (1/2 cases audited). Case outside target timeframe by **72** mins
- May 22 data - compliance out-of-hours stands at **100%** (4/4 cases audited)
- No cases above the Upper Control Limit as yet in May 22
- Mean Time Jan → May 22 stands at **84** mins, above Regional target timeframe of **60** minutes.
- In 2020 Mean Time = **76** minutes - Mean Time 2021 = **74** minutes
- **Issues with coding still remain e.g. Feb 22, Apr 22, May 22 & June 22 incomplete**
- Dr. Suzie Budd has raised cases above the Upper Control Limit with Paul Smith & also has these discussed at M&M meetings

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

	CAH		DHH		TRUST		
Measure		Jun 22		Jun 22		Jun 22	Commentary June 22
Patients who are potentially eligible for thrombolysis are assessed by Acute Stroke Team within 30 minutes of arrival	20/21 100%	100% (56/56)	20/21 100%	100% (31/31)	20/21 100%	100% (87/87)	-
Patients who are potentially eligible for thrombolysis receive CT scan within 45 minutes	20/21 100%	100% (30/30)	20/21 98%	100% (29/29)	20/21 99%	100% (59/59)	-
Patients deemed suitable for thrombolysis receive first bolus within 60 minutes	20/21 90%	100% (5/5)	20/21 73%	80% (4/5)	20/21 86%	90% (9/10)	DHH – Patient presented out-of-hours. Outside target timeframe by 5 minutes. Reason for delay not documented
Patients transferred to Hyper Acute Stroke Unit (or appropriate environment) within 90 mins	20/21 100%	100% (5/5)	20/21 93%	100% (5/5)	20/21 98%	100% (10/10)	-
	CAH		DHH		TRUST		
Outcome Measure	2021/22	Jun 22	2021/22	Jun 22	2021/22	Jun 22	AIM 21/22 (Based on Commissioning Plan) To ensure that the proportion of thrombolysis administration Target 16%
Monthly Thrombolysis Rate		21.7% (5/23)		31.3% (5/16)		25.6% (10/39)	
Thrombolysis Rate (Yearly)	13.0% (44/338)	12.5% (10/80)	10.9% (18/165)	12.5% (6/48)	12.3% (62/503)	12.5% (16/128)	



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

SKIN Care (Pressure Ulcer):

WIT-79372

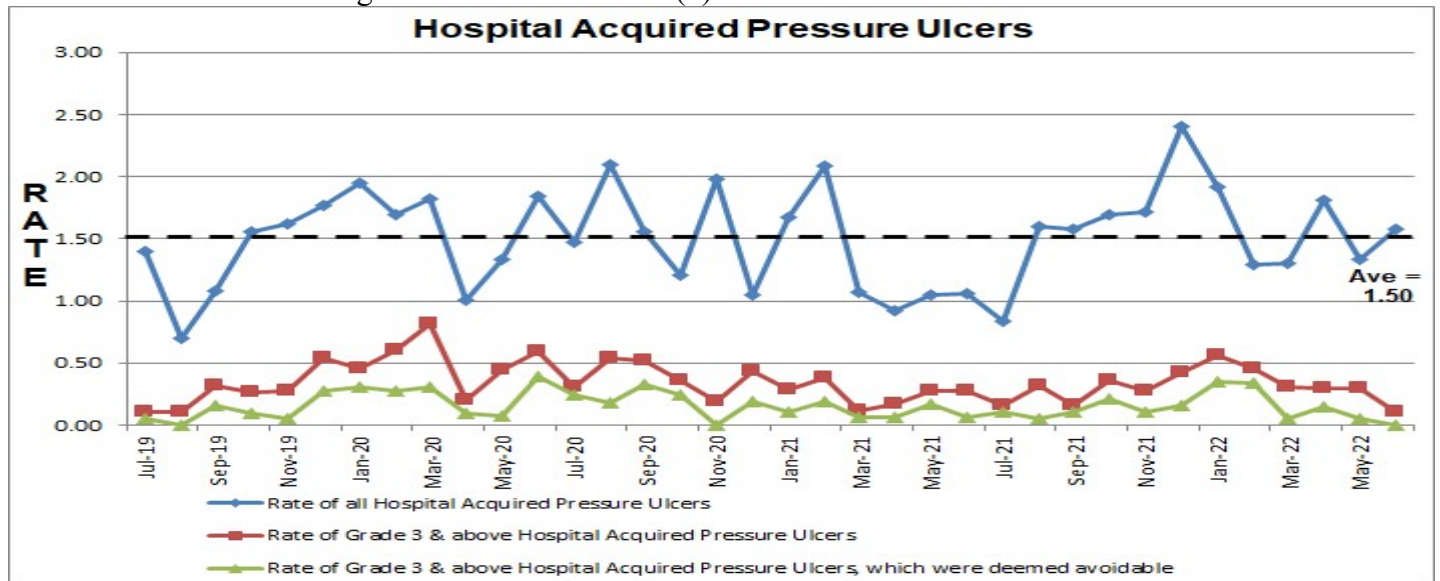
- The figures are a combination of the Independent Audit undertaken by Lead Nurses & the audit undertaken by the Ward Managers/Band 6's. Details of Overall Bundle Compliance is below:

Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
ACUTE	81% (323/401)	79% (148/187)	84% (166/197)	86% (243/283)
TRUST	81% (426/523)	83% (241/290)	83% (264/317)	87% (336/387)

Ward Acquired Pressure Ulcers & Rate per 1,000 Occupied Bed Days 2022/23:

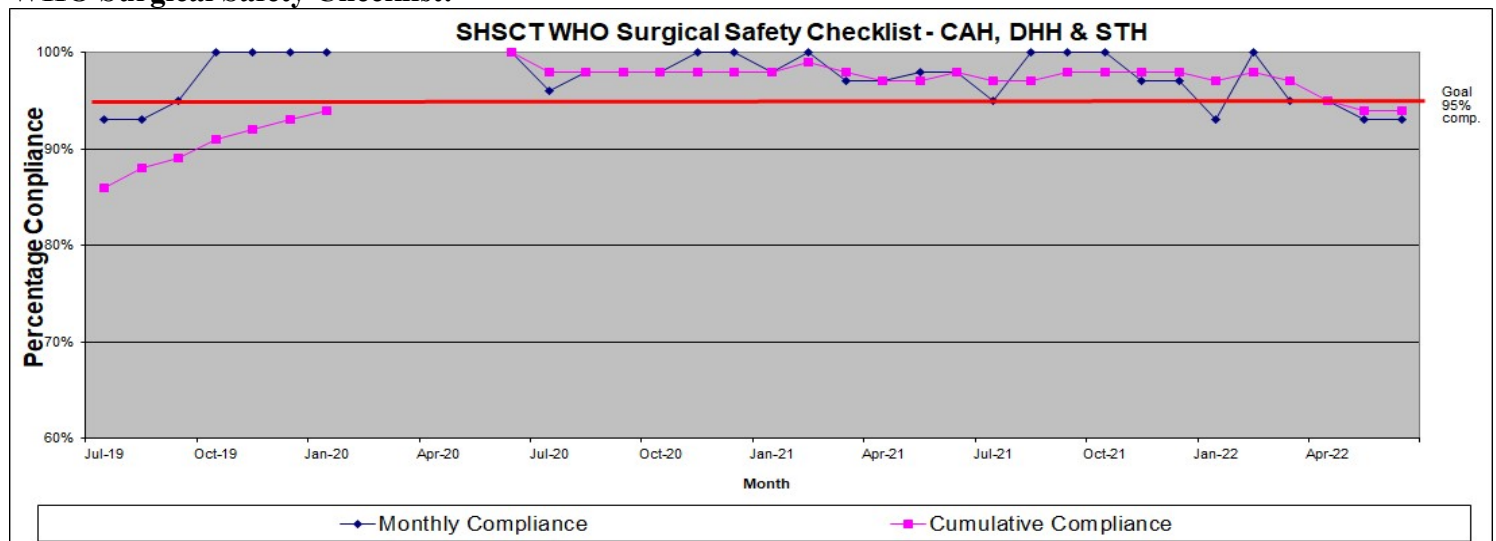
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 22/23	Rate & No 21/22
CAH															
Ward 4 South	1	1	1										3	1.11	1.21 (13) ↓
Ward 4 North	0	1	0										1	0.38	0.98 (11) ↓
Ward 3 South	1	2	1										4	1.34	1.87 (21) ↓
Trauma Ward	1	3	1										5	2.56	1.33 (10) ↑
Orthopaedic Ward	2	1	1										4	2.77	1.42 (9) ↑
Gynae Ward	0	0	0										0	0	2.11 (8) ↓
ICU	6	5	4										15	24.96	22.04(65) ↑
Ward 2 South Med.	2	2	3										7	4.45	2.67 (14) ↑
Ward 2 South Stroke	2	0	0										2	1.31	1.90 (11) ↓
Ward 2 North	1	0	1										2	0.86	0.92 (8) ↓
Ward 5 Haematology	0	1	0										1	1.90	1.67 (4) ↑
Ward 1 South	4	0	1										5	1.49	1.05 (13) ↑
Ward 1 North	1	0	0										1	0.36	0.87 (9) ↓
AMU	4	0	1										5	1.61	1.62 (18) ↓
3 North Med/Ram 1	1	1	0										2	0.91	1.66 (18) ↓
CEAW	0	0	0										0	0	0.62 (2) ↓
Emergency Dept.	1	2	5										8	N/A	17
Ramone 3	2	0	2										4	2.33	2.40 (13) ↓
Misc. Wards/Areas	1	0	1										2	N/A	1
DHH															
Resp. 3B	1	0	1										2	2.06	0.68 (3) ↑
Female Surg/Gynae	0	1	1										2	0.92	0.53 (4) ↑
HDU	0	0	0										0	0	1.54 (4) ↓
Stroke/Rehab	0	0	1										1	0.44	0.70 (7) ↓
Male Med/CCU	0	0	0										0	0	0.26 (3) ↓
Female Medical	3	2	2										7	2.13	1.32 (17) ↑
Emergency Dept.	0	2	0										2	N/A	4
Lurgan															
Ward 1 Stroke	0	1	0										1	0.74	0.48 (3) ↑
Ward 2 Rehab	0	0	1										1	0.57	0.58 (3) ↓
Ward 3	1	1	1										3	1.92	1.03 (6) ↑
STH															
Ward 1 STH	0	1	0										1	0.56	0.32 (2) ↑
Ward 2 STH	1	0	0										1	0.57	0.35 (2) ↑
MHLD															
Gillis	0	N/A	N/A										0	0	0 (0) ↔
Willows	0	0	0										0	0	0.41 (3) ↓
TOTAL	36	27	29										92		
RATE	1.81	1.33	1.58											1.57	1.46 (326) ↑

- There were **29** Hospital Acquired Pressure Ulcers reported in June 22. Of these, **2** were stage 3 or 4 U or DTI's, (1 South, CAH & Ward 2, LGN).
- In 22/23 Post Incident Reviews have been carried out on **11** cases to date with **4** deemed to have been avoidable. This represents **4%** of all Ward Acquired Pressure Ulcers reported in 22/23, down from **10%** in 21/22. The outstanding Post Incident Reviews (**3**) will be carried out in due course.



- The Trust's Monthly Hospital Acquired Pressure Ulcer Rate for June 22, based on **30** Wards was **1.58** (**29/18,409**) per 1,000 Occupied Bed Days up from **1.33** (**29/20,270**) per 1,000 Occupied Bed Days in May 22
- The Trust's 22/23 Hospital Acquired Pressure Ulcer Rate, based on **30** Wards stands at **1.57** (**92**) per 1,000 Bed Days, compared to **1.46** (**326**) in 2021/22.

WHO Surgical Safety Checklist:



- The Monthly Audits were reinstated in May 19 & were suspended Feb → May 20 due to Covid-19
- June 22 Compliance **93%** (56/60), same as May 22
- Cumulative Compliance 22/23 stands at **94%**, compared to **97%** in 21/22

Patient Falls:

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

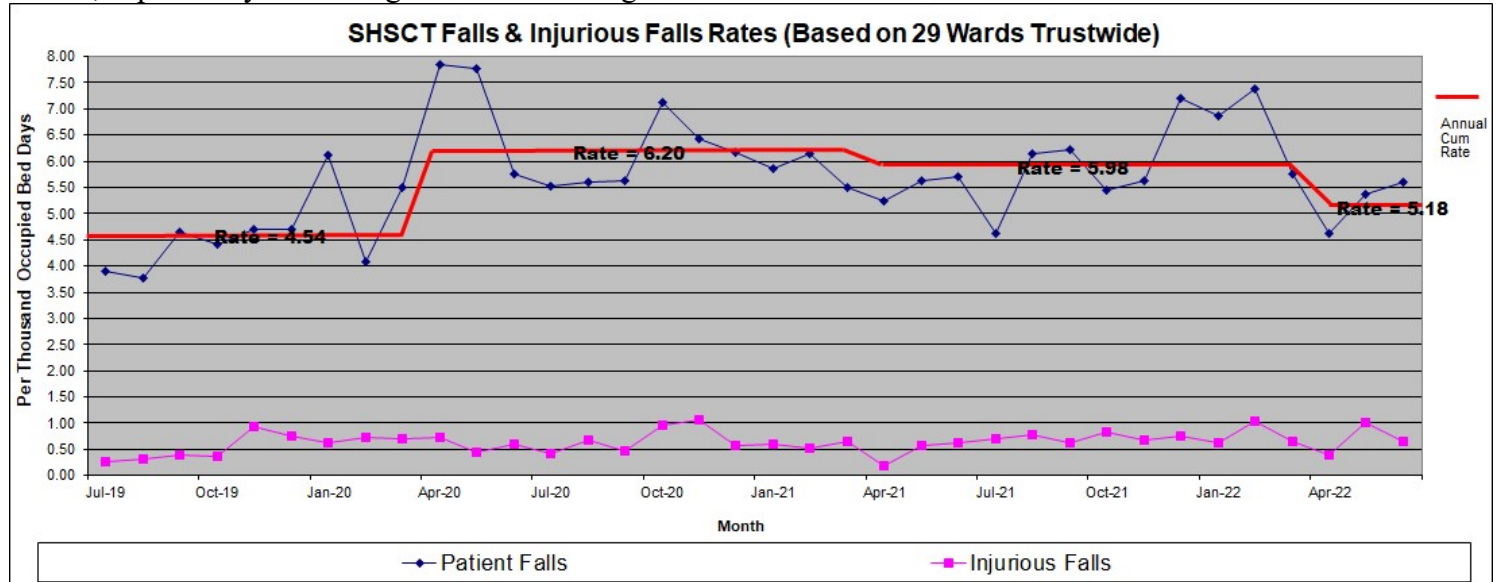
Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
Acute Bundle A Compliance	83% (513/616)	85% (281/329)	79% (255/323)	79% (391/495)
Trust Bundle A Compliance	85% (699/819)	86% (429/501)	81% (421/521)	84% (583/694)

Quarter	Q1 22/23	Q4 21/22	Q3 21/22	Q2 21/22
Acute Bundle B Compliance	81% (423/523)	84% (218/260)	84% (219/262)	81% (337/415)
Trust Bundle B Compliance	85% (616/725)	88% (376/427)	87% (398/460)	87% (533/613)

The table below gives details of individual Ward's Falls Numbers & Falls Rate 21/22:

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	TOTAL	Rate 22/23	Rate 21/22
CAH															
Ward 4 South	0	3	0										3	1.11	2.98 (32) ↓
Ward 4 North	1	1	2										4	1.51	2.32 (26) ↓
Ward 3 South	2	4	2										8	2.69	7.73 (87) ↓
Trauma Ward	0	4	5										9	4.60	9.43 (71) ↓
Orthopaedic Ward	3	4	1										8	5.53	7.25 (46) ↓
Gynae Ward	1	1	5										7	6.72	9.51 (36) ↓
Ward 2 South Med.	6	4	1										11	7.00	7.64 (40) ↓
Ward 2 Sth. Stroke	2	9	4										15	9.86	6.39 (37) ↑
Ward 2 North	5	3	5										13	5.60	3.44 (30) ↑
Haematology Ward	0	0	0										0	0	5.44 (13) ↓
Ward 1 South	4	8	11										23	10.00	7.07 (88) ↑
Ward 1 North	2	3	1										6	2.14	2.90 (30) ↓
AMU	8	5	8										21	6.74	7.22 (80) ↓
3 North Med/Ram 1	1	3	1										5	2.29	6.81 (74) ↓
CEAW	2	0	0										2	2.11	0.93 (3) ↑
Ramone 3	5	1	1										7	4.08	5.54 (30) ↓
DHH															
Resp. 3B	0	3	7										10	10.30	5.41 (24) ↑
Female Surg/Gynae	4	5	8										17	7.79	3.69 (28) ↑
HDU	1	2	0										3	4.85	2.31 (6) ↑
Stroke/Rehab	5	6	7										18	7.94	6.93 (69) ↑
Male Med/CCU	4	8	3										15	5.96	5.31 (62) ↑
Female Medical	6	10	4										20	6.08	7.05 (91) ↓
Lurgan															
Ward 1 Stroke	2	1	0										3	2.23	4.31 (27) ↓
Ward 2 Rehab	2	3	2										7	4.02	4.87 (25) ↓
Ward 3	2	0	1										3	1.92	4.98 (29) ↓
STH															
Ward 1 STH	4	0	1										5	2.82	2.76 (17) ↑
Ward 2 STH	2	2	1										5	2.85	2.81 (16) ↑
MHLD															
Gillis	6	N/A	N/A										6	16.48	18.30 (91) ↓
Willows	5	7	13										25	15.03	12.98 (94) ↑
TOTAL	85	100	94										279		
RATE	4.63	5.36	5.59											5.18	5.98 (1302) ↓

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



- Falls Rate **5.59** (94/16,820 Occupied Bed Days) up from **5.36** (100/18,660) in May 22
- Injurious Falls Rate **0.65** (12/16,820 Occupied Bed Days) down from **1.02** (19/18,660) in May 22
- Cumulative Falls Rate for 22/23 stands at **5.18**, compared to **5.98** in 21/22

Regional Delirium Audit:

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

Ward/Measure	At risk patients who have a SQiD carried out (single question in delirium)	Patients with a 4AT completed (tool to assess for delirium)	Patients with an Investigations & Management Plan completed
Trauma (Aug 20)	95% (19/20)	83% (5/6)	60% (3/5)
1 North (Jun 22)	100% (20/20)	100% (1/1)	100% (1/1)
2 South Med (Jun 22)	100% (20/20)	100% (8/8)	100% (4/4)
3 South (Dec 20)	100% (5/5)	100% (1/1)	N/A (0/0)
4 North (Jun 22)	100% (20/20)	100% (2/2)	0% (0/1)
4 South (Jun 22)	100% (20/20)	100% (2/2)	N/A (0/0)
Ramone 3 (Jun 22)	100% (20/20)	100% (12/12)	100% (4/4)
Stroke/Rehab(Jun 22)	100% (20/20)	100% (6/6)	100% (3/3)
Female Surg. (Jun 22)	100% (20/20)	100% (6/6)	100% (5/5)

- Audits received from Wards highlighted in red. Wards in black audit suspended due to Covid-19 or Audit not received in time to be included in this Report.



Southern Health
and Social Care Trust

Quality care – for you, with you

GOVERNANCE COMMITTEE COVER SHEET

Meeting Date	16 th November 2021	
Agenda item	12. (v) - National Audit Assurance Report (NAAR)	
Accountable Director	Dr Maria O’Kane, Medical Director	
Report Author	Name	Fiona Davidson
	Email Address	Personal Information redacted by USI
This paper is presented for: Assurance		
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>
--	--

1. Detailed summary of paper contents:

The purpose of this paper is to provide:

- An annual overview of the SHSCT's participation in the *NHS England Quality Accounts List* of national audits.
- An updated SHSCT position on the progression of recommendations arising from participation in national audits, including those from previous years.
- A composite SHSCT clinical audit work programme 2020/21, together with the rationale for non-participation in some *NHS England Quality Accounts List* national audits.
- An updated position on the Trust's Clinical Audit Strategy

2. Areas of improvement/achievement:

- On-going level of participation and engagement in national, regional and local audit during the second year of C19 pandemic.
- Increased MHD submissions to the report

3. Areas of concern/risk/challenge:

- Need to ensure that all audits (international, national, regional and local) are reported; action planned and monitored on a regular basis within operational directorate governance arrangements.
- Need to ensure adequate representation of all Directorates / Divisions across national and local clinical audit programmes.
- Section 4 – details specific issues highlighted across 23 audits regarding a range of organisational issues; infrastructure and accommodation, clinical specialism availability, data sharing and staff pressures.
- The on-going impact of C19 service disruption to implementation of recommendations and progress year on year of action plans
- Regional direction on compliance with GDPR requirements
- Clinical Audit Strategy Review –strengthening the clinical audit function for assurance

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

Corporate Risk Register	This work primarily drives improvement in clinical effectiveness or highlights areas of risk and as a result provides an aspect of assurance to the Senior Management Team, Governance Committee and Trust Board on standards of safe and quality care.
Board Assurance Framework	The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance framework. Clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care
Equality and Human Rights	

National Audit Assurance Report (NAAR)

National Audits: 2020/21 Report

November 2021

Section	Content	Page No
1	Executive Summary	5
2	National Audit Participation Summary	6
3	2020/2021 Participation Update	8
4	Key Areas for consideration by Governance Committee as defined by Clinical Leads	18
5	SHSCT Clinical Audit Work Programme 2021/22	26
6	GDPR Requirements	26
6	Clinical Audit Strategy Update	27
Appendices		
1a	Participation in 2021/22 National Audits	26
1b	SHSCT Clinical Audit Programme 2021/22 (all levels – regional and local)	28
2	Priority Level for Clinical Audits	34
3	Rationale for Non-Participation in Audits	32
4	National Reports Disseminated 2020/2021	39
5	Update Submission Process	44
References		
	NHS England Quality Accounts List 2020/2021 nhs-england-quality-accounts-list-2020-21-vjan2020.pdf (hqip.org.uk)	



1.0 Executive Summary

The purpose of this paper is to provide:

- a) An annual overview of the SHSCT's participation in the *NHS England Quality Accounts List*⁽¹⁾ of national audits.
- b) An updated SHSCT position on the progression of recommendations arising from participation in national audits, including those from previous years.
- c) A composite SHSCT clinical audit work programme 2020/21, together with the rationale for non-participation in some *NHS England Quality Accounts List* national audits.
- d) An updated position on the Trust's Clinical Audit Strategy and the resourcing within the Corporate Clinical Audit Department

This report is broken down into two significant sections:

- **Section 3:** summarises the top three performance indicators for each published study, as assessed by the clinical audit lead. It also outlines areas for improvement and the progress made in taking these forward. A sharepoint link to access the 2021 update is embedded. (A full copy is also provided in the report addendum).
- **Section 4:** summarises the areas to raise awareness to SMT/ Governance Committee as assessed by the clinical audit lead these constitute - area of concern / unidentified risk / good practice or barrier to improvement.

This is the second National Audit Assurance Report (NAAR) being produced during the period of the SARS-CoV-2 global pandemic. This has, in overall terms led again to limited involvement and progress in both levels of audit participation and progress in implementing previous action plans. The National Audit Programme has been impacted as a direct or indirect consequence of:

1. Continued clinical pressures and impact on clinical and service capacity required for pandemic management. This is not unique to SHSCT but experienced across the entire HSC in Northern Ireland;
2. National Reports detailing clinical audit findings not being available from national host organisations in year;
3. Participation in some audits needing to be deferred.

In light of this, clinical teams, supported by the corporate clinical audit team are to be commended for participation and improvement progress that has been made across the national audits contained in this report. Additionally regional and local trust based audits continue to be undertaken. The current programme is detailed in appendix 1a & 1b. Those audits not participated in are detailed in appendix 3.

Appendix 4 provides a record of all the national audit reports disseminated to Directorates in the last year. Appendix 5 details the process for requesting audit updates to inform the compilation of this report.



2.0 National Audit Participation Summary 2020/2021

The following reports are available to view via the SharePoint links provided: [National Audit assurance Report 2021](#)

Audit Type	National Audit	SharePoint Link to Audit Update
ACUTE DIRECTORATE		
Anaesthetics, Theatres & Intensive Care Services, incorporating Surgery & Elective Care & Laboratory Services		
On-going	Intensive Care National Audit & Research Centre (ICNARC)	ICNARC
Historical	National Comparative Audit of Blood Transfusion programme – Audit of massive haemorrhage	Audit of massive haemorrhage
Historical	Patient blood management in adults undergoing elective, scheduled surgery	PBM in adults undergoing elective, scheduled surgery Link to supporting documents
Integrated Maternity & Women's Health, incorporating neonatal services		
NEW	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020
NEW	Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020 - March 2021	MBRRACE - UK: Learning from SARS-CoV-2 deaths
NEW	MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2018	MBRRACE-UK Perinatal Mortality Surveillance Report 2018
NEW	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies
On-going	Comparative Audit of management of maternal anaemia and iron deficiency in the UK and ROI	Management of Maternal Anaemia and iron deficiency
MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18		
Cardiology		
On-going	Adult Percutaneous Coronary Interventions- BCIS	Percutaneous Coronary Interventions
On-going	Cardiac rhythm management	Cardiac Rhythm Management
On-going	Cardiac rehabilitation	National audit for Cardiac Rehab (NACR)
On-going	Myocardial Ischaemia National Audit Project	MINAP
Emergency Medicine		
Historical	Severe sepsis and septic shock	Severe sepsis and septic shock
Historical	Feverish Children (care in emergency departments)	Feverish children
Historical	Cognitive Impairment in Older People	Assessing For Cognitive Impairment In Older People
Historical	Care of Children in ED	Care of Children in ED
Historical	Mental Health (Self-Harm)	Mental Health (self-harm)



General Medicine		
Deferred	Society for Acute Medicine's Benchmarking Audit (SAMBA)	SAMBA
Nephrology		
On-going	Renal Registry	UK Renal Registry
Respiratory		
Historical	Inspiring change – non-invasive ventilation (NCEPOD)	Nil Update
Historical	Non-Invasive Ventilation – Adults	NIV - Adults
Historical	Adult Community Acquired Pneumonia	Adult Community Acquired Pneumonia
Stroke Services		
On-going	Sentinel stroke national audit programme	Sentinel stroke national audit programme (SSNAP)
Trauma & Orthopaedics		
On-going	National joint registry	National Joint Registry
On-going	National hip fracture database	National Hip fracture database (NHFD)
MENTAL HEALTH AND DISABILITY		
NEW	Mental Health Clinical Outcome Review Programme	Towards Zero Suicide
NEW	Prescribing Observatory for Mental Health (POMH-UK)	POMH-UK Clozapine POMH-UK Prescribing in Depression POMH-UK Valproate Link to supporting documents
NEW	Mental Health benchmarking	MHD Adult Community NHS Benchmarking Link to supporting document
NEW	Physical Healthcare of Inpatients in Mental Health Hospitals	NCEPOD Physical Healthcare of Inpatients in Mental Health Hospitals
OLDER PEOPLE & PRIMARY CARE DIRECTORATE		
Historical	Intermediate care	National Audit Intermediate Care
Historical	UK Parkinson's audit transforming care	Parkinson's audit
NEW	NCEPOD - Dysphagia in Parkinson's Disease "Hard to Swallow"	NCEPOD - 'Hard to Swallow'
CROSS DIRECTORATE AUDIT		
Historical	Older people's care in acute settings	Older People's Care in Acute Setting
Historical	NHS benchmarking audit – managing frailty in acute settings	Managing frailty in acute settings Link to supporting document
Historical	Treat as One (NCEPOD)	Nil Update



3.0 2020-21 SHSCT Planned Audit Participation in the NHS England Quality Accounts List of National Audits.

Each audit's sharepoint link in the final column contains the Clinical Lead's updated position on the progression of recommendations arising from participation in national audits, including those from previous years. Covid-19 pressures have been noted where this has resulted in a nil return.

SHSCT planned participation in NHS England Quality Accounts List 2020/21:						
SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
ACUTE DIRECTORATE						
Anaesthetics, Theatres & Intensive Care Services, incorporating Surgery & Elective Care & Laboratory Services						
Intensive Care National Audit & Research Centre (ICNARC) Continuous Audit	Yes Continuous National Audit	Next report due to be published: 31/03/2022	Yes	N/A	N/A	ICNARC
National Comparative Audit of Blood Transfusion Programme (NCABT) – Audit of massive haemorrhage (2018)	NCABT Audits for 2020 have been postponed due to COVID-19: - Audit of Patient Blood Management in paediatric surgery - Survey of use of FFP, cryoprecipitate, PCC and fibrinogen concentrate	Audit of Massive Haemorrhage Snapshot Audit from 2018	Yes One non-compliant audit recommendation on regular review of massive transfusions and has been completed in year.	9	9	Audit of massive haemorrhage



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
	- Audit of NICE Quality Standards - Audit of Blood Sample Collection & Labelling					
Patient blood management in adults undergoing elective, scheduled surgery	Not Applicable Historical 2015 audit with re-audit in 2016 Recommendations implementation on-going	N/A Annual update is provided on progress of outstanding recommendations	Yes Compliance with recommendations - no change from 2019	20	12	PBM in adults undergoing elective, scheduled surgery Link to supporting documents
Integrated Maternity & Women's Health, incorporating neonatal services						
MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18	Yes Continuous Audit	Yes Reports NPEU > MBRRACE-UK (ox.ac.uk)	Yes	8 x New 30 x On-going	1 13	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020
Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal	Yes Snapshot Audit	Yes Reports NPEU > MBRRACE-UK	Yes	17	16	MBRRACE - UK: Learning from SARS-CoV-2



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
deaths in the UK June 2020 - March 2021		(ox.ac.uk)				deaths
MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2018	Yes Continuous Audit	Yes Reports NPEU > MBRRACE-UK (ox.ac.uk)	Yes	9	3	MBRRACE-UK Perinatal Mortality Surveillance Report 2018
MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies	Yes Continuous Audit	Yes Reports NPEU > MBRRACE-UK (ox.ac.uk)	Yes	9	6	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies
Comparative Audit of management of maternal anaemia and iron deficiency in the UK and ROI (New)		Yes Report Available for 19/20	Yes Recommendations are progressing via the regional iron deficiency QI project	3	0	Management of Maternal Anaemia and iron deficiency
Medicine & Unscheduled Care						
Cardiology						
Adult Percutaneous Coronary Interventions- BCIS	Yes Continuous Audit	Yes NAPCI-Domain-Report_2021_FINAL.pdf (hqip.org.uk)	Yes Yearly Update Provided on Progress of Recommendations	3	1	Percutaneous Coronary Interventions



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Cardiac Rhythm Management		Yes NACRM-Domain-Report 2021 FINAL.pdf (hqip.org.uk) This report relates to data in 19/20 which SHSCT was unable to submit due to physiology staff shortages.	Yes Update is using local SHSCT 2020/2021 data	7	7 Compliant across all quality metrics	Cardiac Rhythm Management
Cardiac Rehabilitation	Yes – but limited data entry due to C19 disruption Continuous Audit	Yes nacr quality and outcomes report 2020.pdf 2021 Report due Nov 21	Due to severe service disruption over C19 period compliance position remains unchanged from 2019	10	1	National audit for Cardiac Rehab (NACR)
Myocardial Ischaemia National Audit Project	Yes	Yes MINAP-Domain-Report 2021 FINAL.pdf (hqip.org.uk)	Yearly Update Provided on Progress of Recommendations	4	3	MINAP
Emergency Medicine						
Severe sepsis and septic shock	No Historical 2016/2017 audit recommendations implementation on-going Local CAH QI work continues on time to 1 st antibiotic	Report (rcem.ac.uk)	Update provided	11	10	Severe sepsis and septic shock



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Feverish Children (care in emergency departments)	No Historical 2018/2019 audit with recommendations implementation on-going	Report (rcem.ac.uk)	Yearly Update Provided on Progress of Recommendations	1	0	Feverish children
Cognitive Impairment in Older People	No Previous Snapshot Audit	Report (rcem.ac.uk)	Yes	New Audit	N/A	Assessing For Cognitive Impairment In Older People
Care of Children in ED	No Previous Snapshot Audit	Report (rcem.ac.uk)	Yes	New Audit	N/A	Care of Children in ED
Mental Health (Self-Harm)	No Previous Snapshot Audit	Report (rcem.ac.uk)	Yes	New Audit	N/A	Mental Health (self-harm)
Fractured Neck of Femur (care in emergency departments)	Yes Snapshot Audit (05/10/20 – 02/04/21)	No Not available yet				
Infection Control (care in emergency departments)	Yes (on-going) (05/10/20 – 03/10/21)	Report Due Summer 2022				
Pain in Children (care in emergency departments)	Yes (on-going) (05/10/20 – 03/10/21)	Report Due Summer 2022				



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
General Medicine						
Society for Acute Medicine's Benchmarking Audit (SAMBA)	No Planned but staff capacity not available	SAMBA 2021 Report - Society for Acute Medicine (participating Trusts only)	Not Applicable	N/A	N/A	SAMBA
Nephrology						
Renal Registry	Yes Continuous Audit	Annual report The UK Kidney Association	Yearly Update Provided	Compliant	Compliant	UK Renal Registry
Respiratory						
Inspiring change – non-invasive ventilation (NCEPOD)	No Yearly Update Provided on Progress of Recommendations	N/A	No	21	10	No Update
Non-Invasive Ventilation – Adults	No Historical Snapshot Audit (Jan / Feb 2019) No update to be provided	No New Report National Adult Non-Invasive Ventilation Audit 2019 British Thoracic Society Better lung health for all (brit-thoracic.org.uk)	No planned national audit To be removed from participation list for updates	N/A	N/A	NIV - Adults

SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
Adult Community Acquired Pneumonia	No Historical Snapshot Audit (Jan / Feb 2019) No update to be provided	No New Report Adult Community Acquired Pneumonia British Thoracic Society Better lung health for all (brit-thoracic.org.uk)	No planned national audit To be removed from participation list for updates	N/A	N/A	Adult Community Acquired Pneumonia
Stroke Services						
Sentinel stroke national audit programme	YES Continuous Clinical Audit Biannual Organisational Audit	SSNAP - Clinical audit (strokeaudit.org)	YES	5	5	Sentinel stroke national audit programme (SSNAP)
Trauma & Orthopaedics						
National joint registry	Yes Continuous Audit	Yes https://reports.njrcentre.org.uk/	Yes One recommendation moved to non-compliance	3	2	National Joint Registry
National Hip Fracture Database	No Continuous Audit but unable to submit data due to Data Access Issues affecting all NI HSCTs	No KPIs overview (nhfd.co.uk) No planned publication date advised for 2020/21 report "standard data collection has not been affected but reporting publications have been	Yes A further recommendation has been progressed from last year	N/A	N/A	National Hip fracture database (NHFD)

SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
		delayed due to delays from NHS England"				
MENTAL HEALTH AND DISABILITY						
Mental Health Clinical Outcome Review Programme	Yes Continuous	NCISH Annual report 2021: England, Northern Ireland, Scotland and Wales - NCISH (manchester.ac.uk)	Yes Regional TWS QI work	N/A	N/A	Towards Zero Suicide
Prescribing Observatory for Mental Health (POMH-UK)	Yes – Currently On-going Continuous	See Supporting Documents See Supporting Documents See Supporting Documents		See updates provided	See updates provided	POMH-UK Clozapine POMH-UK Prescribing in Depression POMH-UK Valproate Link to supporting documents
Mental Health benchmarking	No in 2021 due to staff secondment	No Participating Trusts Only Mental Health sector —	Yes	N/A	N/A	MHD Adult Community NHS Benchmarking



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
	Previous Submission made in 2020	NHS Benchmarking Network				Link to supporting document
Physical Healthcare of Inpatients in Mental Health Hospitals	Yes Clinical & Organisational Questionnaires Submitted 2021	Due Spring 2022 NCEPOD - Physical Health in Mental Health Hospitals	N/A	N/A	N/A	NCEPOD Physical Healthcare of Inpatients in Mental Health Hospitals
OLDER PEOPLE & PRIMARY CARE DIRECTORATE						
Intermediate care	No Snapshot: April 2018 – Mar 2019	NAIC — NHS Benchmarking Network	No 2021 update due to extreme C19 clinical pressures	Position at 2019 Report 4	Position at 2019 Report 2	National Audit Intermediate Care
UK Parkinson's audit transforming care	No Participation in 2017, next audit due in 2022	UK Parkinson's Audit - Transforming Care Parkinson's UK (parkinsons.org.uk)	No 2021 update due to extreme C19 clinical pressures No Update Provided 2020	Position at 2019 Report 2	Position at 2019 Report 1	Parkinson's audit
NCEPOD - Dysphagia in Parkinson's Disease "Hard to Swallow" NEW	Yes Clinician & Organisational Questionnaires submitted 2020	Yes published 12/08/21 NCEPOD - Dysphagia in Parkinson's Disease:: (2021)	No 1 st update due to extreme C19 clinical pressures	N/A	N/A	NCEPOD - 'Hard to Swallow'



SHSCT National Audit Plan	Did SHSCT Participate in 2020/2021	National Audit Report Received for 20/21	Update provided in relation to 20/21 progress	No of recommendations from audit	Number complete	Link to Audit Recommendations / Action Plan
CROSS DIRECTORATE AUDITS						
Older people's care in acute settings		N/A Update on Progress of Recommendations	No 2021 update due to extreme C19 clinical pressures No Update Provided 2020	<u>Position @ 2019 Report</u> 7	<u>Position @ 2019 Report</u> 1	Older People's Care in Acute Setting
NHS benchmarking audit – managing frailty in acute settings		Yes	Yes – new audit. Work towards recommendations has been progressed	3	2	Managing frailty in acute settings Link to supporting document
Treat as One (NCEPOD)		N/A Yearly Update Provided on Progress of Recommendations	Yes – 1 further recommendation complete	Position at 2019 Report 21	 4	

NB: Change to previous inclusion of Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme. SHOT provide recommendations that SHSCT act on to ensure safe transfusion practice. SHSCT participates in the SHOT reporting scheme (since 2004). Participation in SHOT does not equate to an audit and so no longer fits with the criteria for inclusion in this report.



4.0 Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

This section of the NAAR highlights areas where, despite staff or service efforts, it has not yet been possible to achieve the desired level of compliance with audit standards, or to fully implement action or improvement plan recommendations.

In this context clinical audit leads have been asked to highlight any key areas to be raised for the committees' attention and these are highlighted, under each audit in the following section.

1. INTENSIVE CARE NATIONAL AUDIT & RESEARCH CENTRE (ICNARC)

- Critical Care Admission when more unwell is one marker of a unit potentially functioning beyond optimum occupancy (80% occupancy is considered optimum as per FICM standards). Covid-19 escalation has stretched this further.
- Ensuring timely patient flow of those not requiring further critical care, to deescalate to ward-based care, is paramount in ensuring efficiency.
- Recent commissioned increase to 2 fully fund further Level 2 (HDU) beds will help mitigate.
- Despite high occupancy levels, markers of good care within ICU/HDU itself, such as unit-acquired infection, remained reassuringly low.

2. PATIENT BLOOD MANAGEMENT IN ADULTS UNDERGOING ELECTIVE, SCHEDULED SURGERY

- A plan to relocate The Preoperative Assessment Department has been authorised to enable an Ambulatory Surgical Unit to be created in Main OPD in CAH. The result of this is that the nursing staff, admin and medical staff are being moved to sub-optimal accommodation. In addition, there are plans to separate some staff members which will lead to a disconnect. The strength of this department has always been the close working between admin, nursing and medical staff. The Trust should consider investing in a Preoperative Assessment Dept. that allows us to prepare patients for surgery in the best way possible. The dream is to have a department that is visible, has a high profile within the Trust, which patients recognise and above all, can deliver all the facets of preoperative preparation. Positive outcomes are driven by good preparation. This includes, IV iron, dedicated physiotherapy input for exercise prehabilitation, cardiopulmonary exercise testing in a suitable lab with adequate space, dedicated dietetics input for patients with malnutrition and a waiting area that lends itself to healthcare interventions with bespoke audio-visual messaging.

- The move to get involved in the patient journey earlier has been forced upon us by the change in healthcare delivery we have witnessed over the last 18 months. I am hopeful that earlier medical review and optimisation of anaemia will contribute to

better outcomes. This of course could be offset by the longer waiting times to surgery.

3. MOTHERS AND BABIES: REDUCING RISK THROUGH AUDITS AND CONFIDENTIAL ENQUIRIES ACROSS THE UK (MBRRACE-UK)

- Obstetric Medicine lead(s). Several of the recommendations highlight our weakness as a trust in the area of maternal medicine. Consideration should be given to training within consultant body/future Cons appointment and generation of Obstetric Medicine lead across the trust and development of a high risk maternal medicine clinic. There are excellent existing relationships between neurology, rheumatology, haematology and obstetrics. Further work is required to ensure standardisation of care across the trust for women with existing medical conditions and this would best be served by an obstetric medicine clinic.
- Ongoing work re: PPH. Introduction of the obstetrics Cymru proforma and additional skills and drills training has been valuable. Currently being audited. Massive obstetric haemorrhage is an ongoing concern as a trust and investment is needed in continuous improvement. Consideration should be given within job planning for an Obstetric simulation lead.
- VTE remains the commonest cause of maternal death. There was a maternal death from VTE within the trust in 2020. Audit must be undertaken and QI to ensure robust systems in place to ensure rigorous risk assessment for VTE in all pregnant women.

4. COMPARATIVE AUDIT OF MANAGEMENT OF MATERNAL ANAEMIA AND IRON DEFICIENCY IN THE UK AND ROI

- Identification of women through routine screening at booking and 28 weeks gestation is generally good.
- Streamlining of follow-up and rechecking of low haemoglobin results and response to oral iron required.
- Maternity notes are handheld and will not permit direct entry of results at time of action – standardised letter to be formulated and/or record on NIECR.
- Anaemic population often from ethnic minorities where English not 1st language – attention will be needed to patient information leaflets in other languages.

5. ADULT PERCUTANEOUS CORONARY INTERVENTIONS- BCIS

- The BCIS average for PCI per lab is around 350 per year. We typically do double that. The standard number of labs for a UK hospital with our case volume The BCIS average for PCI per lab is around 350 per year. We typically undertake almost double that. The typical number of labs for a UK hospital with our case volume is 2-3 labs. Our lab capacity is inadequate, which is a patient safety risk.
-
- If the cath lab X-ray equipment goes down mid case, our back up is a general X ray room rather than a cardiology room. This is a patient safety risk.
- Our cath lab is now under-resourced. To maintain clinical practice at a contemporary standard, we need access to OCT imaging when indicated, have access to contemporary coronary technologies and be able to participate fully in national research.
- Our limited capacity leads to :
 - (a) long waits for elective patients which is a concern from a patient safety
 - (b) delay in scheduling 1N/AMU/CCU patients (hence suboptimal bed flow throughout the hospital and difficulty meeting NICE guidelines for patient access.
- The board are aware of our request for a second lab but have not approved. We would advise the trust to develop a second cath lab for pacing and devices for 2-3 days (a key service which is not adequately resourced) and which would also be PCI capable (providing safety back up should lab 1 fail mid case, and allow 1-2 days of additional coronary work). Such configuration is standard in similar sized interventional units across the rest of the UK.

6. CARDIAC RHYTHM MANAGEMENT**Awareness:**

- Ensure two staff are fully trained and aware of data submission to NICOR following submission failure when one staff member went on maternity leave.

Areas for improvement:

- Staff had no training/ CPD for over one year with Coved 19 restrictions in place. Cardiac devices are ever evolving and require continuous training in the area. Reintroduction of staff training and courses following Covid 19 has been identified as a vital for ongoing CPD and improvement of staff skills and knowledge in the device clinics.

- SHSCT is compliant for 2020 / 2021 across all 7 of the quality metrics detailed above across volumes, data completeness and validity, NICE guidance and re-intervention.

7. NATIONAL AUDIT OF CARDIAC REHABILITATION (NACR)

- We are entering basic information on to the database on an on-going basis. However this has been on a limited basis due to staffing issues.
- There are no out-patient cardiac rehab programs since April 2020
- There has been no NACR report since April 2020 due to the ongoing COVID situation. Many cardiac rehab teams in the UK have been redeployed and have not been able to input into the NACR.
- The cardiac rehabilitation teams in the SHSCT have not been able to recommence their out-patient cardiac rehabilitation programmes due to SHSCT COVID response. Many of the cardiac rehabilitation teams have been redeployed.
- In August 2021 the Health and Social Care Board commissioned Queens University to carry out a Regional Needs Analysis of Cardiac Rehabilitation. The final report is awaited.

8. MYOCARDIAL ISCHAEMIA NATIONAL AUDIT PROJECT (MINAP)

- Nice Guidelines (GC94) recommends Acute Coronary Syndromes should have Coronary angiography and PCI within 72 hours. This target is not being achieved because of capacity delays due to SHSCT **only having one Cardiac Catherisation Lab Theatre** which operates Mon – Fri 9-5pm. **Currently only 32% achieve this target (2020 - 2021). National Average 55%.**
- Delays in patients waiting in hospital on Angiography impacts upon bed capacity and results in additional days spent in hospital. (Current average wait - 5 days)

9. SEVERE SEPSIS AND SEPTIC SHOCK

- Difficulty in giving antibiotics within 1 hour to meet the target due to patient flow in the Emergency Department (extreme over-crowding in ED)
- Delays evident in ambulance off loading, time to triage and time for transfer to appropriate clinical areas for management. Staff pressures evident in time to deliver treatment bundle.

- Dedicated Sepsis Bed still in amber resus, and used for immediate assessment and management of stand – by Sepsis patients from NIAS when possible. The management of these patients consistently meets targets.

10. FEVERISH CHILDREN (CARE IN EMERGENCY DEPARTMENTS)

- Difficulty in triaging within 15 minutes to meet the target due to patient flow in the Emergency Department (over-crowding in ED)
- ST4 staffing levels in DHH out of hours is an issue (senior review).

11. RENAL REGISTRY

- Our percentage for late presentation to the renal service (i.e. patients who need to start dialysis not referred within either 90 days or 1 year – was consistently higher than other centres in NI.
- We undertook a detailed audit on this and found that only a very small number (3 patients) might have benefited from earlier referral. We concluded that our percentage is higher due to a combination of small numbers (28 – 30) starting RRT each year and chance, for example – in 2020 we only had 1% late referrals with no change in access to the service.

12. MENTAL HEALTH (SELF-HARM) - NEW

- Fundamental concerns with regard to department footprint, patients absconding, exit block, crowding.
- Concerns remain regarding the designation of the ED regionally as “place of safety”, the interpretation of the absconding protocol / involvement of the PSNI and site security.

13. SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

- SSNAP scoring has been consistently poor in the Trust for many audit cycles. Despite SSNAP evidence/reports, there has not been the required attention to redress this. A Stroke Service Improvement Lead has been appointed and unfortunately due to Covid-19, he has been redeployed to Covid-19 ICU. It is hoped that the post holder will return to the Stroke service in the near future. The Trust is also submitting an IPT to secure additional resources as referenced earlier.
- We are now the worst performing Trust within Northern Ireland. As a means of urgency we need to address gaps in resources, agree priorities including rehabilitation to stroke patients and give time lines for targeted improvements including:

- (a) The Trust need to adopt a stroke admissions policy for both acute sites;
- (b) The strategic stroke committee needs to be reviewed including membership and terms of reference. This group should oversee stroke progress, have the necessary administrative support and work with targeted aims and objectives;
- (c) The management of the stroke service needs to be reviewed. Patients with stroke are managed across five different sites (CAH, DHH, Lurgan, STH and community). Interface is poor and the pathway not patient focussed. Models of in-reach and a dedicated stroke pool of therapists with the ability to work across directorates for the benefit of patient's needs to be considered;
- (d) TIA is an ambulatory speciality. It was not prioritised in the first wave of "no more silos". An identified ambulatory bay available for assessment of patients, staffed with stroke trained medical and nursing staff allowing same day access to imaging is required. This would allow patients to be diverted from ED and managed promptly with reduced need for in-patient admission;
- (e) Access to CTA out of hours has improved. Timeliness of reports needs reviewed as does the process for prompt outsourcing of scans to the independent sector. The Trust is to be complimented on the high number of patients receiving clot retrieval through identification of large vessel occlusion as a result of better access to CTA.
- (f) A number of nurses are currently undertaking specialist practice courses but there is a greater requirement for succession planning for nursing staff with the aim of having more stroke specialist nurses available. This would allow front door assessment of patients 24/7, swallow assessment, triage of TIA patients, thrombolysis assessment, addressing of risk factors and secondary prevention. For the service to progress we need an appropriate training plan, encouragement of new starts into stroke and access to the necessary educational opportunities.

14. NATIONAL JOINT REGISTRY

- The NJR reported position for consent compliance has decreased to amber, with the downturn in elective work, a greater proportion of THRs are done following trauma. This has the issue whereby there is less consent for NJR as cases don't come in via preoperative assessment (where consent is usually obtained).
- Very little data submitted within the past 18 months due to lack of elective operating. That data that has been submitted is in line with quality standards previously recorded.

15. NATIONAL HIP FRACTURE DATABASE (NHFD)

- We have previously struggled to recruit and retain ortho-geriatric cover for trauma and particularly hip fracture care. We have been successful in recruiting a Trust grade doctor, but unfortunately our acting consultant, has been on sick leave for approaching 3 months, with no additional cover.
- Data is imported to FORD and subsequently uploaded to NHFD. Unfortunately, due to changes in staff in FORD, the data was not uploaded in time for publication within the 2020 NHFD report. Report states “The 2020 dashboards reports do not currently include data for Northern Ireland, which has been delayed. Mortality data will be added in due course.” We have been reassured by FORD, these issues have been addressed and we are hopeful, our data will be uploaded for 2021 report.
- Due to structural changes in uploading data through FORD, issues identified updating DAA and MOU. This has been difficult to rectify. DAA now signed off by Medical Director. MOU still unsigned, awaiting information governance advice.

16. TOWARDS ZERO SUICIDE/NATIONAL CONFIDENTIAL INQUIRY INTO SUICIDE AND SAFETY

- An area of good practice noted from this work is good collaborative working between managers, clinicians and full multidisciplinary team working on improvement work and that this links well to wider regional work.
- Support & Recovery Consultants undertake a significant amount of post discharge follow up appointments at present. Increasing capacity to allow us to get closer to a 3 day follow up will require New Ways of Working and more keyworkers undertaking discharge appointments and also other teams such as Primary Mental Health teams or Community Addiction teams undertaking more follow up appointments – the group is actively looking at how these changes could/would be implemented
- One area for improvement is building more capacity and flexibility into the existing “templated system” for allocation of primary mental health team appointments to enable post discharge follow up.
- How this work links into wider regional work with other Trusts is also an example of good practice.

17. THE USE OF CLOZAPINE

- Paper documents developed to support compliance with POMH-UK, need to be scanned to PARIS and be easily retrievable for audit purposes.
 - Regional clozapine care pathway.
 - Clozapine titration charts.

18. IMPROVING THE QUALITY OF VALPROATE PRESCRIBING IN ADULT MENTAL HEALTH SERVICES

- Compliance with PREVENT program not on MH Risk register.
- Delay in getting VALPROATE register available in PARIS.

19. INPATIENT AND COMMUNITY MENTAL HEALTH BENCHMARKING

- Caution continues to be exercised when submitting and comparing indicators within the Mental Health data set due to:
 - o definition interpretation both regionally and nationally. In light of this key metric data and relative positions have been used by SHSCT MH services to drive further investigation and improvement work.
 - o integrated nature of HSC in NI compared to England, Scotland and Wales.
 - o regional work initiated on data definition consistency, started prior to the pandemic needs to be re-instated.

20. OPAC AUDITS - All these audits have been significantly impacted by the Covid-19 pandemic resulting in the inability to participate and progress improvements and action plans. Previously reported areas for committee awareness are therefore included.

21. NATIONAL AUDIT OF INTERMEDIATE CARE

- Good practice highlighted: Step up referrals to home based intermediate care have increased from 5.7% in 2017/18 to 23%.

22. UK PARKINSON'S AUDIT TRANSFORMING CARE

- The demand for this service continues to risk possibly driven to some extent by deficits in Neurology Service.
- To maintain a high quality service for these patients more medical and Parkinson's disease specialist nursing resource required.

23. OLDER PEOPLE'S CARE IN ACUTE SETTINGS

- Low spend on Older Peoples Services.
- Low number of Older People's beds in the Trust- 25 versus mean of 100 in other Trusts.
- High readmission rate possibly related to low number of specialist Older People's beds.
- Requirement to increase access to comprehensive geriatric assessment in the Emergency Department.

5.0 SHSCT Clinical Audit Work Programme 2021/22

Operational directorates were invited to develop a clinical audit work programme consisting of national, regional and Trust-based audits, as follows:

Appendices 1a – 1b	Trust's first composite clinical audit work programme 2020/21, which has been already submitted to the Executive Quality Improvement Group for review and approval. The 2020/21 clinical audit work programme demonstrates planned participation in national audits; this participation is subject to compliance with GDPR requirements.
Appendix 2	Trust's Clinical Audit Strategy criteria for assigning priority levels for clinical audit
Appendix 3	Rationale for non-participation in national audits in the <i>NHS England Quality Accounts List</i>

6.0 GDPR requirements – Position remains as reported in November 2018

Trusts in NI face challenges on sharing patient identifiable data for secondary use with external organisations, as Northern Ireland does not have equivalent legislation to the NHS Act - Section 251.

The Trust's Director of Performance and Reform has endeavoured to find a regional resolution to this issue via the Strategic Information Group (SIG), where the topic received significant discussion however resolution was not immediately clear.

This issue was considered at the Information Governance Advisory Group (IGAG), Information Governance Network and at the Privacy Advisory Committee meeting held on 13th September 2018; however a regionally agreed way forward has yet to be determined¹

In the interim, participation in national audits has been presented in this report (Appendix A) on an on-going basis, taking a discretionary approach based on the benefit of participation in a national audit, versus any data protection risks. Many audits are participated in by all HSCTs in NI. On-going participation and information governance arrangements will be reviewed as part of an updated Clinical Audit Strategy.

It is recognised that participation in Clinical Audit is a fundamental driver for improving patient care, and the Trusts assumed position remains to participate in all audits.

¹ Position remains as advised by the Director of Performance and Reform in November 2021

7.0 Clinical Audit Strategy Update

This section of the National Audit Assurance Report (November 2020) noted that a revised structure for Clinical and Social Care Governance was proposed and had been approved by SMT (Sept 2020) to be implemented on a phased basis into 2021.

With the establishment of the Systems Assurance function within the Medical Directorate, a strengthened and improved organisational clinical audit function will sit within this area.

In September 2021 the Medical Director initiated a strategic review of the Clinical Audit Strategy and supporting organisational infrastructure with the following objectives and outcomes:

The **objectives** are to identify:

- Those aspects of the 2018 strategy that are embedded and working well in terms of the annual programme of audit and assurance mechanism;
- Those aspects that are under developed and require improvement or amendment;
- Any deficits in the strategy

The **outcomes** will be:

1. To develop an improvement plan to support a strengthened clinical audit function.
2. To formulate an updated Clinical Audit Strategy for the next period and associated Clinical Audit Policy (with a set of standard operating procedures) for SHSCT.

Other aspects of the improvement plan will require:

- Clinical Audit Resource Plan
- Clinical Audit Training Plan
- Reporting Schedules for assurance
- Integration with learning from experience

A stakeholder engagement exercise is currently being undertaken to ensure all directorates have their needs and views identified at the start of the strategy review. ([Clinical Audit Stakeholder Survey - NI Direct - Citizen Space](#)).

The key issues and challenges for the Trust in relation to clinical audit include;

1. Ensuring that clinical audit is delivered consistently across all operational directorates, in line with national guidance and
2. Ensuring that there is a sufficient numbers of staff in the Corporate Clinical Audit Team and in the Directorates to support clinical audit leads in the delivery of the approved clinical audit programme.

Both an increased audit network of lead clinicians and corporate clinical audit team will be required to ensure an adequately staffed and trained team can facilitate and support the annual programme. This requires revising current structures and alignment of existing and any new staffing resource (as originally approved in Sept 202) for both the central clinical audit and patient safety functions.

NHS England Quality Accounts List 2021 - 22 :[nhs-england-quality-accounts-list-2021-22.pdf \(hqip.org.uk\)](https://nhs.uk/quality-accounts/2021-22/nhs-england-quality-accounts-list-2021-22.pdf)**SHSCT planned participation****Appendix 1a**

Division	National Clinical Audit & Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?
Anaesthetics, theatre & intensive care unit	Case mix programme (CMP) - ICNARC	Intensive Care National Audit and Research Centre	Yes
Cardiology	Myocardial Ischaemia National Audit Project (MINAP)	Barts Health NHS Trust	Yes
	National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Barts Health NHS Trust	Yes
	National Audit of Cardiac Rhythm Management (CRM)	Barts Health NHS Trust	Yes
Respiratory	National Outpatient Management of Pulmonary Embolism	British Thoracic Society	Yes
Emergency department	Pain in Children (care in Emergency Departments)	Royal College of Emergency Medicine	Yes
	Severe sepsis and septic shock (care in Emergency Departments)	Royal College of Emergency Medicine	Yes
Integrated maternal & women's health	Maternal, newborn and infant clinical outcome review programme	University of Oxford / MBRRACE-UK collaborative	Yes
	National Perinatal Mortality Review Tool	University of Oxford / MBRRACE-UK collaborative	Yes
Nephrology	UK Renal Registry National Acute Kidney Injury programme	UK Renal Registry	Yes
MHLD	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide in Mental Health (NCISH)	Yes
	Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	Yes

		(RCPsych)	
Stroke services	Sentinel Stroke National Audit programme (SSNAP)	King's College London	Yes
Trauma & orthopaedics (FFFAP)	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes
	National Hip Fracture Database	Royal College of Physicians	Yes
Urology	Transurethral Resection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	BURST Collaborative / British Urology Researchers in Surgical Training	Yes
Cross speciality	Medical and Surgical Clinical Outcome Review Programme: 1. Community acquired pneumonia	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Medical and Surgical Clinical Outcome Review Programme: 2. Crohn's disease	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	Medical and Surgical Clinical Outcome Review Programme: 3. Epilepsy study	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	4. Child Health Clinical Outcome Review Programme - Transition from child to adult health services	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes
	National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network	Yes

SHSCT Clinical audit work programme 2021 -22
(audits registered with the clinical audit directory)
(outside of the NHS England Quality Accounts List)

Appendix 1b

Directorate / Division	Division	Audit type	Audit Level	Audit title
Acute, SEC	General Surgery	International	1	BURST Resect Study
Acute, SEC	Breast cancer	National	1	National Unilateral nipple discharge study
Acute, Cross Specialty	Cross Specialty	National	1	BTS Pleural Services Organisational Audit 2021
Acute, Cross Specialty	Cross Specialty	National	2	Covid-19 Impact on Pancreatic Cancer Care Pathway
Acute, SEC	T&O	National	2	Open study-Open fracture Patient Evaluation Nationwide
Acute, Cross Specialty	Cross Specialty	Regional	2	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with confirmed urological cancer
Acute, Cross Specialty	Cross Specialty	Regional	2	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the time taken to initial treatment for patients with suspected Urological cancer
Acute, Cross Specialty	Cross Specialty	Regional	2	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department, the time taken to initial treatment for patients with confirmed urological cancer and the impact of COVID on treatment
Acute, Cross Specialty	Cross Specialty	Regional	2	Audit of the GP "Two Week Wait Referrals" to a DGH Urological Surgery Department and the impact of COVID on the time taken to review patients with suspected Urological cancer
Acute, CYP	Cross Specialty	Regional	2	PIVFAIT Audit- IV fluids in Children 0-16 years
Acute, IMWH	IMWH	Regional	2	Regional Ablation Audit

SHSCT Clinical audit work programme 2021 - 22
(audits registered with the clinical audit directory)

Appendix 1b

Directorate / Division	Division	Audit type	Audit Level	Audit title
Acute, Cross Specialty	Cross Specialty	SHSCT	2	Ensuring Pregnancy Testing is undertaken prior to surgery
Acute, IMWH	IMWH	SHSCT	2	Impact of the pandemic on ectopic pregnancy outcomes
Acute, Pharmacy	Pharmacy	SHSCT	2	Audit of Intravenous paracetamol
Acute, SEC	Urology	SHSCT	2	Audit of prescribing of anti-androgen medicine "Bicalutamide"
Acute, SEC	T&O	Regional	3	Restarting DOAC's Post -operatively in Trauma Patients
Acute, ATICS	ATICS	SHSCT	3	Survey of practice in the management of the patient in the prone position
Acute, IMWH	IMWH	SHSCT	3	Obstetric anal sphincter injury audit
Acute, IMWH	IMWH	SHSCT	3	Foley Catheter Induction of Labour
Acute, IMWH	IMWH	SHSCT	3	Postnatal obstetric adverse effects and complications
Acute, IMWH	IMWH	SHSCT	3	Retrospective Audit of outcomes with mechanical induction of labour
Acute, IMWH	IMWH	SHSCT	3	Audit for quality improvement of antenatal VTE risk assessment in DHH
Acute, IMWH	IMWH	SHSCT	3	Female Lower urinary tract service audit
Acute, MUSC	General Medicine	SHSCT	3	Sepsis
Acute, MUSC	General Medicine	SHSCT	3	Delivery of Palliative Care in DHH General Medicine
Acute, MUSC	General Medicine	SHSCT	3	Review of COVID-19 transfer policy
Acute, MUSC	General Medicine	SHSCT	3	Alcohol Admission and management
Acute, Pharmacy	Pharmacy	SHSCT	3	Procalcitonin testing and antibiotic use in suspected Covid-19
Acute, SEC	ENT	SHSCT	3	5 year retrospective review of hypocalcaemia rates & management following total thyroidectomy and completion thyroidectomy surgery in SHSCT

**SHSCT Clinical audit work programme 2021 -22
(As registered with clinical audit team)**
Appendix 1b

Directorate / Division	Division	Audit type	Audit Level	Audit title
Acute, SEC	General Surgery	SHSCT	3	Quality of biopsy sampling in suspected eosinophilic oesophagitis in SHSCT
Acute, SEC	General Surgery	SHSCT	3	National Emergency Laparotomy Audit
Acute, SEC	General Surgery	SHSCT	3	Antibiotic prophylaxis for patients diagnosed with SBP
Acute, SEC	T&O	SHSCT	3	Audit of accuracy of form V13.3 for input to National Fracture database from Trauma ward December 2020
Acute, SEC	T&O	SHSCT	3	Compliance with local Trust prophylactic antibiotic guidelines in trauma patients-1 month follow up
Acute, SEC	Urology	SHSCT	3	Operative note documentation
Acute, SEC	Urology	SHSCT	3	Comparison of LUTS assessment in Southern Trust against guidelines
Acute, SEC	Urology	SHSCT	3	The efficacy and cost savings of chemolysis for suspected uric acid stones compared to uteroscopy, PCNL or ESWL: a prospective study
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Audit of clinical effectiveness of Heart failure nursing care
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Audit of ED Documentation to determine recorded level of burn cooling received by Paediatric patients presenting to Craigavon ED
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Craigavon POPS (peri-operative care of older people undergoing surgery) PILOT service Quality improvement project
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Audit into the management of intracranial bleeds
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Unplanned admissions following daycase elective surgery
Acute, Cross Specialty	Cross Specialty	SHSCT	3	Which trauma patients should receive a screening CT angio in detecting blunt cerebrovascular injury as per denver guidelines

CYP	CYP	SHSCT	4	The effectiveness of virtual clinics in Community Paediatrics
CYP	CYP	SHSCT	4	Antipyretic Interventions
Acute, MUSC	Stroke services	SHSCT	4	Orthoptic Stroke Service Audit
OPPC	OPPC	SHSCT	4	Evaluation of Parents Plus Special Needs Group Work Programmes
Acute, Pharmacy	Pharmacy	SHSCT	4	Audit to determine the number of true penicillin allergy patients on the AMU in CAH
Acute, SEC	ENT	SHSCT	4	Parotid Surgery in the Southern Trust: An overview of techniques, complications and changing trends
Acute, SEC	ENT	SHSCT	4	Hypocalcaemia in the post-operative parathyroidectomy patient
Acute, SEC	General Surgery	SHSCT	4	Follow up of Emergency laparotomies and laparoscopic surgeries in daisy Hill Hospital and compare it with National Emergency Laparotomy Audit
Acute, Cross Specialty	Cross Specialty	SHSCT	4	Assessment of Severity of Pancreatitis in Patients in DHH

Priority levels for clinical audits

Appendix 2

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

NHS England Quality Accounts List 2021 - 22

SHSCT non participation and rationale

Appendix 3

	Division	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating ?	Rationale
Non participation	Cross Directorate	National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists (RCOA)	No	GDPR / data access
		National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK	No	GDPR / data access
		Audit of Patient Blood Management & NICE Guidelines	NHS Blood and Transplant	No	No - audit postponed due to COVID-19
		Audit of the perioperative management of anaemia in children undergoing elective surgery	NHS Blood and Transplant	No	No - audit postponed due to COVID-19
	Cardiology	National Audit of Cardiac Rehabilitation (limited data input available) Regional HSCB / QUB Review	University of York	No	Not able to participate due to COVID. Many of the cardiac rehab team redeployed
	Gastroenterology	Inflammatory bowel disease programme / IBD Registry	Inflammatory Bowel Disease Registry	No	Regional IBD registry software has not yet been developed - still ongoing
	Medical	Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	No	Unable to participate due to covid / staff pressures
	OPPC	National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	No	Regional agreement not to complete this year due to pressures related to COVID.

	Respiratory	National Outpatient Management of Pulmonary Embolism	British Thoracic Society	No	Unable to participate due to covid/ staff pressures
		National Smoking Cessation 2021 Audit	British Thoracic Society	No	Unable to participate due to covid/ staff pressures
	Urology	Cytoreductive Radical Nephrectomy	British Association of Urological Surgeons	No	GDPR / data access
	Urology	Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	British Association of Urological Surgeons	No	GDPR / data access

NHS England Quality Accounts List 2021/22⁽¹⁾**SHSCT non participation and rationale****Appendix 3**

	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Will SHSCT be participating?	Rationale
Non participation	National Vascular Registry	Royal College of Surgeons	N/A to SHSCT	Index cases are carried out in Belfast Trust
	Neurosurgical National Audit Programme	The Society of British Neurological Surgeons	N/A to SHSCT	Service not provided by SHSCT
	Out-of-Hospital Cardiac Arrest Outcomes Registry	University of Warwick	N/A to SHSCT	Data provided by ambulance service
	Paediatric Intensive Care Audit	University of Leeds / University of Leicester	N/A to SHSCT	Service provided by BHSCT
	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	N/A to SHSCT	Service not provided by SHSCT
	Cleft Registry and Audit Network Database	Royal College of Surgeons - Clinical Effectiveness Unit	N/A to SHSCT	Service not provided by SHSCT
	National Cardiac Audit Programme: <i>f. National Congenital Heart Disease</i>	Barts Health NHS Trust	Not eligible	RVH participates in audit
	Elective Surgery (National PROMs Programme)	NHS Digital	Not eligible	Data collection England
	Falls and Fragility Fracture Audit Programme <i>a. Fracture Liaison Service Database</i>	Royal College of Physicians	Not eligible	Data collection England & Wales
	Falls and Fragility Fracture Audit Programme <i>b. National Audit of Inpatient Falls</i>	Royal College of Physicians	Not eligible	Data collection England & Wales
	Learning Disabilities Mortality Review Programme	NHS England	Not eligible	Data collection England
	National Adult Diabetes Audit	NHS Digital	Not eligible	Data Collection England
	National Asthma and Chronic Obstructive Pulmonary Disease Audit	Royal College of Physicians	Not eligible	Data collection England & Wales
	National Audit of Breast Cancer in Older Patients	Royal College of Surgeons	Not eligible	Data collection England & Wales
	National Audit of Cardiovascular Disease Prevention	NHS Benchmarking Network	Not eligible	Primary care

	National Audit of Dementia	Royal College of Psychiatrists	Not eligible	Data collection England & Wales
Non participation	National Audit of Pulmonary Hypertension	NHS Digital	Not eligible	Data Collection England & Scotland
	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Royal College of Paediatrics and Child Health	Not eligible	Data collection England & Wales
	National Cardiac Audit Programme: c. <i>National Adult Cardiac Surgery Audit</i>	Barts Health NHS Trust	Not eligible	Data collection England & Wales
	National Cardiac Audit Programme: e. <i>National Heart Failure Audit</i>	Barts Health NHS Trust	Not eligible	Data collection England & Wales
	National Child Mortality Database	University of Bristol	Not eligible	Data Collection England
	National Clinical Audit of Psychosis	Royal College of Psychiatrists	Not eligible	Data collection England & Wales
	National Early Inflammatory Arthritis Audit	British Society of Rheumatology	Not eligible	Data Collection England & Wales
	National Gastro-intestinal Cancer Programme a. <i>National Oesophago-gastric Cancer</i>	NHS Digital	Not eligible	Data Collection England & Wales
	National Gastro-intestinal Cancer Programme b. <i>National Bowel Cancer Audit</i>	NHS Digital	Not eligible	Data Collection England & Wales
	National Lung Cancer Audit	Royal College of Physicians	Not eligible	Data Collection England & Wales
	National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	Not eligible	Data Collection England, Scotland and Wales
	National Neonatal Audit Programme 1, 2	Royal College of Paediatrics and Child Health	Not eligible	Data Collection England, Scotland and Wales
	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	Not eligible	Data Collection England & Wales
Non participation	National Prostate Cancer Audit	Royal College of Surgeons	Not eligible	Data Collection England & Wales
	Trauma Audit & Research Network	The Trauma Audit & Research Network	Not eligible	Data Collection England & Wales

HQIP National Audit Published Reports December 2020 – October 2021 Dissemination Record

Appendix 4

HQIP Audit Report Title	Date Issued	Directorates disseminated to	Trust participation
HQIP National Bowel Cancer Audit Annual Report 2020	11/12/2020	Acute	NO
HQIP National Oesophago-Gastric Audit 2020	11/12/2020	Acute	NO
HQIP Perinatal Mortality Review Tool -Second Annual Report	14/12/2020	Acute/CYP	YES
HQIP Maternal, Newborn and Infant Clinical Outcome Review Programme-Perinatal Surveillance Report 2018	14/12/2020	Acute/CYP	YES
HQIP National Diabetes Audit 2018-19 Full Report 1:Core processes and treatment targets	14/12/2020	Acute/OPPC	NO
HQIP National Cardiac Audit Programme Annual Report 2020	15/12/2020	Acute	NO
HQIP National Audit of Percutaneous Coronary Intervention (PCI) 2020 Summary Report	15/12/2020	Acute	YES
HQIP Myocardial National Audit Project (MINAP) 2020 Summary Report	15/12/2020	Acute	YES
HQIP Heart Failure 2020 Summary Report	15/12/2020	Acute	NO
HQIP Congenital Heart Disease Audit 2020 Summary Report	15/12/2020	Acute	NO
HQIP National Audit of Cardiac Rhythm Management 2020 Summary Report	15/12/2020	Acute	NO
HQIP National Adult Surgery Audit (NACSA)-2020 Summary Report	15/12/2020	Acute/CYP	NO
HQIP Pulmonary Rehabilitation Clinical and Organisational Audits 2019	17/12/2020	Acute	NO
HQIP National Maternity and Perinatal Audit Mental health Sprint Audit Report (Scotland data)	18/01/2021	Acute/CYP	NO
HQIP MBRRACE Maternal and Infant Programme: Stillbirths and neonatal Deaths in Twin Pregnancies	18/01/2021	CYP/Acute	YES
HQIP MBRRACE Maternal, Newborn and infant Programme: Saving Lives, Improving Mothers' Care 2020 Report	18/01/2021	CYP/Acute	YES
HQIP Hip Fracture Database Annual Report 2020	18/01/2021	Acute	YES

HQIP National Audit of Dementia-RDMA 20	18/01/2021	OPPC/Acute	NO
HQIP National Maternity Perinatal Audit-RDMA 20	18/01/2021	Acute/CYP	NO
HQIP Paediatric Intensive Care Audit Network (PICA) Annual Report 2020	12/02/2021	Acute/CYP	NO
HQIP Medical and Surgical-Out of Hospital Cardiac Arrest Report-Final	12/02/2021	Acute	YES
HQIP National Confidential Inquiry into Suicide by Middle aged Men	14/05/2021	Acute/MHLD/OPPC	NO
HQIP National Confidential Inquiry into Suicide and Safety in Mental Health-Annual report 2021	14/05/2021	Acute/MHLD/OPPC	YES
HQIP Children and Young People asthma combined clinical and organisational Audit 2019/2020	14/05/2021	CYP	NO
HQIP National Audit of Inpatient falls, Interim Annual report Spring 2021	14/05/2021	Acute/OPPC/MHLD	NO
HQIP National Vascular Register Short report March 2021	14/05/2021	Acute	YES
HQIP 2021 Impact Report SSNAP	28/05/2021	Acute	NO
HQIP 2021 Impact Report NEIAA	28/05/2021	Acute	NO
HQIP 2021 Impact Report NCAP	28/05/2021	Acute/MHLD	NO
HQIP Impact Reports 2019/2020/2021	28/05/2021	Acute/CYP/OPPC/MHLD	NO
HQIP National Paediatric Diabetes Audit Annual Report 2019/2020	11/06/2021	CYP	NO
HQIP National Vascular Registry: Short Report-Developing & Implementing implantable medical device capture for aortic aneurism repair-June 2021	11/06/2021	Acute	YES
HQIP National bowel Cancer Audit - Short Report Published 10th June 2021-Trends, characteristics and outcomes for patients diagnosed with metastatic colon cancer in England	11/06/2021	Acute	NO
HQIP National Child Mortality Database (NCMD) Second Annual Report-England Only	11/06/2021	CYP	NO
HQIP Non-diabetic Hyperglycaemia 2019/20 Report	19/07/2021	Acute/OPPC	NO
HQIP Early Intervention in Psychosis (EIP) Audit	19/07/2021	Acute/CYP/MHLD/OPPC	NO
HQIP National Clinical Audit of Seizures and Epilepsies for Children and Young People	19/07/2021	Acute/CYP/MHLD	NO
MBRRACE Learning from SARS-CoV-2 related and associated maternal deaths in the UK	19/07/2021	CYP/Acute	YES

National Diabetes Audit Type 1 England & Wales, 2019-2020	13/08/2021	Acute	NO
National Diabetes Audit Type 2 Diabetes 2019-2020	13/08/2021	Acute	NO
Young people with Type 2 Diabetes, 2019-2020	13/08/2021	CYP/Acute	NO
National Audit of Breast Cancer in Older Patients: Annual Report 2021	13/08/2021	OPPC/Acute	NO
National Clinical Audit of Psychosis: Early intervention in Psychosis Audit (Wales), 2020/2021	13/08/2021	Acute/MHLD	NO
Medical and Surgical Clinical Outcome Review Programme: Dysphasia in Parkinson's Disease	13/08/2021	OPPC/Acute	YES
HQIP National Oesophago-Gastric Cancer Audit 2021 Short Report	19/10/2021	Acute	NO
HQIP Myocardial Ischemia National Audit Project (MINAP) 2021 Summary Report	19/10/2021	OPPC/Acute	YES
HQIP National Audit of Cardiac Rhythm Management (NACRM) 2021 Summary Report	19/10/2021	OPPC/Acute	YES
HQIP National Adult Cardiac Surgery Audit (NACSA)-2021 Summary Report	19/10/2021	OPPC/Acute	NO
HQIP National Audit of Percutaneous Coronary Intervention (NAPCI) 2021 Summary Report	19/10/2021	OPPC/Acute	YES
HQIP National Congenital Heart Disease Audit (HCHDA) 2021 Summary Report	19/10/2021	OPPC/Acute	NO
HQIP National Heart Failure Audit (NHFA) 2021 Summary Report	19/10/2021	OPPC/Acute	NO
HQIP National Cardiac Audit Programme (NCAP) Report 2021	19/10/2021	OPPC/Acute	YES
HQIP National Perinatal Mortality Review Tool 2021:Third Annual Report	18/10/2021	CYP/Acute	YES
HQIP National Maternity and Perinatal Audit Clinical Report 2021	18/10/2021	CYP/Acute	NO
HQIP MBRRACE-UK Perinatal Mortality Surveillance Report 2019	18/10/2021	CYP/Acute	YES
HQIP National Pregnancy in Diabetes Audit Report (NPID) 2020	18/10/2021	Acute	NO
HQIP National Child Mortality Database Programme Thematic Report 2021-Suicide in Children and Young People	18/10/2021	MHLD/CYP/Acute	NO

Process for Submitting NAAR Updates**Appendix 5**

The following link includes documents relevant to the process of compiling the annual National Audit Assurance Report

[Process for submitting NAAR updates](#)

Stage 1 – Medical Director Memo Issued

Stage 2 – Clinical Lead Request by email with submission template

Stage 3 – Reminder email – as required

Addendum - NAA Summary Report 2021 Contents

2021 Audit Updates by Directorate

Audit Type	National Audit	Page No
Directorate	ACUTE DIRECTORATE	
Division / Specialty	Anaesthetics, Theatres & Intensive Care Services, incorporating Surgery & Elective Care & Laboratory Services	
On-going	Intensive Care National Audit & Research Centre (ICNARC)	3
Historical	National Comparative Audit of Blood Transfusion programme – Audit of massive haemorrhage	7
Historical	Patient blood management in adults undergoing elective, scheduled surgery	9
Division / Specialty	Integrated Maternity & Women's Health, incorporating neonatal services	
NEW	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18	18
NEW	Rapid report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020 - March 2021	25
NEW	MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2018	31
NEW	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies	34
On-going	Comparative Audit of management of maternal anaemia and iron deficiency in the UK and ROI	38
Division / Specialty	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18	
Division / Specialty	Cardiology	
On-going	Adult Percutaneous Coronary Interventions- BCIS	40
On-going	Cardiac rhythm management	42
On-going	Cardiac rehabilitation	45
On-going	Myocardial Ischaemia National Audit Project	49
Division / Specialty	Emergency Medicine	
Historical	Severe sepsis and septic shock	51
Historical	Feverish Children (care in emergency departments)	53
Historical	Cognitive Impairment in Older People	57
Historical	Care of Children in ED	62
Historical	Mental Health (Self-Harm)	66
	General Medicine	
Deferred	Society for Acute Medicine's Benchmarking Audit (SAMBA)	72
	Nephrology	
On-going	Renal Registry	74
	Respiratory	
Historical	Inspiring change – non-invasive ventilation (NCEPOD)	Nil Update
Historical	Non-Invasive Ventilation – Adults	76
Historical	Adult Community Acquired Pneumonia	78
Division / Specialty	Stroke Services	
On-going	Sentinel stroke national audit programme	80

Addendum - NAA Summary Report 2021

	Trauma & Orthopaedics	
On-going	National joint registry	86
On-going	National hip fracture database	88
Directorate	MENTAL HEALTH AND DISABILITY	
NEW	Mental Health Clinical Outcome Review Programme	90
NEW	Prescribing Observatory for Mental Health (POMH-UK)	93
NEW	Mental Health benchmarking	102
NEW	Physical Healthcare of Inpatients in Mental Health Hospitals	107
Directorate	OLDER PEOPLE & PRIMARY CARE DIRECTORATE	
Historical	Intermediate care	109
Historical	UK Parkinson's audit transforming care	111
NEW	NCEPOD - Dysphagia in Parkinson's Disease "Hard to Swallow"	113
Directorate	CROSS DIRECTORATE AUDIT	
Historical	Older people's care in acute settings	117
Historical	NHS benchmarking audit – managing frailty in acute settings	120
Historical	Treat as One (NCEPOD)	Nil Update

This document is provided, for a reference, as a full copy of the information already accessible via the sharepoint links embedded in the summary report at sections 2 & 3.

Addendum - NAA Summary Report 2021

National Audit Title	Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme	
Host Organisation	ICNARC	
Clinical Audit Lead(s) Divisional / AMD	Dr Chris Clarke, CD Anaesthetics Dr Damian Scullion, AMD ATICS	
Contact details	Personal Information redacted by USI	
Time period	Continuous	
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES Please comment: The Intensive Care Unit in Craigavon Area Hospital submits data on all admissions to ICNARC, who collate the data and issue quarterly reports. This allows the performance of the Intensive Care/High Dependency Unit to be compared over time, both with previous Unit results, and also to other units (matched in terms of size, patient demographics to be fair comparators) throughout England, Wales and Northern Ireland. Data for 2020-2021 include that for periods of significantly expanded critical care bed capacity (to 16 beds at high surge peak) due to covid-19 escalation needs. Figures are reflective of a team based approach to critical care provision within the Trust, delivered in the ICU/HDU on CAH site. The quality indicator dashboard (below) allows eleven different parameters to be compared. The data is consistent with previous reports. It identifies that the patients admitted to ICU from the ward are sicker than the average across the UK. The difference is less in this report than before. There has also been a decrease in delay to discharge compared to the last report. These factors may be related. The other performance markers show a similar pattern to before with any variation demonstrated being within statistical variation. Risk-adjusted hospital mortality is similar to all other similar units.	
Directorate	ATICS	
Division / speciality	Intensive Care	
Full Report accessed via	2020/2021 Report - Not yet available	
Update provided	Progress Report	

Addendum - NAA Summary Report 2021**1) The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.**

		Site specific data	SHSCT compliance	National or regional compliance
1.	Unit acquired bloodstream infections consistently remain lower than expected (5 years) (Fig.1)	Observed 2.7% (95% pred. range 0-7.7%)		Expected 3.2%
2.	Risk adjusted Acute Hospital Mortality remained in line with benchmarked predictions (within +/- 1SD) (Fig.2)	Observed 32.5% (95% pred. range 13.1-38.9%)		Expected 26.2%

Craigavon Hospital, Intensive Care Unit
Quarterly Quality Report: 1 April 2020 to 31 March 2021

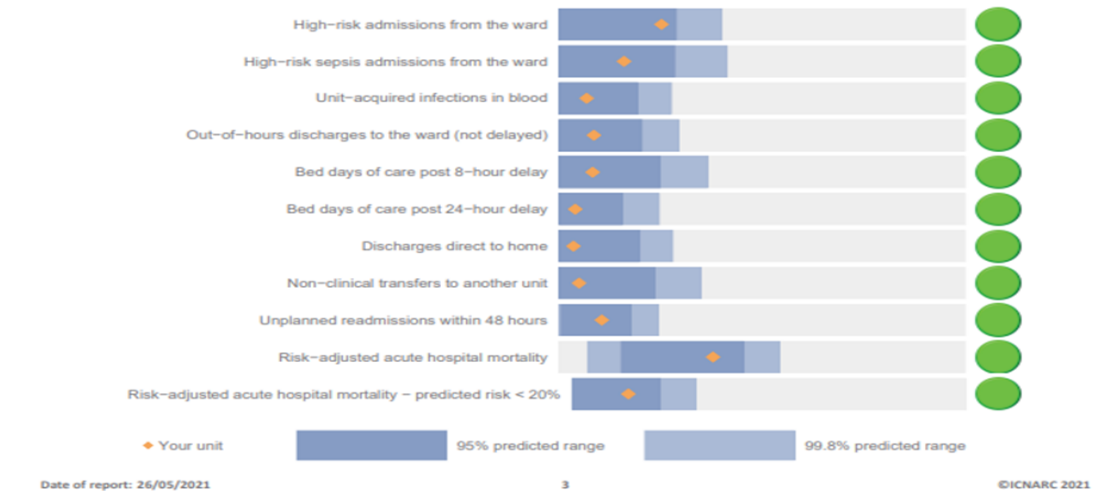
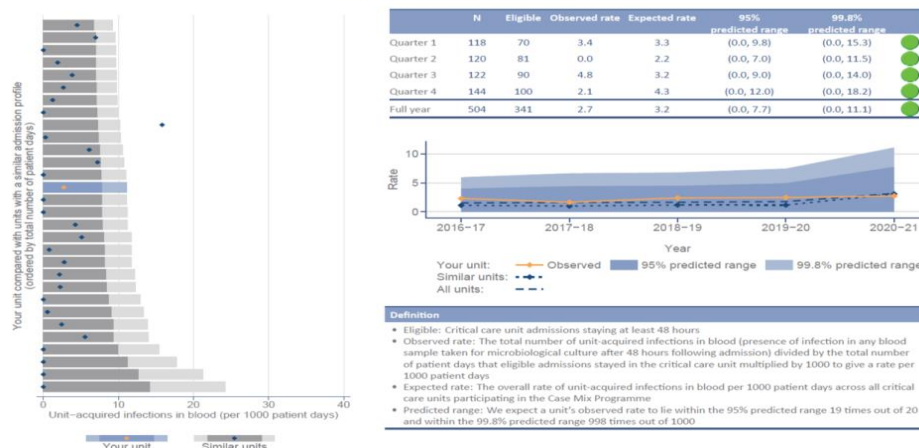
**Quality indicator dashboard**

Fig. 1

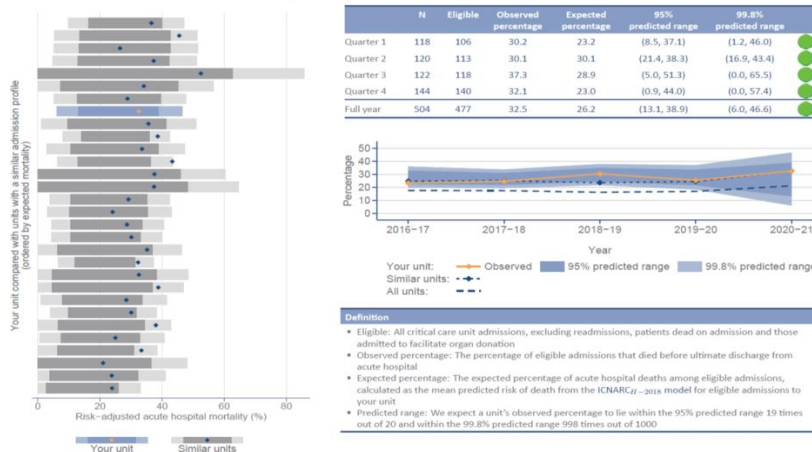
Craigavon Hospital, Intensive Care Unit
Quarterly Quality Report: 1 April 2020 to 31 March 2021

**Unit-acquired infections in blood**

Addendum - NAA Summary Report 2021

Fig. 2

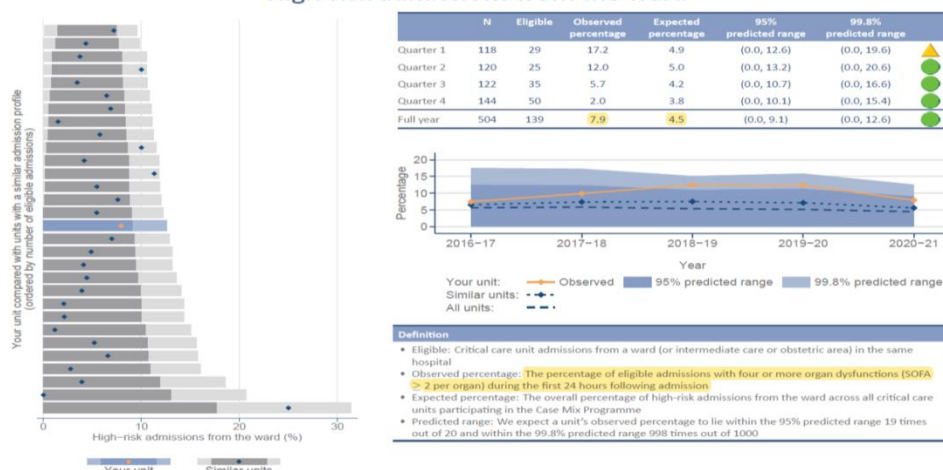
Craigavon Hospital, Intensive Care Unit
Quarterly Quality Report: 1 April 2020 to 31 March 2021

**Risk-adjusted acute hospital mortality****2) If appropriate, areas for improvement and actions taken**

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Report continues to highlight patients are more unwell at ICU/HDU admission than peer benchmarks. (Fig. 3)	Ward staff reminded of need to utilise NEWS and clinical judgement to ensure timely referral/escalation	In progress

Fig. 3

Craigavon Hospital, Intensive Care Unit
Quarterly Quality Report: 1 April 2020 to 31 March 2021

**High-risk admissions from the ward**

Addendum - NAA Summary Report 2021**3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement**

- Critical Care Admission when more unwell is one marker of a unit potentially functioning beyond optimum occupancy (80% occupancy is considered optimum as per FICM standards). Covid-19 escalation has stretched this further.
- Ensuring timely patient flow of those not requiring further critical care, to deescalate to ward-based care, is paramount in ensuring efficiency.
- Recent commissioned increase to 2 fully fund further Level 2 (HDU) beds will help mitigate.
- Despite high occupancy levels, markers of good care within ICU/HDU itself, such as unit-acquired infection, remained reassuringly low.

4) Update on non-participation if national audit work has been delayed / not progressed.

Not Applicable

Addendum - NAA Summary Report 2021

National Audit Title	National Comparative Audit of Blood Transfusion programme – Audit of massive haemorrhage		
Host Organisation	NHS Blood and Transplant		
Clinical Audit Lead(s) Divisional / AMD	Dr Mark Bridgham and Dr James Crockett Dr Shaid Tariq		
Contact details	Personal Information redacted by UST 		
Time period	Continuous Snapshot October 2018 (please specify dates)		
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES / NO Please comment: Not Applicable - no audit programme in 2020/2021		
Directorate	Acute - Cross Directorates		
Division / speciality	ATICS / Haematology		
Full Report accessed via	Microsoft Word - 2018 Audit of the Management of Major Haemorrhage - H&S.docx (windows.net)		
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	The audit report makes eleven recommendations to improve practise in the management of massive haemorrhage nationwide. Of these eleven recommendations, two are not directly applicable to SHSCT as they relate to transfusion practise in larger tertiary centres. Of the nine remaining recommendations eight are already implemented within SHSCT and are reflected in our current day to day practise, guidelines and			

Addendum - NAA Summary Report 2021

	procedures.			
--	-------------	--	--	--

2.0 If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
The one recommendation where SHSCT has scope for improvement relates to review and audit of activations of the massive haemorrhage protocol. Such review has historically always taken place in SHSCT for many years on an 'as required' basis if issues were identified with a particular patient case. However, the national audit advises that the local review process should be regular and more formalised.	The Trust Transfusion Team has developed a system to review clinical cases where there was significant blood component usage following activation of the Massive Haemorrhage Protocol. This review will take place regularly on a monthly basis. Any learning points will be shared.	Complete The Trust Transfusion Team undertake 3 monthly reviews of activation of the massive haemorrhage protocol. Any relevant learning points are disseminated

The 2018 audit was a one off snapshot of massive haemorrhage and any required actions against the relevant recommendations are now completed.

3.0 Key areas to raise awareness to SMT/ Governance committee

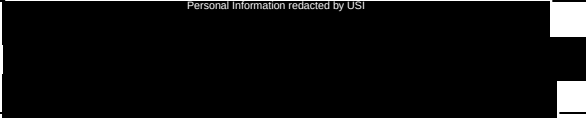
- None

4.0 Update on non-participation if national audit work has been delayed / not progressed.

All NCABT Audits for 2020 have been postponed due to COVID-19:

- Audit of Patient Blood Management in paediatric surgery
- Survey of use of FFP, cryoprecipitate, PCC and fibrinogen concentrate
- Audit of NICE Quality Standards
- Audit of Blood Sample Collection & Labelling

Addendum - NAA Summary Report 2021

National Audit Title	Patient blood management in adults undergoing elective, scheduled surgery <i>National comparative audit of blood transfusion</i>
Host Organisation	NHS Blood and Transplant (NHSBT)
Clinical Audit Lead(s) Divisional / AMD	Dr Aidan Cullen, Mr Graham Scott & Mr D McKay (currently on sabbatical) Dr Damian Scullion / Dr Shaid Tariq
Contact details	
Time period	Snapshot (September - November 2016)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES / NO Please comment: I don't think so. I have not received any updated data
Directorate	Acute
Division / speciality	Surgery and elective care, Anaesthetics, Theatres & Intensive Care and laboratory services
Full Report accessed via	http://hospital.blood.co.uk/audits/national-comparative-audit/
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

The national re-audit compared practice against 10 audit standards, looking at pre-operative, intra-operative and post-operative 'patient blood management' (PBM) practice, in patients undergoing surgery who had received a transfusion.

The following table compares SHSCT compliance in the 2015 and 2016 audits, against the national average.

Standard	Description	SHSCT compliance 2015	SHSCT compliance re-audit 2016	National audit findings re-audit 2016
1	Pre-operative anaemia management	40%	50%	50%
2	Pre-operative transfusion indicated	0%	N/A	16.9%
3	Pre-operative transfusion indicated only if pre-operative anaemia optimisation has been attempted, where appropriate	0%	N/A	2.4%
4	Pre-operative transfusion - single unit transfusion policy	100%	N/A	35%
6a	Patients having intra-operative transfusion in whom at least one PBM measure has been attempted,	71%	100%	82%

Addendum - NAA Summary Report 2021

	where appropriate			
7a	Patients having intra-operative transfusion in whom all PBM measures have been attempted, where appropriate	14%	100%	21%
8	Post-operative transfusion allowed (whether or not PBM measures attempted) - first episode	50%	14%	34%
9	Post-operative transfusion following the single unit policy – first episode	50%	100%	50%
10a	Post-operative in whom at least one PBM measure has been attempted, where appropriate - first episode	67%	71%	84%
11a	Post-operative in whom all PBM measures have been attempted, where appropriate - first episode	0%	14%	

- 20 Recommendations below – SHSCT Position - 12 Compliant, 3 Amber and 5 Red

Nationally agreed recommendations and suggested actions				
Recommendation	Action required	SHSCT status as at Nov 2019	SHSCT status as at Sep 2020	SHSCT status as at Oct 2021
Pre-operative anaemia management – Hospital Transfusion Committee / Hospital Transfusion Team				
Work with commissioners to formalise integrated pathways and funding for the referral of patients found to be anaemic during surgical workup	The Chief Medical Officer's letter, HSS (MD) 22/2012, has directed all clinicians to detect, investigate and optimise anaemia in patients prior to major surgery. GAIN (Guidelines Audit Implementation Network) guidance outlines how to go about this.	No specific formal/integrated pathways currently. Any patient found to be anaemic prior to scheduled surgery is highlighted to the consultant anaesthetist. The need for onward referral is currently on a case by case basis in discussion with the GP or colleagues in the relevant specialty in secondary care.	No change	No change
Ensure that healthcare pathways are structured to enable anaemia screening and investigation / correction before surgery.	Continue to increase awareness of this stream of work to surgical colleagues to ensure timely referral to POA (preoperative assessment) clinic. This is through a bottom up approach, copying the surgical consultant into relevant electronic correspondence when appointments and prescriptions for iron	Pre-Operative Assessment Clinic has steadily increased involvement in patients found to be anaemic in the run up to routine/urgent and red flag major surgical procedures since 2015.	Change (No longer compliant). Screening and investigation of anaemia prior to surgery are now an integral part of the preoperative assessment clinic. Anaemia is also commonly investigated by our General Surgery	Patients undergo FBP checks prior to surgery as outlined by NICE Guideline NG45. Anaemia if picked up is escalated highlighted and brought to the attention of the anaesthetics consultant staff. Depending on the

Addendum - NAA Summary Report 2021

	supplementation being arranged. Through education sessions e.g. Perioperative Medicine Symposium held in Jan 2019 in which the POA department championed the optimisation of anaemia patients through POA clinic. Credit has to go to the staff in DCC (STH) and DAU (DHH) who have worked closely with staff in the POA clinic to allow timely access to IV iron infusions for surgical patients. As this work stream grows, further resources likely to be needed in these departments.	GAIN pathway used as standard to ensure correct approach. Band 6 nursing staff aware to highlight any anaemic patient to anaesthetic consultant for consideration of optimisation / need for further investigation.	and Gynaecology Teams. The ability to deliver timely treatment for urgent and red flag patients requiring intravenous iron supplementation is a huge concern. Our Day Assessment Unit in DHH has shut. The Day Clinical Centre in CAH has moved to STH and only offers 3 slots on a Monday for the whole Trust. We are unable to treat our patients in a timely fashion who are most in need prior to surgery as a result. The answer to this I believe lies in providing some sort of intravenous iron service within the 4 walls of the Preop Assessment Department. That way we would be in control of demand and supply and could provide a higher standard of care for this patient population.	circumstances and time permitted, anaemia may be treated before, during or after surgery. The following guidance is used by anaesthetic staff in the Preoperative Assessment Clinic Access to IV iron has improved over the last 12 months.  Anaemia Poster Guidance.pptx
--	---	---	---	---

Recommendation	Action required	SHSCT status as at November 2019	SHSCT status as at October 2020	SHSCT status as at Oct 2021
Pre-operative anaemia management – clinical staff involved in the care of surgical patients				
Clinical staff (including GPs) should ensure that a recent haemoglobin result is available for every patient as part of their referral	Outreach to SHSCT GP federations required on the concept of fit4surgery. Hb level, BP management, diabetic status, fitness, BMI. Targeting Hb only in primary care would be short sighted. This is planned for Autumn 2018 as part of Dr Cullen's role as clinical lead for POA.	GPs do not include a recent Hb in their referral. There are a finite amount of occasions in which a GP actually makes a referral for an operation.	No change from Nov '19 (Non-compliant). I have been unable to get access to local GP federation meetings despite requests. I will continue to try.	No change from 2019 / 2020.
Clinical staff should ensure that	Potential to intervene at an even earlier stage may be	Patients attend POA clinic after	No change from last year.	No change from last year.

Addendum - NAA Summary Report 2021

anaemia screening occurs as soon as possible after the decision to proceed (ideally at the same visit) in order to allow investigation and correction if appropriate.	possible if NIECR is interrogated and evidence of anaemia sought prior to initial screening. To discuss with nursing staff in POA clinic.	listing and Hb level is checked for the surgeries in this audit. Anaemic patients, as defined by WHO, are highlighted to POA consultants and a pragmatic PBM approach is considered balancing urgency of surgery with the need for IV/oral iron, further investigation.	Compliant	Compliant.
Clinical staff should ensure that blood results are reviewed in a timely fashion, and that patients with previously undetected and potentially serious anaemia are appropriately referred, including deferring non-urgent, non-cancer surgery where appropriate.	No action required.	This is the current standard in POA clinic.	No change (compliant)	No change (compliant) This standard has now been formalised with a local guideline for the preoperative assessment department.  Checking and Actioning Blood Result
When surgery is urgent and cannot be deferred, clinical staff should use the available time for anaemia investigation and treatment initiation (if appropriate).	No action required.	This is the current standard in POA clinic.	As stated above – big concern about ability to deliver intravenous iron in a timely fashion due to current shortfall in provision.	This is the current pragmatic approach when time is limited.  Anaemia Poster Guidance.pptx

Recommendation	Action required	SHSCT status as at November 2019	SHSCT status as at October 2020	SHSCT status as at Oct 2021
Surgeons should know whether any individual patient is anaemic or not when they undertake the consent process and discuss the patient's individual clinical risks related to blood transfusion to comply with the Montgomery ruling.	Education of surgical colleagues. This will take a complete paradigm shift.	Consent is not standardised. Carried out by different grades of surgeon at different times. I do not believe that surgeons alter the consent in any way to take account of anaemia.	No change (as before)	No change. Patients seen at High Risk Preoperative Assessment Clinic have a higher level of consent / risk assessment. This includes an appreciation of the increased risk of preoperative anaemia.

Addendum - NAA Summary Report 2021

Transfusion practice – Hospital Transfusion Committee / Hospital Transfusion Team				
If a stable non-bleeding patient has a pretransfusion Hb >80g/L, the transfusion laboratory staff should query the request prior to issuing blood, with support from Hospital Transfusion / PBM team to do so.	No action required.	It is policy that transfusion laboratory staff challenges all potentially incorrect pre-transfusion requests prior to issuing blood. This was standardised after the implementation of HSS(MD) 17/2011 (BBT3).	No change (compliant)	No change (compliant)
The team should consider how best to work with clinical trainers to ensure that induction and ongoing education programmes for clinical staff include randomised trial findings which compare the patient outcomes of different red cell transfusion strategies.	Potential for using the three pillars of PBM, to base decision to transfuse on the most recent Hb, not to give two without review and pre-op anaemia correction (use of iron etc.)	The Trust is aware of randomised control trial findings and encourage staff to become involved in audit of various aspects of blood transfusion practice. All of our standards are based on the British Society for Haematology (BSH), Serious Hazards of Transfusion (SHOT) and Department of Health recommendations, discussed by the Trust Transfusion Team / Hospital Transfusion Committee for agreement and endorsement, before incorporating into training.	No change (compliant)	No change (compliant)

Addendum - NAA Summary Report 2021

Recommendation	Action required	SHSCT status as at November 2018	SHSCT status as at October 2020	SHSCT status as at Oct 2021
For hospitals with access to electronic order comms systems, the team should consider how best to work with the IT department to design a system of decision support that encourages best practice at the time of ordering.	The SHSCT is currently developing and implementing bloodhound. This system has the potential to provide decision support.	Bloodhound system has been installed and verified in the laboratory environment. Awaiting barcode wristbands on patients so that it can be rolled out to the clinical area.	No change	No change The trust is contributing to the regional LIMS and BPAT solutions to fully implement decision support as an outcome of the NIPIMS and Encompass projects
If more than one unit of red cells is being requested for routine transfusions in post-operative patients, the laboratory staff should be encouraged to challenge the request before issuing the blood, with the support of the Hospital Transfusion / PBM team. This also strengthens team working.	No action required.	It is Trust policy that porters can only lift one unit of red cells at a time. All other requests are challenged by laboratory staff. This has been Trust policy for some time.	No change	No change
Transfusion practice – clinical staff involved in the care of surgical patients				
Clinical staff should only prescribe a red cell transfusion in stable, asymptomatic, non-bleeding patients who have a pre-transfusion Hb of less than 70g/L, or less than 80g/L in those with cardiovascular disease.	Only with ongoing audit and snapshot surveys can we understand if this standard is being maintained.	Current transfusion documentation has visual prompts and <i>aide memoires</i> to encourage appropriate transfusion triggers. These guidelines are laid down from medical school and are part of the current Perioperative and Emergency Medicine module for 4 th year medical students.	As before – No change	No change

Addendum - NAA Summary Report 2021

Recommendation	Action Required	SHSCT status as at November 2019	SHSCT status as at October 2020	SHSCT status as at Oct 2021
Clinical staff should record the reason for transfusion in the patient's case notes and record a justification for transfusion if the transfusion was prescribed for a patient with an Hb higher than the recommended thresholds.	Only with ongoing audit and snapshot surveys can we understand if this standard is being maintained.	Current transfusion documentation (request forms and prescription forms) ask clinician to justify the need for a blood transfusion.	As before – no change	As before – no change
In stable non-bleeding patients, staff should recheck the patient's Hb after each transfused unit.	Only with ongoing audit and snapshot surveys can we understand if this standard is being maintained.	This directive has been issued by the Trust Haemovigilance Team and was highlighted at recent Patient Safety Meetings.	As before – no change	As before – no change
Implementation of patient blood management measures – Hospital Transfusion Committee / Hospital Transfusion Team				
The Committee should ensure that local guidelines exist regarding the use of PBM measures, including clear recommendations on the individuals or teams responsible for implementing these measures.	No action required.	Local guidelines exist in the form of the local transfusion policy. This has clear recommendations on practice and contains a specific section on responsibilities for implementation and monitoring compliance.	No change (compliant)	As before – no change
The Committee should ensure that the use of Tranexamic Acid (TXA), unless contraindicated, is the standard of care for surgical patients expected to have moderate or more significant blood loss.	No further action needed. TXA currently used in cases where >500ml blood loss is estimated. It is also considered on a case by case basis for other non-routine surgeries if potential for blood loss high.	TXA currently part of standard operating procedure in patients undergoing elective hip, knee and shoulder arthroplasty. Also part of standard operating procedure for hip fracture surgery.	No change (compliant)	No change – as before

Addendum - NAA Summary Report 2021

Recommendation	Action required	SHSCT status as at November 2019	SHSCT status as at October 2020	SHSCT status as at Oct 2021
The Committee should identify the need for intra-operative cell salvage and resource appropriately; this would normally be used in relevant high blood loss procedures in association with Tranexamic Acid.	No current plans to get cell salvage in SHSCT. Minimal requirement and issues in terms of maintenance of competencies.	Cell salvage not currently available in SHSCT.	As before (non-compliant)	As before – no change
Implementation of patient blood management measures – clinical staff involved in the care of surgical patients				
The theatre team, anaesthetists and surgeons should ensure that the PBM measures identified by the Hospital Transfusion / Patient Blood Management Committee are implemented as appropriate.	No specific deficit to be actioned currently.	Many standard operating procedures exist around the 3 pillars of PBM such as management of anticoagulant/antiplatelet drugs, patient warming, transfusion triggers, Hb optimisation and optimisation of oxygen delivery.	As before - compliant	As before – no change
Where available, peer data should be applied to compare individual surgical teams and encourage participation in PBM.	Unsure if this data could actually be mined to allow such comparison.	Not currently done.	As before (non-compliant)	As before – non compliant
Additional SHSCT action				
Blood transfusion leaflet to be available in other languages.	<u>Will I need a Blood Transfusion</u> leaflet has been translated into 10 languages and can be downloaded from the Haemovigilance section of the SHSCT intranet site.	Completed.	As before - compliant	As before - compliant

2. If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Provide the resources necessary (staff, accommodation and access to medicines and equipment) for the Preoperative Assessment	A new process to enable nursing staff in Craigavon Preoperative Assessment Department to deliver intravenous iron supplementation	Complete (but on hold currently due to staff shortage)

Addendum - NAA Summary Report 2021

Department to deliver intravenous iron supplementation to appropriate patients discovered to have iron deficiency anaemia during their preparation for urgent, red flag or major surgery.	was launched in spring 2021. Our ability to do this has been limited by staff shortages. We continue to utilise the DAU in DHH and DCC in STH when possible.	
For red flag colorectal patients we have launched a new initiative. The MDT lead for Colorectal Surgery (Mr McElvanna) will alert the medical staff in the Preoperative Assessment Dept when patients are listed for surgery (weekly communication). Traditionally medical staff only made aware of these patients after going through nurse led preoperative assessment. This will hopefully allow more patients have anaemia optimised earlier in the patient journey.		In progress

3. Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

- A.** A plan to relocate The Preoperative Assessment Department has been authorised to enable an Ambulatory Surgical Unit to be created in Main OPD in CAH. The result of this is that the nursing staff, admin and medical staff are being moved to sub-optimal accommodation. In addition, there are plans to separate some staff members which will lead to a disconnect. The strength of this department has always been the close working between admin, nursing and medical staff. The Trust should consider investing in a Preoperative Assessment Dept that allows us to prepare patients for surgery in the best way possible. The dream is to have a department that is visible, has a high profile within the Trust, which patients recognise and above all, can deliver all the facets of preoperative preparation. Positive outcomes are driven by good preparation. This includes, IV iron, dedicated physiotherapy input for exercise prehabilitation, cardiopulmonary exercise testing in a suitable lab with adequate space, dedicated dietetics input for patients with malnutrition and a waiting area that lends itself to healthcare interventions with bespoke audiovisual messaging.
- B.** The move to get involved in the patient journey earlier has been forced upon us by the change in healthcare delivery we have witnessed over the last 18 months. I am hopeful that earlier medical review and optimisation of anaemia will contribute to better outcomes. This of course could be offset by the longer waiting times to surgery.

Addendum - NAA Summary Report 2021

National Audit Title	MBRRACE-UK: Saving Lives, Improving Mothers' Care 2020: Lessons to inform maternity care from the UK and Ireland Confidential Enquiries in Maternal Death and Morbidity 2016-18		
Host Organisation	MBRRACE-UK & Oxford University (NPEU)		
Clinical Audit Lead(s) Divisional / AMD	Dr Susanna Finnegan (CAH) & Mr Richard DeCourcy Wheeler (DHH) Dr Beverley Adams		
Contact details	Personal Information redacted by USI		
Time period	Continuous		
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		YES
	Please comment:		
Directorate	ACUTE		
Division / speciality	Integrated maternity & women's health		
Full Report accessed via	https://www.npeu.ox.ac.uk/mbrance-uk/reports		
Update provided	Progress Report		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.				
2.				
3.				

2) If appropriate, areas for improvement and actions taken

34 Recommendations identified from existing guidance requiring improved implementation		
Recommendation	Action taken	SHSCT status as at October 2021
Care of women with neurological complications		
Women with epilepsy taking antiepileptic drugs who become unexpectedly pregnant should be	Excellent team working with neurology colleagues. MBRRACE to be disseminated via Dr Forbes	In progress

Addendum - NAA Summary Report 2021

able to discuss therapy with an epilepsy specialist on an urgent basis. It is never recommended to stop or change antiepileptic drugs abruptly without an informed discussion.	(NEURO) and Drs Finnegan and Wheeler (audit leads). No current obstetric medicine lead. (consideration should be given within job planning and future consultant appointments for a holder of the ATSM in maternal medicine)	
Pregnant women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff. Healthcare professionals should help support these women's uptake of antenatal care services by: using a variety of means to communicate with women; telling women about antenatal care services and how to use them; undertaking training in the specific needs of women in these groups.	Interpreter provided for all planned appointments, some difficulty obtaining interpreters for certain language groups but appointment times changed in order to provide this where possible. In an emergency, it is not always possible to provide face to face interpreting. Big word is used in these situations and a formal interpreter requested asap. The nature of obstetrics is such that this is likely to remain and ongoing problem.	Complete
Offer antihypertensive treatment to pregnant women who have chronic hypertension and who are not already on treatment if they have: sustained systolic blood pressure of 140 mmHg or higher; or sustained diastolic blood pressure of 90 mmHg or higher.	Implementation of the hypertensive risk assessment regionally. Aspirin commenced and referral for consultant-led care	Complete
In women with chronic hypertension who have given birth: aim to keep blood pressure lower than 140/90 mmHg; continue antihypertensive treatment, if required.	NICE disseminated via clinical audit meeting. In keeping with existing practice	Complete
Care of women with medical and general surgical disorders		
Women with pre-existing medical conditions should have pre-pregnancy counselling by doctors with experience of managing their disorder in pregnancy	Pre-conceptual counselling lies within the remit of medical and general practice. Excellent provision within the endocrine team. Consideration should be given to developing antenatal high risk maternal medicine clinic for MDT cre and pre-conceptual care	In progress

Addendum - NAA Summary Report 2021

	in high risk women.	
Services providing care to pregnant women should be able to offer all appropriate methods of contraception, including long-acting reversible contraception, to women before they are discharged from the service	Postnatal contraceptive guideline in progress under the lead of Drs Skelly and Hadjieva. Training of midwives delayed due to service pressures during COVID-19 pandemic.	In progress
Women admitted with sickle cell crisis should be looked after by the multidisciplinary team, involving obstetricians, midwives, haematologists and anaesthetists	Very small numbers, rare in NI. No known cases within last 5 years. Audit planned to identify numbers and training needs. Lead: Dr Finnegan/Kate Maxwell	Not yet commenced
Critical care support can be initiated in a variety of settings. Critical care outreach nurses can work in partnership with midwives to provide care before transfer to the critical care unit. Delay caused by bed pressures in a critical care unit is not a reason to postpone critical care	Excellent working relationships between obstetric anaesthetist and intensivists. Critical care very supportive of both maternity units in the rare event of admission being required. DS in CAH provides high dependency care under the supervision of the obstetric and anaesthetic teams	Complete
Anaesthetics		
Pregnant women with complex needs or a complex medical history should have timely antenatal multi-disciplinary planning, and an experienced obstetric anaesthetist should contribute to the planning	Tertiary unit in Belfast accept transfer of high risk cardiac patients. High risk obstetric medical patients suitable for care in SHSCT are transferred to CAH. Anaesthetic obstetric clinic in place. Ad-hoc MDT for high risk patients in place. Consideration should be made to identifying a trust obstetric medicine lead, preferably one who has undertaken ATSM in maternal medicine.	In progress
Prompt action and good communication within and between teams are crucial when dealing with sudden unexpected catastrophes, especially when the diagnosis is not immediately clear	Ongoing training via PROMPT.	In progress
In sudden onset severe maternal shock e.g. anaphylaxis, the presence of a pulse may be an unreliable indicator of adequate cardiac output. In the absence of a recordable blood pressure or other indicator of cardiac output, the early initiation of external	ongoing during prompt training	In progress

Addendum - NAA Summary Report 2021

cardiac compressions may be life-saving		
Pregnant or postpartum women recovering from anaesthesia require the same standard of postoperative monitoring, including documentation, as non-obstetric patients.	OEWS and continuous monitoring in CAH and DHH recovery in place	Complete
Audits should be conducted not only to assess whether thromboembolism risk assessment was performed, but also whether the calculated risk score was correct	Audit of compliance completed in 2019 in CAH and DHH. Re-audit to be undertaken on both sites 2021-22.	In progress
Reassessment of VTE risk after miscarriage or ectopic pregnancy to consider whether thromboprophylaxis is required is as important as reassessment of risk after giving birth	Disseminated but further work needed to ensure VTE risk assessment is not forgotten in these situations. Lead Dr Finnegan	In progress
Thrombolysis or surgical embolectomy should be considered for pregnant women with high-risk PE	Further work required in liaison with ED and anaesthetic teams-consideration to MDT simulation training across specialities. Practice development midwife to discuss with CPR lead for trust.	In progress
Women should be offered a choice of LMWH or oral anticoagulant for postnatal therapy after discussion about the need for regular blood tests for monitoring of warfarin, particularly during the first 10 days of treatment	Current regional VTE postnatal checklist specifies LMWH. Identify lead for patient information leaflet to be used on postnatal ward for those on LMWH and information regarding warfarin as alternative. Action lead: Lead midwife	In progress
Women should be advised that neither heparin (unfractionated or LMWH) nor warfarin is contraindicated in breast feeding	as above	In progress
Postnatal review for women who develop VTE during pregnancy or the puerperium should, whenever possible, be that at an obstetric medicine clinic or a joint obstetric haematology clinic	No provision in trust of obstetric medicine clinic. Job planning into future should consider employment of consultant with ATSM in obstetric medicine to take on trust lead. Action: DMD/Medical director	Not yet commenced
Care of women with haemorrhage or amniotic fluid embolism		
Haemorrhage (which might be concealed) should be considered when classic signs of hypovolaemia are present (tachycardia and/or agitation with hypotension often a late sign) even in the absence of revealed bleeding	Actioned within PROMPT and skills and drills. This remains virtual at present.	Complete

Addendum - NAA Summary Report 2021

When there has been a massive haemorrhage and the bleeding is ongoing, or there are clinical concerns, then a massive haemorrhage call should be activated	Actioned within PROMPT and skills and drills. This remains virtual at present.	Complete
In major PPH (blood loss greater than 1000 ml) and ongoing haemorrhage or clinical shock monitor temperature every 15 minutes.	Actioned within PROMPT and skills and drills. This remains virtual at present.	Complete
One member of the team should be assigned the task of recording events, fluids, drugs, blood and components transfused, and vital signs [RCOG Green-top guideline 52] ACTION: Service managers, All Health Professionals	Ongoing PPH audit (Donna King practice development midwife)	In progress
Resort to hysterectomy sooner rather than later (especially in cases of placenta accreta or uterine rupture)	Actioned within PROMPT and skills and drills. This remains virtual at present.	Complete
Coagulation factors should be administered promptly after multidisciplinary discussion in accordance with the principles in RCOG Green-top Guideline 52	Ongoing PPH audit (Donna King practice development midwife)	In progress
Prevention and treatment of infection		
Offer influenza vaccine to pregnant women at any stage of pregnancy (first, second or third trimesters)	All women offered flu vaccine	Complete
Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language. When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly.	Interpreter provided for all planned appointments, some difficulty obtaining interpreters for certain language groups but appointment times changed in order to provide this where possible. In an emergency, it is not always possible to provide face to face interpreting. Big word is used in these situations and a formal interpreter requested asap. The nature of obstetrics is such that this is likely to remain an ongoing problem.	Complete
"Think Sepsis" at an early stage when presented with an unwell pregnant or recently pregnant woman, take the appropriate observations and act on them	Sepsis 6 proforma introduced and actioned across the trust.	Complete

Addendum - NAA Summary Report 2021

In the postnatal period health professionals must perform and record a full set of physiological vital signs, pulse, blood pressure, temperature and respiratory rate, in any woman with symptoms or signs of ill health	OEWS (Obstetric early warning scores) recording is standard practice	Complete
Midwives and others carrying out postnatal checks in the community should have a thermometer to enable them to check the temperature of women who are unwell.	unaware if this is the case-Lead midwife for community to feedback re same	Not yet commenced
When assessing a woman who is unwell consider her condition in addition to her MEOWS score.	use of OEWS is standard practice in the trust	Complete

8 New recommendations to improve care		
Recommendation	Action taken	SHSCT status as at October 2020
Use the scenarios identified from review of the care of women who died for 'skills and drills' training.	For input into skills and drills training.	Not yet commenced
Ensure early senior involvement in the care of women with extremely preterm pre-labour rupture of membranes and a full explanation of the risks and benefits of continuing the pregnancy. This should include discussion of termination of pregnancy.	These women are looked after through the Day Obstetric Unit (DOU) and meet specialist high risk midwives and a Consultant either through the DOU or through the antenatal clinic.	In progress
Regard nocturnal seizures as a 'red flag' indicating women with epilepsy need urgent referral to an epilepsy service or obstetric physician.	For dissemination at audit meeting	In progress
Ensure that women on prophylactic and treatment dose anticoagulation have a structured management plan to guide practitioners during the antenatal, intrapartum and postpartum period.	Use of VTE risk assessment is widespread. Women on prophylactic enoxaparin are under Consultant led antenatal care and decision regarding this is individualised according to delivery plan.	Complete
Ensure at least one senior clinician takes a 'helicopter view' of the management of a woman with major obstetric haemorrhage to coordinate all aspects of care.	For dissemination via PROMPT and skills and drills.	In progress
Ensure that the response to obstetric haemorrhage is tailored to the	Noted on new PPH prompt sheet. Audit currently being undertaken to	In progress

Addendum - NAA Summary Report 2021

proportionate blood loss as a percentage of circulating blood volume based on a woman's body weight.	look at compliance with use of new scribe sheet.	
Do not perform controlled cord traction if there are no signs of placental separation (blood loss and lengthening of the cord) and take steps to manage the placenta as retained.	For dissemination at prompt and skills and drills along with audit meeting.	In progress
Be aware that signs of uterine inversion include pain when attempting to deliver the placenta, a rapid deterioration of maternal condition and a loss of fundal height without delivery of the placenta	For dissemination at prompt and skills and drills along with audit meeting.	In progress

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

1. Obstetric Medicine lead(s). Several of the recommendations highlight our weakness as a trust in the area of maternal medicine. Consideration should be given to training within consultant body/future Cons appointment and generation of Obstetric Medicine lead across the trust and development of a high risk maternal medicine clinic. There are excellent existing relationships between neurology, rheumatology, haematology and obstetrics. Further work is required to ensure standardisation of care across the trust for women with existing medical conditions and this would best be served by an obstetric medicine clinic.
2. Ongoing work re: PPH. Introduction of the obstetrics Cymru proforma and additional skills and drills training has been valuable. Currently being audited. Massive obstetric haemorrhage is an ongoing concern as a trust and investment is needed in continuous improvement. Consideration should be given within job planning for an Obstetric simulation lead.
3. VTE remains the commonest cause of maternal death. There was a maternal death from VTE within the trust in 2020. Audit must be undertaken and QI to ensure robust systems in place to ensure rigorous risk assessment for VTE in all pregnant women.

Addendum - NAA Summary Report 2021

National Audit Title	Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK March-May 2020		
Host Organisation	National perinatal epidemiology unit, Oxford (www.npeu.ox.ac.uk)		
Clinical Audit Lead(s) Divisional / AMD	Dr Nicola-Ann Henderson & Dr Susie Finnegan Dr Beverley Adams		
Contact details	Personal Information redacted by UST		
Time period	Continuous		
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		YES
Directorate	Acute		
Division / speciality	Integrated maternity & women's health		
Full Report accessed via	MBRRACE-UK: Saving Lives, Improving Mothers' Care		
Update provided	Progress Report		
Site Specific	CAH & DHH		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Clarify level of consultant obstetric input to patients on medical wards to ensure parity across trust.			
2.				
3.				

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Ensure protocols for assessment and monitoring of pregnant women with COVID-19 in the community take account of known risk factors for severe disease in pregnancy	All covid result tests ask women to notify maternity department. Escalation advice given over the phone	Complete
Ensure early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID-19, whatever	All Covid positive patients admitted to hospital have input from obstetric team. Any patients admitted under maternity will be reviewed by the	In progress

Addendum - NAA Summary Report 2021

her gestation and wherever in the hospital she receives care	medical team if their condition deteriorates. (No specific maternal medicine team in SHSCT). MBRRACE recommend daily review by consultant obstetrician. This was felt to be unnecessary by a number of colleagues. All agreed that patients should be reviewed on admission but if stable daily face to face reviews were putting the team at risk on entering a covid ward to review a stable patient. Discussions are ongoing to come to an agreement.	
Ensure care for pregnant and postpartum women with COVID-19 follows RCOG/RCM guidance	RCOG guidance followed by medical and obstetric teams.	Complete
Ensure protocols for assessment of pregnant women with respiratory symptoms include the consideration of SARS-CoV-2 and the different pattern of symptoms in pregnant compared to non-pregnant women. Be aware that the degree of respiratory symptoms may mask the severity of underlying lung pathology and that progression to respiratory failure in COVID-19 can occur rapidly.	Covid considered number 1 differential in all respiratory symptoms and would prompt swab. Presentation of MBRRACE recommendations at Audit (13/10/21) have highlighted this to staff	Complete
Referrals to the NHS ECMO service should be made for pregnant women or women post-pregnancy using the same criteria as for other adult patients i.e. if worsening severe respiratory failure despite appropriate conventional ventilatory support, or for women in whom lung protective ventilation cannot be achieved because of the severity of hypoxaemia or hypercapnia, or significant air-leak (e.g, barotrauma or bronchopleural fistula)	Remit of ICU to refer for ECMO. Presentation of MBRRACE recommendations at Audit (13/10/21) have highlighted this to obstetric staff	Complete
Treat pregnant and postpartum women the same as non-pregnant women unless there is a clear reason not to (<i>Multiple MBRRACE-UK</i>	All pregnant and postpartum women receive the same investigations and interventions as non pregnant women	Complete

Addendum - NAA Summary Report 2021

Reports)		
The limitations of remote consultation methods should be recognised, including being aware that some women will not have sufficient internet access on their mobile devices or other computer hardware, there are challenges for women from socially vulnerable groups, women for whom English is not their first language or women who are hearing impaired, and that women may have unvoiced concerns regarding their care if they have less contact in person (<i>RCOG/RCM Coronavirus guidance version 13</i>)	At the start of the pandemic remote consultations were used for a number of antenatal appointments. Most of these appointments have reverted to face to face with the exception of 16wk reviews in some locations due to ongoing accommodation issues. All patients who require an interpreter, have social input or where concerns have been noted are seen face to face at all appointments.	Complete
Face to face treatment may be preferable when the patient has complex clinical needs, you need to examine the patient or [it is] hard to ensure, by remote means, that patients have all the information they want and need about treatment options (<i>GMC guidance on remote consultations</i>)	All complex patients are reviewed face to face	Complete
Women should be advised to continue their routine antenatal care, although it may be modified, unless they meet self-isolation criteria for individuals or households (including social bubbles) with suspected or confirmed COVID-19 (<i>RCOG/RCM Coronavirus guidance version 13</i>)	All women are advised of the importance of attending for antenatal care. Where patients are self-isolating or have confirmed covid their appointments are deferred if it is deemed safe to do so. Facilities are available to undertake appts for those patients who are covid positive or are self-isolating whose appointment cannot be deferred. Care has been modified within the SHSCT to allow for covid challenges.	Complete
Maternity units should develop triage tools to assess the severity of illness for women who telephone with suspected or confirmed COVID-19. This should include an assessment of symptoms, clinical and social risk factors and escalation pathways.	Triage tools have been developed for use in the assessment unit	Complete

Addendum - NAA Summary Report 2021

This should include 'safety netting advice' about the risks of deterioration and when to seek urgent medical attention (RCOG/RCM Coronavirus guidance version 13)		
While pyrexia may suggest COVID-19, clinicians should not assume that all pyrexia is due to COVID-19. The possibility of bacterial infection should be considered and a full sepsis screen performed in line with the UK Sepsis Trust Sepsis Screening and Action Tool and intravenous (IV) antibiotics administered when appropriate (RCOG/RCM Coronavirus guidance version 13)	All patients with Temperature fully screened for sepsis and treated as per Sepsis 6 guidelines regardless of covid status.	Complete
Clinicians should be aware that young, fit women can compensate for deterioration in respiratory function and are able to maintain normal oxygen saturations until sudden decompensation (RCOG/RCM Coronavirus guidance version 13)	This forms part of mandatory prompt training and has been recently highlighted as part of dissemination of these recommendations.	Complete
An urgent multidisciplinary team meeting should be arranged for any unwell [pregnant or postpartum] woman with suspected or confirmed COVID-19 (RCOG/RCM Coronavirus guidance version 13)	All unwell covid positive women are reviewed by the medical team and HDU/ICU if required.	Complete
Women should have a venous thromboembolism (VTE) risk assessment performed during their pregnancy in line with RCOG Green-top Guideline No. 37a. Infection with SARS-CoV-2 should be considered a transient risk factor and trigger reassessment (RCOG/RCM Coronavirus guidance version 13)	VTE risk assessment proformas have been developed to reassess pregnant women who contact the assessment unit for advice. Women are advised to attend for bloods and issue of clexane if required.	Complete
Arrange urgent assessment (of pregnant women with UTI) in secondary care if there are any	All women are screened with an MSSU at booking	Complete

Addendum - NAA Summary Report 2021

features of serious system illness such as sepsis or pyelonephritis (NICE Clinical Knowledge Summary Urinary Tract Infection (lower) – Women)	Presentation of MBRRACE recommendations at Audit (13/10/21) have highlighted this to obstetric staff	
Employers should ensure pregnant women are able to adhere to any active national guidance on social distancing and/or advice for pregnant women considered to be clinically extremely vulnerable. Employers should consider both how to redeploy staff who are 28 weeks pregnant and beyond or with underlying health conditions that place them at a greater risk of severe illness from coronavirus and how to maximise the potential for homeworking, where possible. Where adjustments to the work environment and role are not possible and alternative work cannot be found, (pregnant women) should be suspended on paid leave. (Department of Health and Social Care guidance Coronavirus: Advice for Pregnant Employees)	All pregnant healthcare staff are in non-patient facing roles from 28 weeks.	Complete
Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language. When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly. NICE Guideline CG110 Pregnancy and complex social factors (National Institute for Health and Care Excellence 2010) . If it is considered more appropriate for appointments to be conducted remotely, for example during periods of 'local lockdown', units should employ teleconferencing or videoconferencing consultations. The limitations of remote consultation	Interpreters provided for all clinical contact with patients. Face to face appts arranged for clinically vulnerable women and those who require interpreters	Complete

Addendum - NAA Summary Report 2021

methods should be recognised, including being aware that some women will not have sufficient internet access on their mobile devices or other computer hardware. It should be acknowledged that remote appointments, particularly by telephone, may cause new challenges in relationship-building between women and healthcare professionals, especially among socially vulnerable groups, women for whom English is not their first language or women who are hearing impaired. Healthcare professionals should be aware that the women may have unvoiced concerns regarding their care if they have less contact in person. RCOG/RCM Coronavirus guidance version 13 (Royal College of Obstetricians and Gynaecologists and The Royal College of Midwives 2021)		
--	--	--

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

Addendum - NAA Summary Report 2021

National Audit Title	MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2018		
Host Organisation	National perinatal epidemiology unit, Oxford (www.npeu.ox.ac.uk)		
Clinical Audit Lead(s)	Dr Nicola-Ann Henderson & Dr Susie Finnegan		
Divisional / AMD	Dr Beverley Adams		
Contact details	Personal Information redacted by UST		
Time period	Continuous		
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		YES
	Please comment: Ongoing submission of all perinatal deaths to MBRRACE-UK		
Directorate	Acute		
Division / speciality	Integrated maternity & women's health		
Full Report accessed via	MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2018		
Update provided	Progress Report		
Site Specific	CAH & DHH		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Implementation of Saving Babies Lives 2		In progress	Regional work ongoing
2.	Development of small group reviews of all neonatal deaths and stillbirths		In progress	
3.				

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Ensure that healthcare providers have implemented national initiatives to reduce stillbirth and neonatal deaths and are monitoring their impact on reducing preterm birth.	Currently working with Saving Babies Lives 1 as national recommendation to reduce stillbirth and neonatal deaths. SHSCT engaging with regional working group looking at implementation of Saving Babies Lives 2 on a regional	In progress

Addendum - NAA Summary Report 2021

	basis. As part of Saving Babies Lives 2 CAH are looking at the implementation of preterm birth clinic – proforma out for comments with CAH team (unsure of DHH position on preterm birth clinic but they are part of regional group looking at saving babies lives 2)	
Ensure that there is a multi-agency targeted approach affecting women living in areas of high socio-economic deprivation across all points of the reproductive, pregnancy and neonatal healthcare pathway.	Currently dedicated clinic set up in South Tyrone Hospital for patients from East Timor. This group of women live in socio-economic deprivation and through audit we have identified their increased risk of adverse outcomes in pregnancy.	Complete
Identify the specific needs of Black and Asian populations and ensure that these are addressed as part of their reproductive and pregnancy healthcare provision.	As above Dedicated clinic for East Timor population. Small numbers of other Black and Asian patients who are risk assessed in line with national guidance and care provided according to this	Complete
Use the MBRRACE-UK real-time data monitoring tool as part of regular mortality meetings to help identify why an organisation's stabilised & adjusted stillbirth, neonatal mortality or extended perinatal mortality rate falls into the red or amber band.	All stillbirths and neonatal deaths are reviewed using the PMRT and findings discussed at monthly M&M meetings. Data is reviewed annually and collated at the annual perinatal meeting to identify themes and learning. We currently do not use the MBRRACE-UK real-time data monitoring tool	In progress <i>To look at whether MBRRACE-UK real time data monitoring tool is available in NI</i>
Investigate potential modifiable factors in the treatment of neonates when an organisation's stabilised and adjusted neonatal mortality rate falls into the red or amber bands after exclusion of deaths due to congenital anomalies. Ensure that this encompasses both local population characteristics and quality of care provision.	All neonatal deaths are currently reviewed at M&M process and through PMRT – recent application for funding to provide support to develop the review process further with dedicated time for staff to undertake reviews that will strengthen this process.	In progress
Explore local variation in post mortem uptake by different population groups, particularly by ethnicity and deprivation, and tailor training for consent takers based on	Post-mortem uptake in SHSCT greater than national average. Dedicated PM consent training is run annually by the histopathology department and is supported by the	Complete

Addendum - NAA Summary Report 2021

the local population.	bereavement midwives. Training is tailored to our local population and highlights frequent errors within the trust.	
Undertake placental histology for all babies admitted to a neonatal unit, preferably by a specialist perinatal pathologist.	All placentas sent for histopathology are carried out by a perinatal pathologist in Alderhey hospital via a regional agreement. Currently all babies who die have their placentas sent for HP but not all babies who are admitted to the neonatal unit. This will require regional agreement with Alderhey in relation to the number of placentas they can review. There have been updates to SOPs within the southern trust following a case where the placenta was not sent.	Not yet commenced <i>To liaise regionally re current provision of placental histopathology in Alderhey</i>
Notify all deaths via the MBRRACE-UK system within 7 working days of the death occurring, but with an aim to notify within 2 working days. Incorporate mechanisms for timely notification into local processes	NIMACH office contacted re notification timings figures.	Complete In progress Not yet commenced To Be Confirmed
Aim for completion of all surveillance data within 90 days to enable timely review with the PMRT and effective use of the MBRRACE-UK real-time data monitoring tool. Utilise the real-time data monitoring tool to ensure the data entered is complete and of high quality.	NIMACH office contacted to check re-monitoring tool	Complete In progress Not yet commenced To Be Confirmed

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

Addendum - NAA Summary Report 2021

National Audit Title	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies		
Host Organisation	National perinatal epidemiology unit, Oxford (www.npeu.ox.ac.uk)		
Clinical Audit Lead(s) Divisional / AMD	Dr Nicola-Ann Henderson & Dr Susie Finnegan Dr Beverley Adams		
Contact details	Personal Information redacted by USt		
Time period	Continuous		
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		YES
Directorate	Acute		
Division / speciality	Integrated maternity & women's health		
Full Report accessed via	MBRRACE-UK Perinatal Confidential Enquiry: Stillbirths and Neonatal Deaths in Twin Pregnancies		
Update provided	Progress Report		
Site Specific	CAH & DHH		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Introduction of the National Bereavement Care Pathway		nil	
2.	Further Develop PMRT review process		In progress	
3.	Formalise neonatal counselling based on BAPM framework		In progress	

Addendum - NAA Summary Report 2021

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Fully implement national guidance and resources. This includes: National guidance for care of women with multiple pregnancy, particularly: - Core, multidisciplinary team of specialists within a dedicated multiple pregnancy clinic, including specialist midwife and sonographer. (A.1) - Discussion with parents of risks associated with twin pregnancy before 24 weeks. (A.3) - High quality ultrasound service with dedicated expertise in multiple pregnancy. (S.1)	NICE guidance for care of multiple pregnancy implemented. (No dedicated sonographer as felt due to small numbers this would reduce the ultrasound experience of the team providing care). All twin notes were updated on publication of new twin NICE guidance. No specialist twin midwife although care provided on CAH site from small number of DOU midwives. (Not on DHH site)	Complete
Fully implement national guidance and resources. This includes: BAPM Clinical Framework for the Perinatal Management of Extreme Preterm Birth, in particular: Involvement of parents in the joint decision making around resuscitation, stabilisation and on-going care. (L.9-11, N.2-6)	All preterm infants reviewed by neonatal team. Most discussions are based on BAPM framework. Neonatal team currently working on formalising this.	In progress
Fully implement national guidance and resources. This includes: National Bereavement Care Pathway for parents of twins experiencing pregnancy and one or more baby loss. (F.1)	National Bereavement Care Pathway not currently implemented for any bereavement	Not yet commenced
Fully implement national guidance and resources. This includes: High quality pathological examination of the placenta and the baby, including ensuring the pathologist is	All patients offered post-mortem and placenta histopathology after loss. These are carried out in Alderhey Hospital under regional agreement by a perinatal pathologist. Standardised request forms ensure a complete clinical	Complete

Addendum - NAA Summary Report 2021

provided with a complete clinical history. (P.1-2)	history is provided.	
Fully implement national guidance and resources. This includes: Review of the perinatal death using the National Perinatal Mortality Review Tool and early engagement with parents in the process with the offer of a follow up appointment once the review is completed.	All deaths are reviewed with PMRT and their care discussed through the M&M process. All patients are reviewed at the postnatal debrief clinic to discuss the cause of death and plan for future pregnancies. Parents are informed of the review process and invited to input into this via the bereavement midwives, the debrief clinic and an email address. Reports are not currently completed and forwarded to the parents due to a lack of funding and time to complete. Funding has been secured for a dedicated midwife and funding has been applied for clinical time and admin support to allow completion of the review process and feedback to parents.	In progress
Improve communication (verbal, written and electronic) throughout the care pathway. (C.1-2)	Patient information resources have been developed using QR codes for SANDs information and post-mortem process. Proformas have been completed to help aid PMRT review process for coroners discussion	Complete
The lead specialist obstetrician of the core team should provide each woman with a 16 week antenatal check to assess and explain the general and specific risks of her pregnancy. (A.2)	All twin mums seen at 16 weeks in twin clinic where risks of twin pregnancy are discussed. This is always provided by a twin specialist but due to staffing at clinic will not always be by the lead specialist obstetrician.	Complete
Ensure prompt review by an obstetrician (experienced in the management of multiple pregnancies), for all women upon attendance at maternity triage units and upon admission in labour, and throughout labour. In particular: Ensure that all clinical staff working within a maternity triage or emergency assessment area are able to recognise the warning signs of	All twins in labour will be reviewed by a senior obstetrician. The consultant on call is informed of all twins in labour and will be present for all twin vaginal births. All twin mums are given clear information on signs and symptoms of preterm birth and TTTS – both verbal and written in the MHHR. All twins in preterm labour will have a clear discussion about monitoring in labour, mode of birth and transfer if appropriate. The neonatal team	Complete

Addendum - NAA Summary Report 2021

preterm labour and TTTS. (A.5-7) - Produce a clear plan for monitoring in labour, mode of birth and when referral is required, particularly in extremely preterm labour: senior review at least daily. (L.1, L.3). - Where necessary ensure prompt review by senior neonatologist. (L.1)	are involved in counselling when necessary. Consultant ward rounds occur daily for those patients who remain inpatients	
Following spontaneous birth of Twin 1 at less than 24 weeks consider delaying the birth of the surviving second twin, if there are no contraindications such as infection, fetal compromise, bleeding or coagulopathy. (L.4, Counsel parents prior to the birth of Twin 1, regarding the possible option of delayed birth of Twin 2 including the maternal risks as well as the risk of Twin 2 being born at the extremes of prematurity. (L.5) L.6)	Most twins at the extremes of prematurity will be born in the regional unit.	Complete

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

Addendum - NAA Summary Report 2021

National Audit Title	Comparative Audit of management of maternal anaemia and iron deficiency in the UK and ROI		
Host Organisation	NHS Blood and Transplant		
Clinical Audit Lead(s) Divisional / AMD	Dr Susanna Finnegan Dr Beverley Adams		
Contact details	Personal information redacted by UST (previously Dr Katherine Loane)		
Time period	Continuous-		Snapshot: November 2018
Data Collection	Did SHSCT contribute data to this study in 2020/2021? No Please comment: Recommendations are follow-up to 2018 snapshot audit		
Directorate	ACUTE		
Division / speciality	Integrated maternity & women's health		
Full Report accessed via	https://hospital.blood.co.uk/audits/national-comparative-audit/		
Update provided	Progress Report		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Review and update local guidelines for the detection and management of anaemia in pregnancy to align local guidance with the latest BSH and NICE guidelines	http://www.southernhscni.net/?wpfb_dl=794	Guideline due rv Mar 2021 BSH guideline updated since last rv in 2018 ?needs antenatal ferritin check for higher risk women included – guideline contact Dr Loane aware	National
2.	Ensure local screening uptake at the first trimester/presentation and at 28 weeks exceeds 95%	No recent audit data on uptake	QI project to be commenced Lead Dr Finnegan	National
3.	Provide written information on how to increase dietary uptake of iron and how to take oral iron to maximise absorption	No current written information given	Will be addressed through QI project Leaflet circulated from BHSCT ? will be adopted regionally	National

Addendum - NAA Summary Report 2021**2.0 If appropriate, areas for improvement and actions taken**

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Review local screening at booking, 28 weeks gestation and postnatally. Ensure women identified at higher risk of anaemia are appropriately screened including serum ferritin where indicated	Regional iron deficiency QI project To add a risk assessment tool to the regional notes Next Meeting – December 2021	In progress
Identification and action on abnormal results within 2 weeks and followup of treatment response at 2-4 weeks post commencement of oral iron	Regional iron deficiency QI project To add a risk assessment tool to the regional notes Next Meeting – December 2021	In progress
Improve management of postnatal anaemia – check FBC post delivery when indicated against nationally defined criteria	Regional iron deficiency QI project To add a risk assessment tool to the regional notes Next Meeting – December 2021	In progress

3.0 Key areas to raise awareness to SMT/ Governance committee

- Identification of women through routine screening at booking and 28 weeks gestation is generally good.
- Streamlining of follow-up and rechecking of low haemoglobin results and response to oral iron required.
- Maternity notes are handheld and will not permit direct entry of results at time of action – standardised letter to be formulated and/or record on NIECR.
- Anaemic population often from ethnic minorities where English not 1st language – attention will be needed to patient information leaflets in other languages.

Addendum - NAA Summary Report 2021

National Audit Title	Adult Percutaneous Coronary Interventions- BCIS		
Host Organisation	National Institute of Cardiovascular Outcomes Research, (NICOR)		
Clinical Audit Lead(s)	Dr Ian Menown		
Divisional / AMD	Dr Philip Murphy		
Contact details	[Redacted]		
Time period	Continuous - Snapshot (please specify dates)		
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES / NO Please comment: Ludman BCIS database then submitted to NICOR		
Directorate	ACUTE		
Division / speciality	Medicine & unscheduled care: Cardiology		
Full Report accessed via	NAPCI-Domain-Report_2021_FINAL.pdf (hqip.org.uk)		
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available.

		Site specific data- SHSCT				SHSCT 2020/21 compliance	National or regional compliance
1	Excellent Clinical outcome	MACE observed 0 of 578 cases which was favourable compared with the risk-adjusted expected MACE of 1.4%				Compliant	National
2	High annual individual operator volume: (associated with better clinical outcomes - BCIS advise a minimum of 150 cases over 2 years which may include 30 interventional-diagnostic cases)	2020-2021	1st operator PCI	PCI & pressure wire	Sessions per wk	Compliant (but we need to ensure adequate lab sessions for all operators to maintain numbers. A second lab would be beneficial providing an extra 2 sessions for AM)	National
		AM*	71	83	1		
		MM	116	131	3		
		AMcC	142	161	2.5		
		IM	179	204	2.5		

2) If appropriate, areas for improvement and actions taken

SHSCT areas for improvement				
	Recommendation	Action taken	Status as at September 2020	Status as at September 2021
1	Maintain quality of outcomes and advance new techniques and interventional procedures	1. Ongoing annual CPD for all PCI operators. 2. To optimise patient outcomes, contemporary imaging equipment (eg OCT) and availability of	CDP satisfactory. PCI equipment & procedures partly restricted by	CDP satisfactory. PCI equipment & procedures partly restricted by

Addendum - NAA Summary Report 2021

		contemporary interventional techniques (eg CTO PCI) is being requested.	COVID	COVID
2	High volume operating figures to maintain quality, patient safety and timely patient access	Need for a second catheterisation lab to allow for high volume for all operators and to meet demands for acute and elective cases. BCIS report shows CAH has patient poor access.	The board have our request but have not approved	The board have our request but have not approved
3	Continue to maintain data completeness	Ongoing data submission during PCI and annual audit submission	2019/20 Audit data submitted	2020/21 Audit data submitted

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

1. The BCIS average for PCI per lab is around 350 per year. We typically undertake almost double that. The typical number of labs for a UK hospital with our case volume is 2-3 labs. Our lab capacity is inadequate, which is a patient safety risk.
2. If the cath lab X ray equipment goes down mid case, our back up is a general X ray room rather than a cardiology room. This is a patient safety risk.
3. Our cath lab is now under-resourced. To maintain clinical practice at a contemporary standard, we need access to OCT imaging when indicated, have access to contemporary coronary technologies and be able to participate fully in national research.
4. Our limited capacity leads to :
 - (a) long waits for elective patients which is a concern from a patient safety
 - (b) delay in scheduling 1N/AMU/CCU patients (hence suboptimal bed flow throughout the hospital and difficulty meeting NICE guidelines for patient access.

4) Update on national audit work delayed / not progressed.

The board are aware of our request for a second lab but have not approved. We would advise the trust to develop a second cath lab for pacing and devices for 2-3 days (a key service which is not adequately resourced) and which would also be PCI capable (providing safety back up should lab 1 fail mid case, and allow 1-2 days of additional coronary work). Such configuration is standard in similar sized interventional units across the rest of the UK.

Addendum - NAA Summary Report 2021

National Audit Title	Cardiac Rhythm Management
Host Organisation	National Institute of Cardiovascular Outcomes Research, (NICOR)
Clinical Audit Lead(s) Divisional / AMD	Natalie Archer, Cardiac Physiologist Dr Philip Murphy
Contact details	Personal information redacted by USI
Time period	Continuous
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES Please comment: Via SHSCT anonymised extract to CVIS Tomcat / NICOR
Directorate	Acute
Division / speciality	Medicine & unscheduled care: Cardiology
Full Report accessed via	NACRM-Domain-Report 2021 FINAL.pdf (hqip.org.uk)
Update provided	Progress Report

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Provides assurance that the Trust is meeting British Heart Rhythm Society standards to maintain high centre and individual operator volumes: <i>Standards for implantation and follow-up of cardiac rhythm management devices in adults, April 2017.</i>	Achieved 125 implants in one year period 2020/2021, which is in excess of the national standard minimum of 80 per annum. Operator volumes were higher than the national minimum requirement of 35 per annum – this improves patient outcome and quality implants. The Trust meets the standard of having three active implanting cardiologists for this period.	Compliant	National
2.	Complication rate during and following pacemaker implant.	The re-intervention of first implants performed in 2020/2021 was 2.4% within 1 year- below national average	Compliant	National

Addendum - NAA Summary Report 2021

		of 4.0%		
3.	Data completeness/ submission	Data completeness remains stable with >95% of fields completed. Submission for 2020/21 complete.	Compliant	National

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Maintain standards to assure high operator volumes- improvement for patient outcomes	Appointment of another device consultant in 2020 has ensured high operator volumes with two operators implanting in the SHSCT and BHSCT. Patient outcomes are excellent with a below average complication rate. Two operators are highly specialised in device, implanting complex devices in BHSCT. One operator implants solely in the SHSCT.	In progress
Maintain quality and sustained low complication rates	Continual CPD- New cardiac device team meetings introduced and more technical training in the implant setting and follow up clinic for all device staff. Maintain high operator volumes with dedicated device lists and two operators working across two Trusts.	In progress
Ensure data submission and completeness	Failure for submission of 2019/2020 data due to physiology staff shortages and IT problems with staff shortages and formatting of data. Data for 2020/2021 has been submitted via NICOR in July 2021. To ensure submission two staff are trained and submission will occur every 6 months to NICOR.	Complete

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

Awareness:

Addendum - NAA Summary Report 2021

- Ensure two staff are fully trained and aware of data submission to NICOR following submission failure when one staff member went on maternity leave.

Areas for improvement:

- Staff had no training/ CPD for over one year with Covid restrictions in place. Cardiac devices are ever evolving and require continuous training in the area. Reintroduction of staff training and courses following Covid has been identified as a vital for ongoing CPD and improvement of staff skills and knowledge in the device clinics.
- SHSCT is compliant for 2020 / 2021 across all 7 of the quality metrics detailed above across volumes, data completeness and validity, NICE guidance and re-intervention.

Addendum - NAA Summary Report 2021

National Audit Title	National Audit of Cardiac Rehabilitation (NACR)		
Host Organisation	British Association for Cardiovascular Prevention and Rehabilitation (BACPR)		
Clinical Audit Lead(s) Divisional / AMD	Sean Cartmill, Hazel Wilson, Jayne Montgomery/Chris Magee		
Contact details	Personal Information redacted by USI		
Time period	Continuous		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

NI key performance indicators for cardiac rehabilitation, 2015/16 – No Updated 2020 / 2021 Indicator Data			
		SHSCT	NI
1.	% of eligible patients offered cardiac rehabilitation:	34%	43%

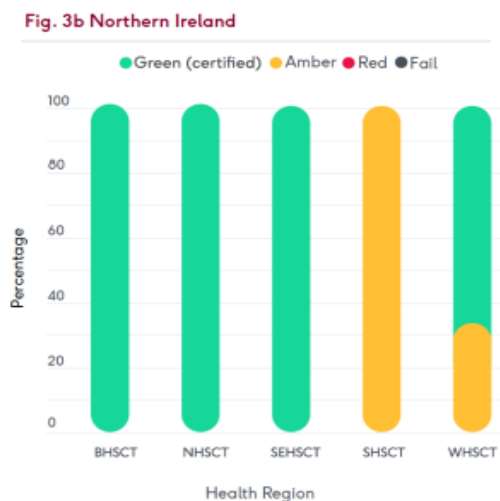
National audit of cardiac rehabilitation : Top 3 key performance indicators as determined by the clinical audit leads:				
	No Updated 2020 / 2021 Data	SHSCT	NI	UK
1.	% of patients in SHSCT receiving cardiac rehabilitation for the recommended 56 day minimum standard:	12.0%	46.0%	58.0%
2.	%change in patients undertaking 150minutes of physical activity:	46.7%	41.3%	28.1%
3.	Preparedness for service accreditation - national certification programme for cardiac rehabilitation, as outlined in the table below: 2020 / 2021 Update – All localities amber	Armagh/ Dungannon	Amber	
		Craigavon / Banbridge	Amber	
		Newry/Mourne	Amber	

Addendum - NAA Summary Report 2021

Seven key performance indicators (KPIs) required for certification by the NCP_CR.	<i>Armagh / Dungannon</i>	<i>Craigavon / Banbridge</i>	<i>Newry / Mourne</i>
1. Receives referrals from all priority groups	Yes	Yes	Yes
Record of pre assessment (1)	Yes	Yes	Yes
Record of post assessment (2)	Yes	Yes	Yes
Duration of cardiac rehab programme ≥ 56 days	Yes	No	Yes
MI/PCI referral to start waiting time	No	Yes	Insufficient data
CABG referral to start waiting time	No	Yes	Insufficient data
Number of standards met	5	5	5
MDT (3 or more staff types)	Yes	No	Yes
Would your cardiac rehabilitation team be certified based on above information?	Amber	Amber	Amber
Green Certified	Amber Meeting 4-6 standards	Red Meeting 1-3 standards	Fail Meeting 0 standards

- Fig 3b from the 2020 Quality Outcomes Report, confirms SHSCT progress to amber certification status.

See section 4 of this update, as the awaited HSCB regional needs analysis for Cardiac Rehabilitation will review all HSCT service positions.

**2) If appropriate areas for improvement and actions taken**

National recommendations / areas for improvement			
National recommendation	National recommended action	SHSCT status October 2019	SHSCT status October 2021
Programmes should aim to recruit a greater proportion of eligible female patients.	Greater positive action is required to recruit more female patients which is likely to require significant changes to the type and location of cardiac	In place.	C19 disruption to service No progress update

Addendum - NAA Summary Report 2021

	rehabilitation offered.		
A much bigger proportion of eligible heart failure patients should be referred to cardiac rehabilitation and supported to take up the offer.	Referral of patients with heart failure should increase in line with clinical recommendations.	This will commence when recurrent funding from PHA is confirmed.	As above
A greater range of modes of delivery, beyond just group-based, should be offered to patients.	Programmes need to offer and strongly promote a wider portfolio of cardiac rehabilitation delivery options.	Not commenced.	As above
Assessment of patients who complete cardiac rehabilitation should be at 100%.	Assessment of patients as they complete their programme should be a major priority.	In progress.	As above
The duration of cardiac rehabilitation should meet the minimum requirement of eight weeks.	Services operating below minimum standards should strive to increase the duration and frequency of rehab sessions.	Unachievable within existing resources.	As above
Programmes should seek to have their service accredited as part of the National Certification Programme for Cardiac Rehabilitation.	All programmes should contact the National Audit of Cardiac Rehabilitation (NACR) team to assess their extent of readiness for a possible submission to the National Certification Programme for cardiac rehabilitation. This service is free to NACR users.	In progress.	As above
Recruitment of staff to run stand-alone heart failure cardiac rehabilitation classes	Recruitment process is underway. It is anticipated stand-alone heart failure cardiac rehabilitation classes will be commenced by Dec 2018 - secure recurrent funding from PHA to achieve this	In progress.	As above

SHSCT areas for improvement			
Recommendation	Recommended action	SHSCT status October 2019	SHSCT status October 2021
Scope the availability of accommodation in order to deliver cardiac rehabilitation programmes.	Explore availability of accommodation via district councils or use	Not yet commenced.	C19 disruption to service No progress

Addendum - NAA Summary Report 2021

	of physio departments in the out of hour's period 4.30pm - 8.30pm in both acute sites.		update
Increase duration of cardiac rehabilitation programmes.	Explore possibility of increasing duration of programmes to eight weeks without affecting the number of patients attending per year.	Not yet commenced.	As above
Achieve accreditation for SHSCT Cardiac Rehabilitation programmes from National Certification Programme.	Increase the number of national standards achieved for cardiac rehabilitation.	Not yet commenced.	As above

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

- We are entering basic information on to the database on an on-going basis. However this has been on a limited basis due to staffing issues.
- There are no out -patient cardiac rehab programs since April 2020

4) Update on non-participation if national audit work has been delayed / not progressed.

- There has been no NACR report since April 2020 due to the ongoing COVID situation. Many cardiac rehab teams in the UK have been redeployed and have not been able to input into the NACR.
- The cardiac rehabilitation teams in the SHSCT have not been able to recommence their out-patient cardiac rehabilitation programmes due to SHSCT COVID response. Many of the cardiac rehabilitation teams have been redeployed.
- **In August 2021 the Health and Social Care Board commissioned Queens University to carry out a Regional Needs Analysis of Cardiac Rehabilitation. The final report is awaited.**

Addendum - NAA Summary Report 2021

National Audit Title	Myocardial Ischaemia National Audit Project (MINAP)		
Host Organisation	National Institute of Cardiovascular Outcomes (NICOR)		
Clinical Audit Lead(s)	Denise Nelson		
Divisional / AMD	Dr Philip Murphy		
Contact details	Personal information redacted by USI		
Time period	Continuous	Snapshot	(please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		YES
	Please comment:		
Directorate	Acute		
Division / speciality	Medicine & unscheduled Care : Cardiology		
Full Report accessed via	MINAP-Domain-Report_2021_FINAL.pdf (hqip.org.uk)		
Update provided	Progress Report	or	NIL Return (complete section 4 to make 'nil' return update)

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	Patients with Myocardial Infarction were seen by a cardiologist during their admission	100% CAH	Compliant	National
	National Average : 96%	100% DHH		
2.	Patients were referred to Cardiac Rehabilitation	99% CAH	Compliant	National
	National Average : 81%	99% DHH		
3.	100% Patients had In-house Echocardiography carried out during admission (CAH – 348 patients)	CAH 100%	Compliant	National
	98% of patients had In-house Echocardiography carried out during admission (DHH -131 patients)	DHH 98%		
	National average : 76%			

Addendum - NAA Summary Report 2021**2) If appropriate, areas for improvement and actions taken**

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Continue to interrogate the data on a regular basis.	Use the data to facilitate quality improvement initiatives	In progress
Ensure MINAP findings are widely disseminated to clinical team	Regular governance meetings where areas for improvement are discussed	In progress
Ensure Non Stemi patients have access to more timely angiography and reduce their length of stay in hospital.	- Ensure timely referral. - Evaluate whiteboard daily and raise any delays - Continuous monitoring and recording of date and time of admission to date and time of Angiography. - Feedback results to governance meetings	In progress

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

- Nice Guidelines (GC94) recommends Acute Coronary Syndromes should have Coronary angiography and PCI within 72 hours. This target is not being achieved because of capacity delays due to SHSCT only having one Cardiac **Catherisation Lab Theatre** which operates Mon – Fri 9-5pm. **Currently only 32% achieve this target (2020 - 2021). National Average 55%.**
- Delays in patients waiting in hospital on Angiography impacts upon bed capacity and results in additional days spent in hospital. (Current average wait - 5 days)

Addendum - NAA Summary Report 2021

	Severe sepsis and septic shock
Host Organisation	Royal College of Emergency Medicine (RCEM)
Clinical Audit Lead(s) Divisional / AMD	Dr Susan Budd (QI Lead) , Dr David Patton & Dr David Mawhinney (RCEM) Dr Gareth Hampton & Dr Philip Murphy
Contact details	Personal information redacted by USI
Time period	Continuous✓ & Snapshot Local SHSCT QI Work (1 August 2017 – 31 January 2018)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES –/ NO Please comment: Through the local SHSCT QI work – performance of antibiotic within 1 hour is an on-going improvement work
Directorate	ACUTE
	Medicine & unscheduled care: emergency medicine
Full Report accessed via	David Personal information redacted by the USI
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)

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

None noted from national audit. Time to antibiotic remains the local focus for QI work in CAH ED

2) If appropriate, areas for improvement and actions taken

National recommendations and SHSCT progress in implementation			
	Recommendation	Action taken	Status as at OCTOBER 21
1	All emergency departments should have a sepsis lead and a sepsis protocol.		Complete.
2	RCEM recommends that all sepsis leads consider the following:		Complete.
a)	Is everything being done to ensure that a full set of timely observations is performed on every patient?		Complete.
b)	Is there a more senior doctor available to review patients with sepsis 24/7?		Complete.
c)	Is oxygen considered part of the treatment for sepsis and how is this clearly documented?		Complete.
d)	Is lactate measurement possible and simple in your department?		Complete.
e)	Does your hospital give clear instructions on which antibiotics should be used?		Complete.
f)	Does your protocol encourage urine output monitoring, especially if the patient does not require a catheter?		Complete.

Addendum - NAA Summary Report 2021

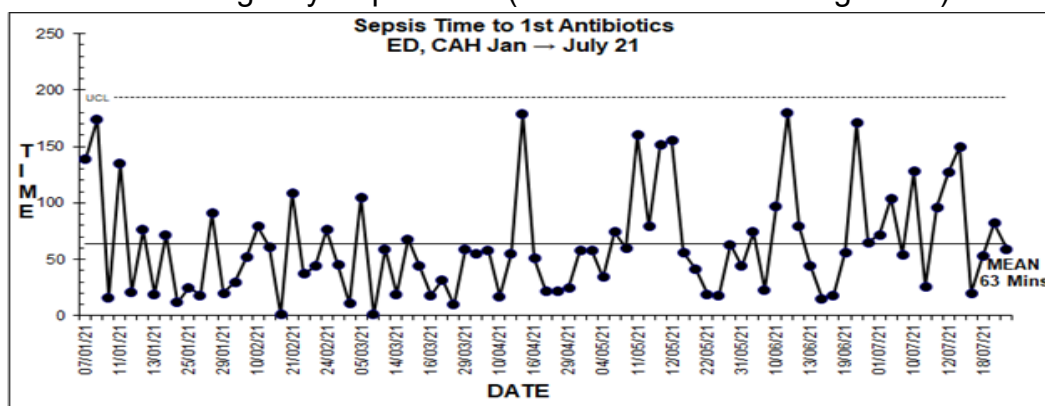
3	Early recognition of sepsis is critical to the clinical outcome. All patients with suspected sepsis and a NEWS of 3 should undergo immediate screening for sepsis.		Complete.
4	Patient information should be provided to all patients, and/or relatives, admitted with sepsis.	In receipt of PHAs Sepsis information leaflet. Current Covid restrictions prevent relative attendance in ED. Patients informed of diagnosis on admission	Not completed.
5	Standardise pathways of care for patients fulfilling sepsis criteria to improve timely delivery of care and therefore outcomes.		Complete.
6	Education and training around these for wider team for early recognition and instigation of optimal care.		Complete.

From the sepsis trust toolkit - Endorsed by NICE/RCEM

- We recommend that patients be screened for sepsis if they present with unexplained illness, if they clearly look unwell and have a likely infective cause, or if they present with (or subsequently deteriorate to) an individual parameter score of 3 or aggregate score of 4 or higher on the National Early Warning Score (NEWS) (or locally derived equivalent).

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

- Difficulty in giving antibiotics within 1 hour to meet the target due to patient flow in the Emergency Department (extreme over-crowding in ED)



- Delays evident in ambulance off loading, time to triage and time for transfer to appropriate clinical areas for management. Staff pressures evident in time to deliver treatment bundle.
- Dedicated Sepsis Bed still in amber resus, and used for immediate assessment and management of stand – by Sepsis patients from NIAS when possible. The management of these patients consistently meets targets.

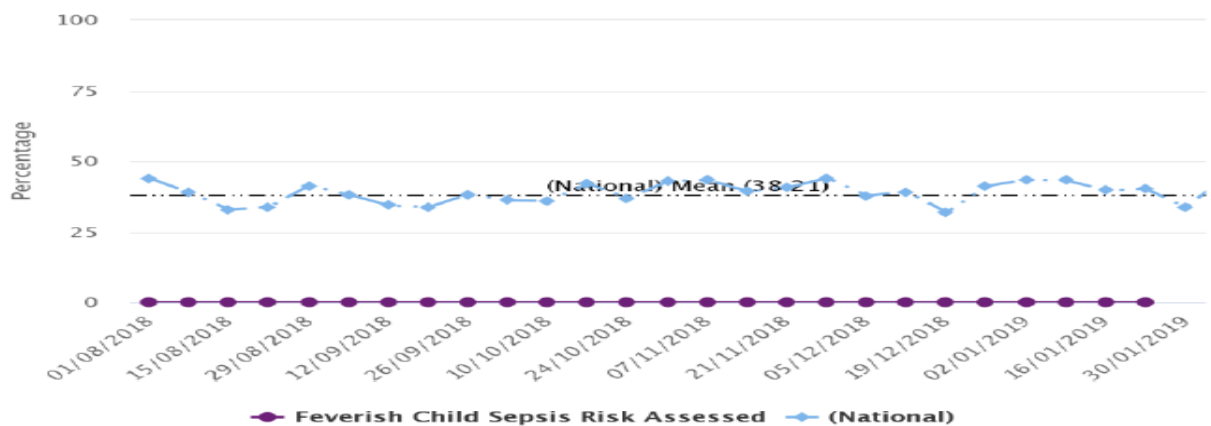
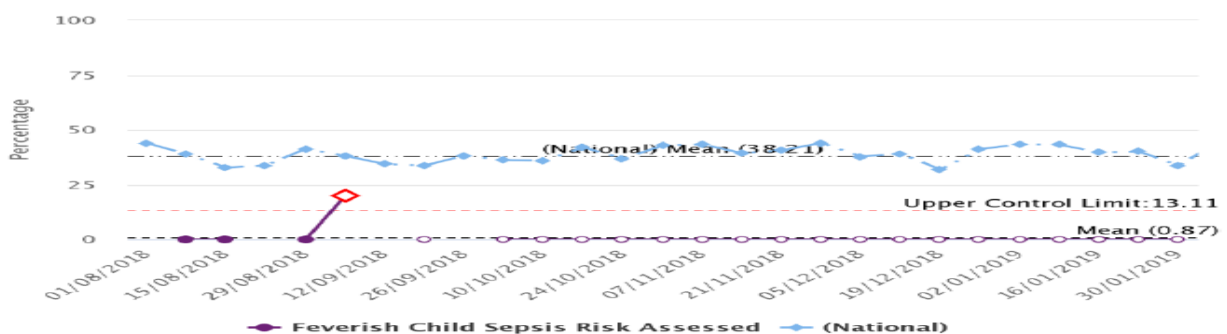
Addendum - NAA Summary Report 2021

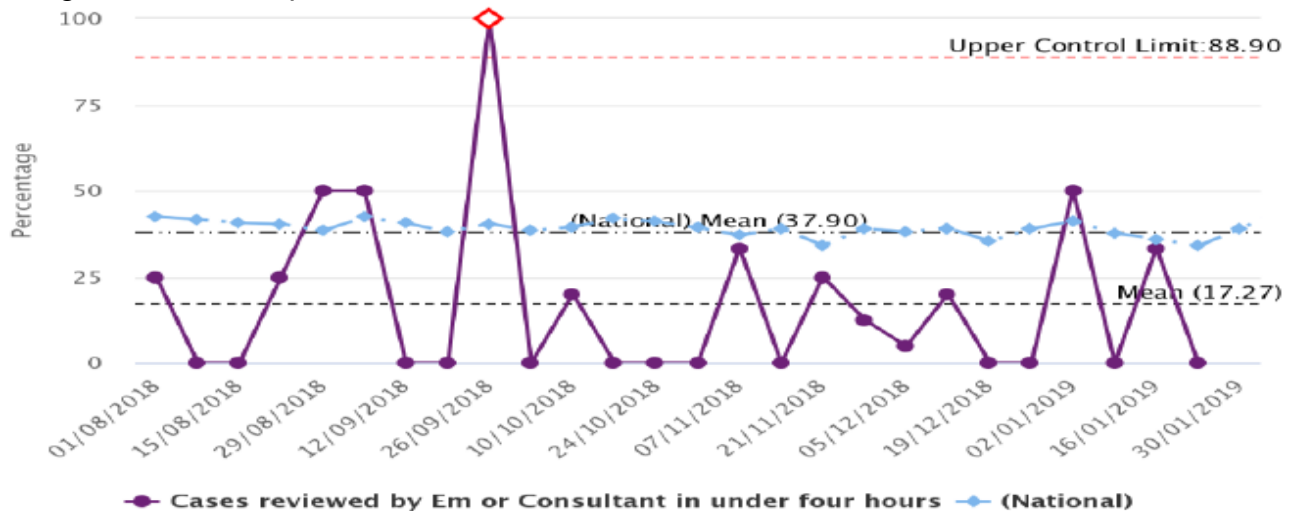
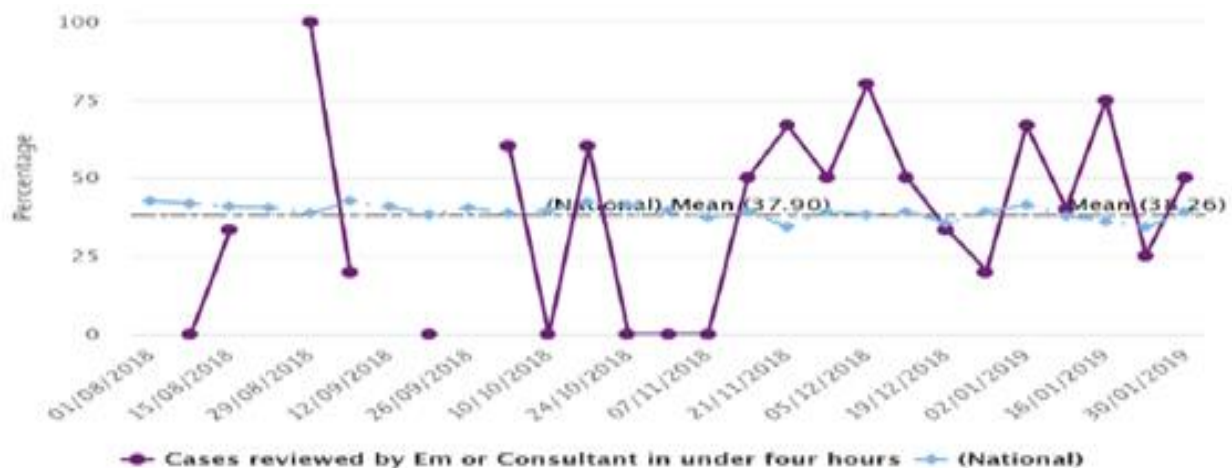
National Audit Title	Feverish Children (care in emergency departments)	
Host Organisation	Royal College of Emergency Medicine (RCEM)	
Clinical Audit Lead(s)	Dr D Patton, Dr D Mawhinney Dr G Hampton	
Divisional / AMD		
Contact details	Personal Information redacted by USI	
Time period	Continuous	Snapshot: 01/08/2018 – 31/01/2019 (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021?	NO
	Please comment:	
Directorate	ACUTE	
Division / speciality	Medicine & unscheduled care: emergency medicine	
Full Report accessed via	www.recm.ac.uk/quality-policy/clinical-audit	
Update provided	Progress	

1) The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.
1. Triage and observations of child within 15 minutes of arrival
Craigavon Area Hospital

Addendum - NAA Summary Report 2021**Daisy Hill Hospital**

2. Children presenting to EDs with fever or febrile illness should be assessed as to their risk of sepsis using a stratified risk assessment/ screening tool.

Craigavon Area Hospital**Daisy Hill Hospital**

Addendum - NAA Summary Report 2021**3. Senior review where a patient is under 1 year of age or is an intermediate or high risk of sepsis****Craigavon Area Hospital****Daisy Hill Hospital****2) If appropriate, areas for improvement and actions taken**

Area for improvement		
Recommendation	Action taken	SHSCT status as at October 2021
Use of sepsis proforma	Staff awareness and teaching	Trust sepsis proforma for children is laminated and on the walls in the paediatric area and in resus. It is not filled out for every individual patient, but is in use in the dept.

Addendum - NAA Summary Report 2021**3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement**

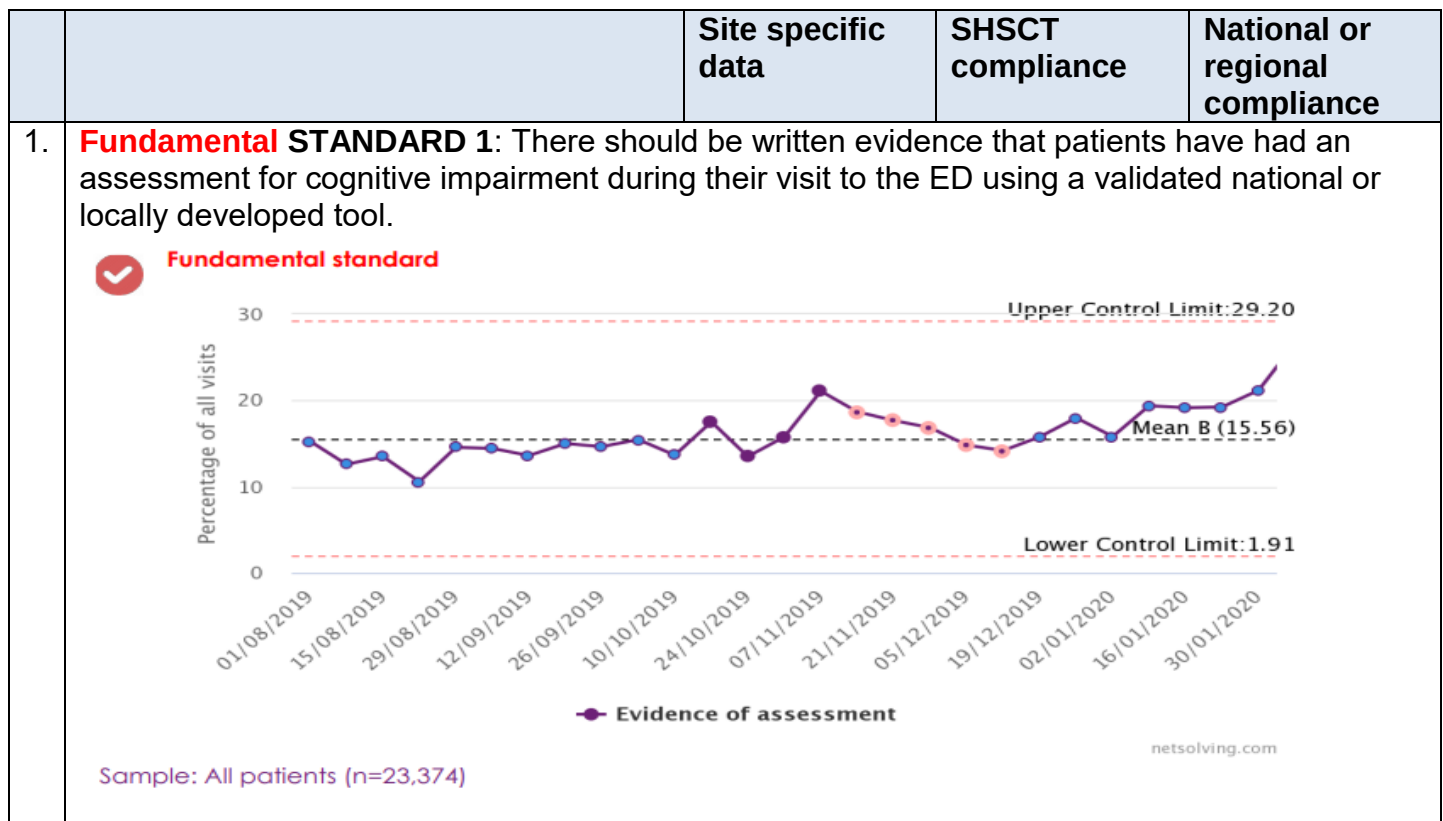
- Difficulty in triaging within 15 minutes to meet the target due to patient flow in the Emergency Department (over-crowding in ED)
- ST4 staffing levels in DHH out of hours is an issue (senior review).

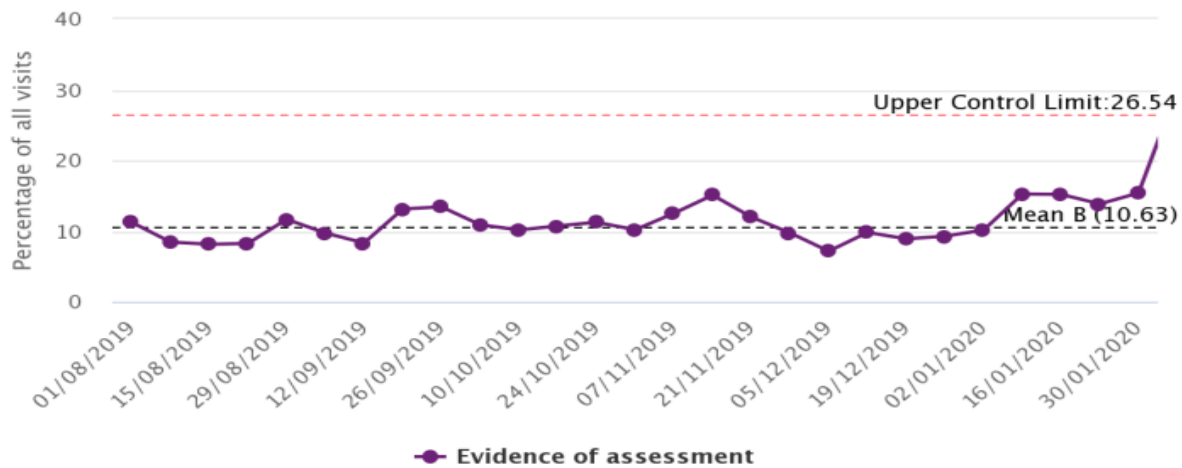
Addendum - NAA Summary Report 2021

National Audit Title	Assessing For Cognitive Impairment In Older People (NEW)
Host Organisation	The Royal College of Emergency Medicine (RCEM)
Clinical Audit Lead(s) Divisional / AMD	Dr D Patton, Dr D Mawhinney Dr G Hampton
Contact details	Personal information redacted by USI
Time period	Continuous Snapshot 1/8/2019 – 31/01/2020 (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? NO Please comment: Snapshot Audit Report published February 2021
Directorate	ACUTE
Division / speciality	Medicine & unscheduled care: emergency medicine
Full Report accessed via	Report (rcem.ac.uk)
Update provided	Progress Report - further update awaited

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

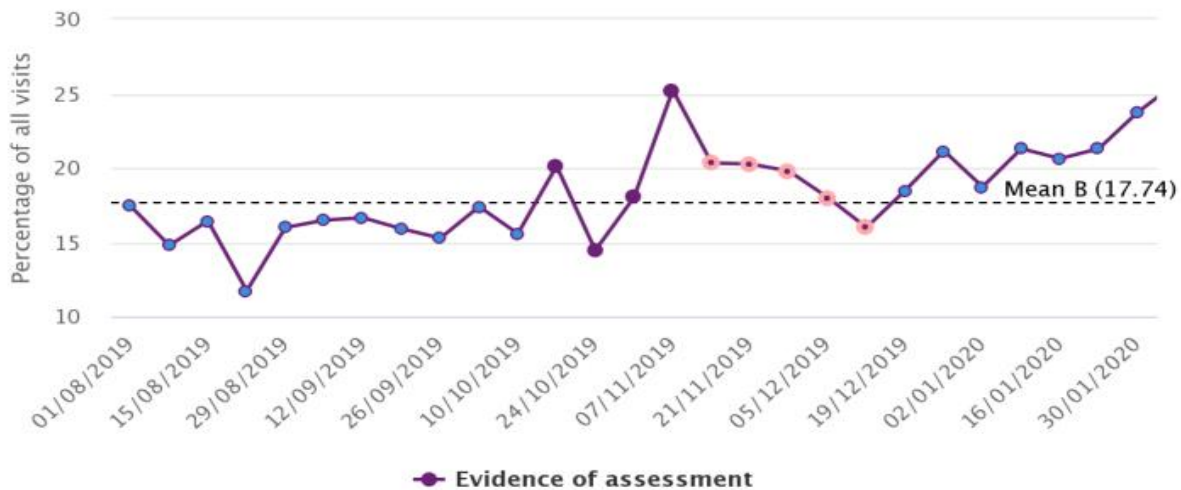
Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available



Addendum - NAA Summary Report 2021

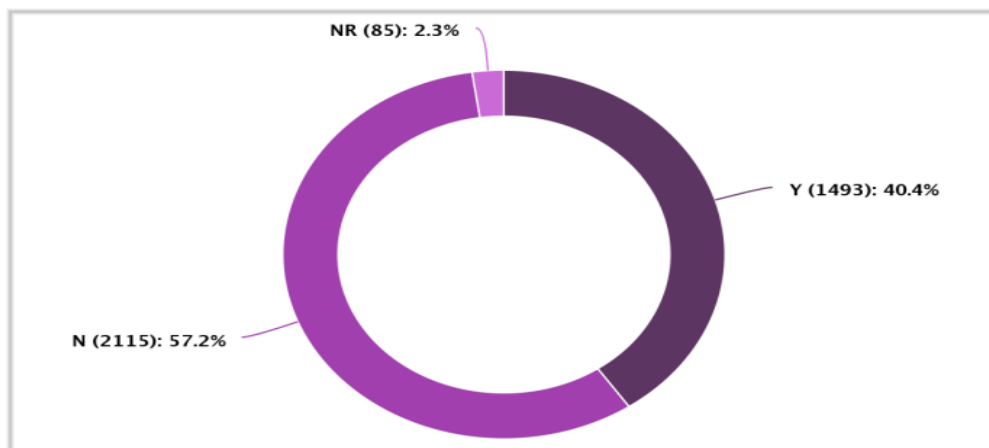
netsolving.com

Sample: Age 65-74 (n=7353)



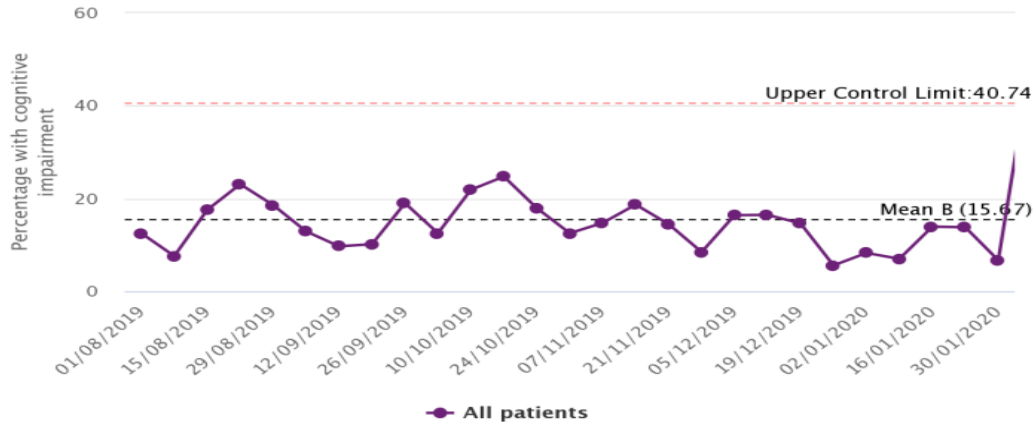
netsolving.com

Sample: Age 75+ (n=16,021)

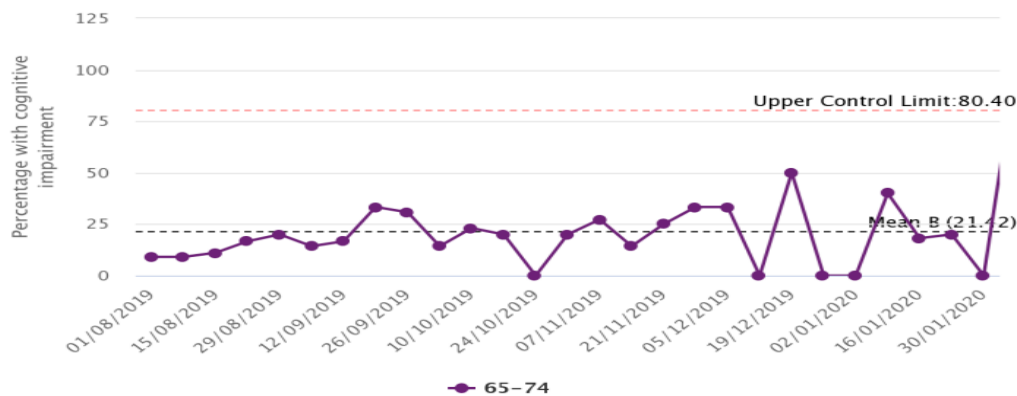


Addendum - NAA Summary Report 2021

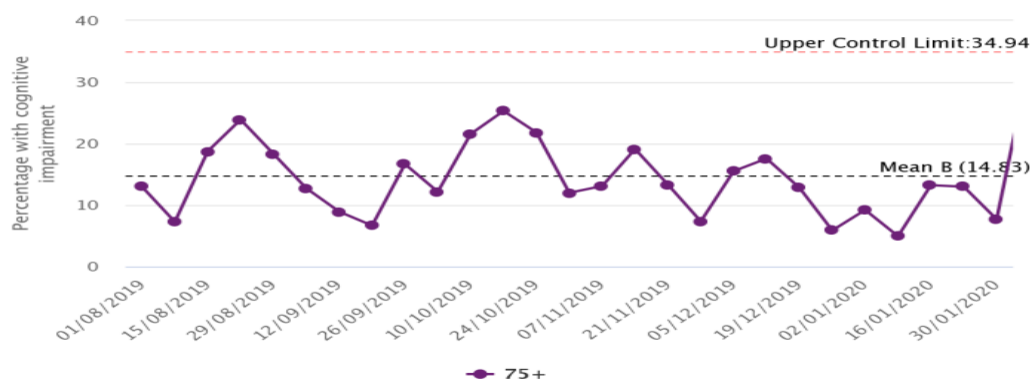
2. **Aspirational STANDARD 2:** Whenever cognitive impairment has been identified, there should be documented evidence that the patient was assessed using a delirium bundle.

Aspirational standard

Patients aged 65-74: Whenever cognitive impairment has been identified, there should be documented evidence that the patient was assessed using a delirium bundle

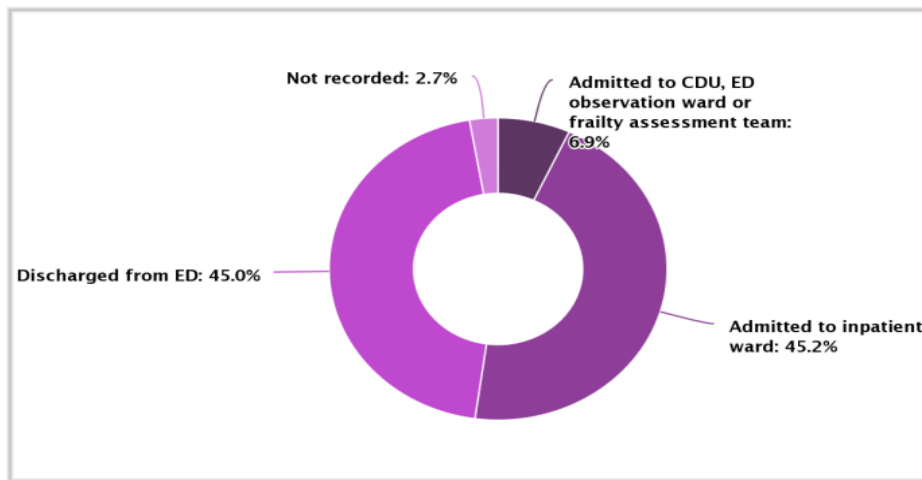


Patients aged 75+: Whenever cognitive impairment has been identified, there should be documented evidence that the patient was assessed using a delirium bundle

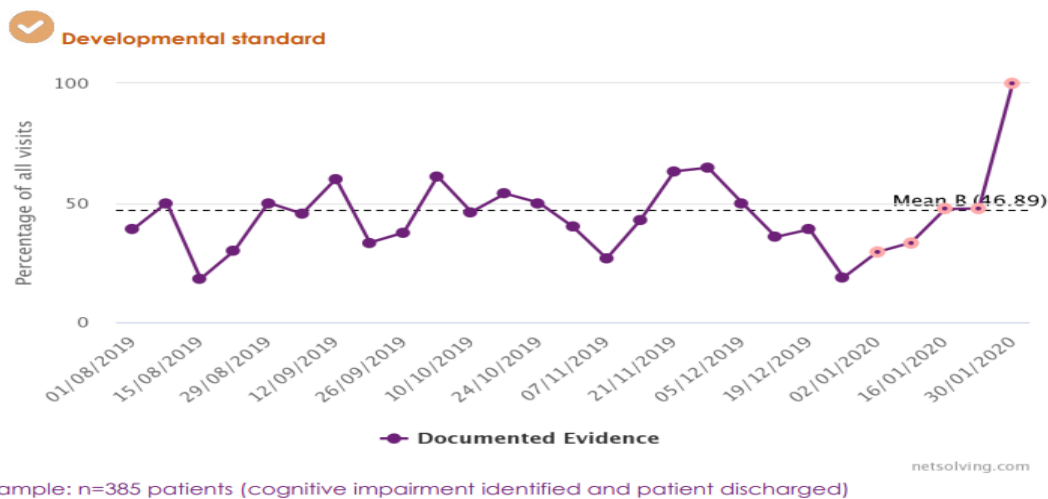


240 records conforming to standard from a total of 1760 eligible

netsolving.com

Addendum - NAA Summary Report 2021

3. **Developmental STANDARD 3:** Whenever cognitive impairment has been identified, there should be documented evidence that this information was included in the ED discharge letter.

**2. If appropriate, areas for improvement and actions taken**

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021

Addendum - NAA Summary Report 2021

3. Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

4. Update on non-participation if national audit work has been delayed / not progressed.

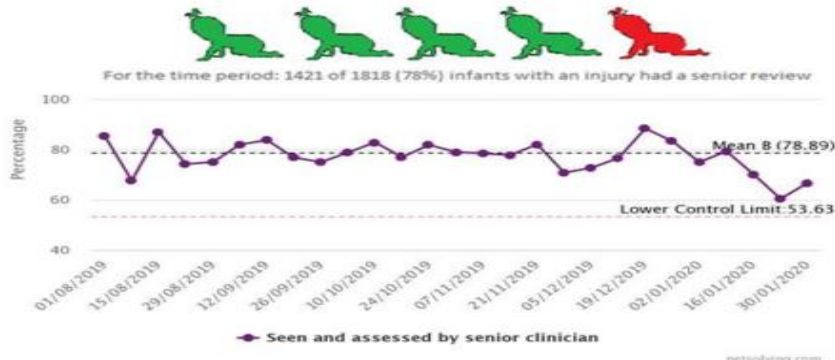
- Update awaited on areas for improvement and actions taken.
- Update awaited on areas to raise awareness.

Addendum - NAA Summary Report 2021

National Audit Title	Care of Children in ED (NEW)
Host Organisation	The Royal College of Emergency Medicine (RCEM)
Clinical Audit Lead(s)	Dr Eli McCormick
Divisional / AMD	Dr Gareth Hampton & Dr Philip Murphy
Contact details	Personal information redacted by USI
Time period	Continuous Snapshot: 01/08/2019 – 31/01/2020 (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? NO Please comment: Snapshot Audit Report Published March 2021
Directorate	ACUTE
Division / speciality	Medicine & unscheduled care: emergency medicine
Full Report accessed via	Report (rcem.ac.uk)
Update provided	Progress Report - further update awaited

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

	Indicator	Site specific data	SHSCT compliance	National or regional compliance
1.	STANDARD 1: Infants at high risk of potential safeguarding presentations* are reviewed by a senior (ST4+) clinician whilst in the ED. <i>*For the purpose of this project we are focussing on children aged 12 months and under presenting with an injury only.</i> Standard 1: Infants presenting with injury reviewed by a senior clinician whilst in the ED  Sample: Patients aged 0 -12 months presenting with an injury and identified as being in high risk of potential safeguarding. (n=1818)			

Addendum - NAA Summary Report 2021

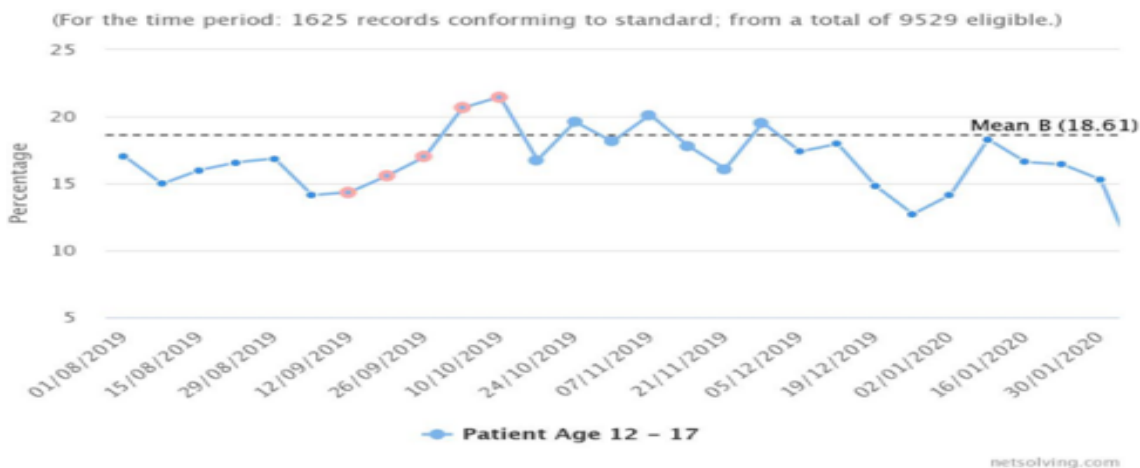
2. **STANDARD 2:** A review of the notes is undertaken by a senior clinician when an infant, child or adolescent leaves or is removed from the department without being seen.

Standard 2: Senior clinician review of the notes when patient leaves or is removed from the department without being seen



3. **STANDARD 3:** Older child and adolescent psychosocial risk is assessed using a national or locally developed risk assessment tool suitable for use with children or adolescents (e.g. HEADSSS or similar)

Standard 3: Psychosocial risk is assessed using a national or locally developed risk assessment tool



Addendum - NAA Summary Report 2021

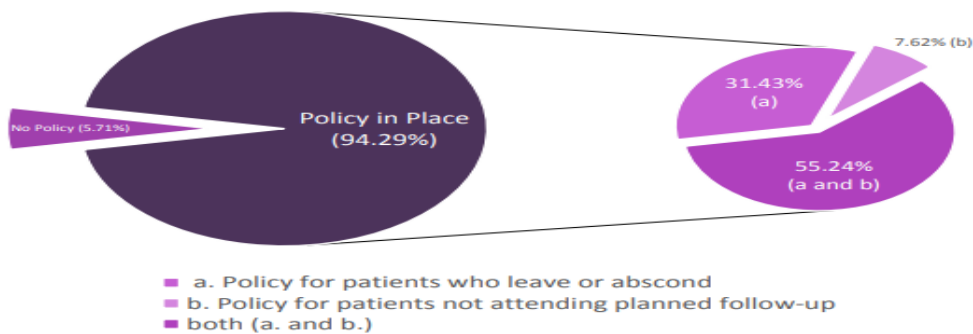
- 4 **STANDARD 4:** Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up.

 **94.3%**
(99/106 EDs)

STANDARD 4:

Policies are in place to review cases where an infant, child or adolescent either leaves or absconds from a department unexpectedly prior to discharge, or when they do not attend for planned follow up.

Policy Arrangements per site

**Understanding this data**

The chart above shows the percentage of sites that have and do have any policy in place aimed at meeting Standard 4. The same chart also shows a breakdown of the specific policy arrangements of those sites that have policies in place.

5. **STANDARD 5:** Systems are in place to identify children and young people who attend frequently

 **97.1%**
(102/106 EDs)

STANDARD 5:

Systems are in place to identify children and young people who attend frequently.

Percentage of sites that have a system in place to identify children and young people that attend frequently

**Understanding this data**

The above chart shows the percentage of sites that have a system in place to identify children and young people that attend frequently, compared to the sites that do not have systems in place to identify these same patients.

Addendum - NAA Summary Report 2021

6. **STANDARD 6:** Policies are in place to identify and review children at high risk of potential safeguarding

 **99%**
(104/106 EDs)

STANDARD 6:
Policies are in place to identify and review children at high risk of potential safeguarding

Percentage of sites that have Policies are in place to identify and review children at high risk of potential safeguarding

**Understanding this data**

The above chart shows the percentage of sites that have policies in place to identify and review children at high risk of potential safeguarding, compared to the sites that do not have policies in place to identify these same patients.

2. If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
National Report Recommendation	Action taken	SHSCT status as at October 2021
.		Complete In progress Not yet commenced

3. Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

4. Update on non-participation if national audit work has been delayed / not progressed.

- Update awaited on areas for improvement and actions taken.
- Update awaited on areas to raise awareness

Addendum - NAA Summary Report 2021

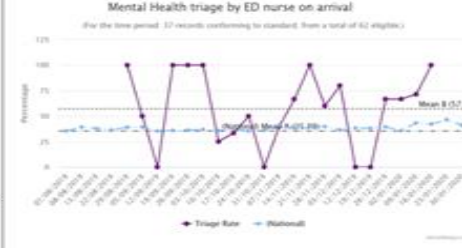
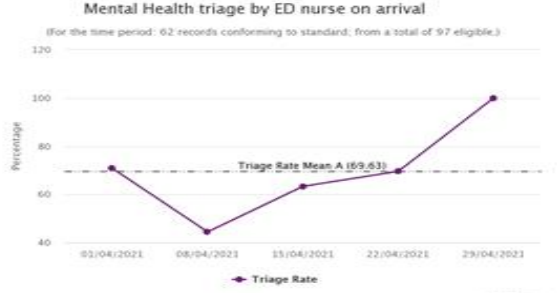
National Audit Title	Mental Health (self-harm) - NEW
Host Organisation	The Royal College of Emergency Medicine (RCEM)
Clinical Audit Lead(s)	Dr Michael Perry
Divisional / AMD	Dr Gareth Hampton & Dr Philip Murphy
Contact details	Personal Information redacted by USI
Time period	Continuous Snapshot: 1/8/2019 – 31/01/2020 (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? NO Please comment: Snapshot Audit Report Published March 2021
Directorate	ACUTE
Division / speciality	Medicine & unscheduled care: emergency medicine
Full Report accessed via	Report (rcem.ac.uk)
Update provided	Progress Report

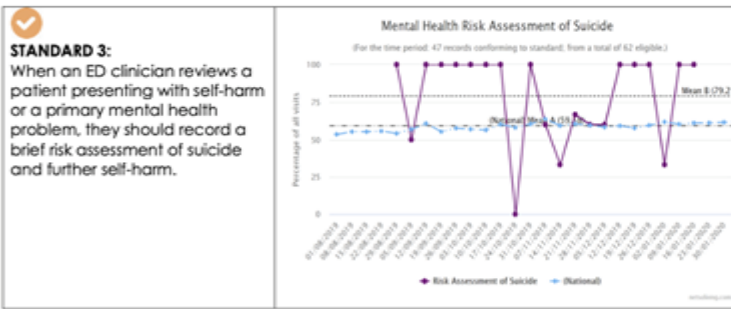
6) The 3 most important performance indicators in SHSCT, as identified by the clinical audit lead.

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

	Indicator	Site specific data	SHSCT compliance	National or regional compliance
1.	Patients should have mental health triage on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED. The QI system accepted patients who had evidence of triage within 15 minutes of arrival.			

Addendum - NAA Summary Report 2021

	Clinical standard STANDARD 1: Patients should have mental health triage on arrival to briefly gauge their risk of self-harm or suicide and risk of leaving the department before assessment or treatment is complete. This is used to determine what level of observation the patient requires whilst in the ED. The QI system accepted patients who had evidence of triage within 15 minutes of arrival. SPC chart of weekly performance Mental Health triage by ED nurse on arrival (For the time period: 57 records conforming to standard, from a total of 62 eligible.)  CAH Mean 57.61% vs National Mean 35.88% However, performance variable rather than consistent Mental Health triage by ED nurse on arrival (For the time period: 62 records conforming to standard, from a total of 97 eligible.)  April 2021 – have improved performance to 69.6%
2.	Patients at medium or high risk of suicide, harm or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of action to mitigate risk, such as continuous observation or intermittent checks (e.g. every 15 minutes), whichever is most appropriate. STANDARD 2: Patients at medium or high risk of suicide, harm or of leaving before assessment and treatment are complete should be observed closely whilst in the ED. There should be documented evidence of action to mitigate risk, such as continuous observation or intermittent checks (e.g. every 15 minutes), whichever is most appropriate. Mental Health – Documented Continuous Observation or Intermittent Checks (For the time period: 3 records conforming to standard, from a total of 47 eligible.)  CAH mean 7.67% vs National 31.2% Mental Health – Documented Continuous Observation or Intermittent Checks (For the time period: 0 records conforming to standard, from a total of 86 eligible.)  April 2021 No currently part of our trust risk assessment
3.	When an ED clinician reviews a patient presenting with self-harm or a primary mental health problem, they should record a brief risk assessment of suicide and further self-harm.

Addendum - NAA Summary Report 2021

**Risk assessment
performance**

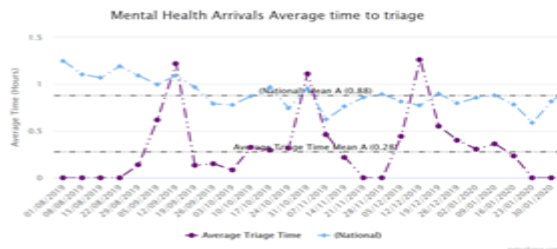
**CAH 79.21% vs National
59.68%**



April 2021

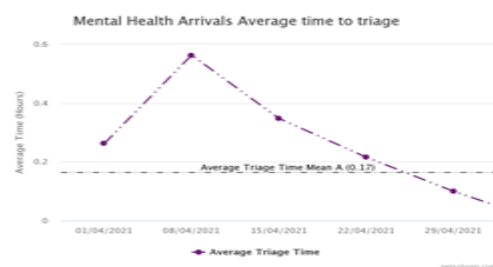
Mean 51%

**Averaging between 55 to 70%
Drop in performance week
22/4/21**

Other Results:**1. Average Time to Triage**

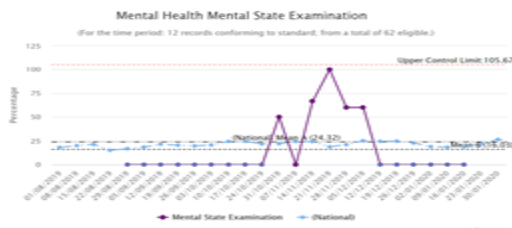
**CAH average 28 mins vs National
mean 88mins**

**However vast variation in
consistency**



**April 2021 – performance
improved**

17mins

Addendum - NAA Summary Report 2021**2. Documentation of mental state examination**

CAH mean 16.03% vs National 24.32

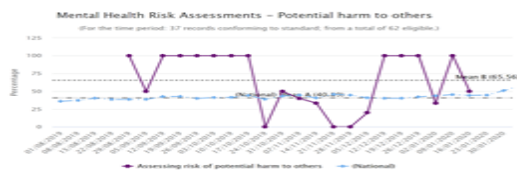
However risk assessment since this now contains an MSE grid.



April 2021 – 51%

3. Documentation of risk of repetition

CAH 69.84% vs National 51.79%

**4. Documentation of risk of harm to others**

CAH 65.56% vs National 40.89%



Addendum - NAA Summary Report 2021

5. Documentation of suicidal intent and acts



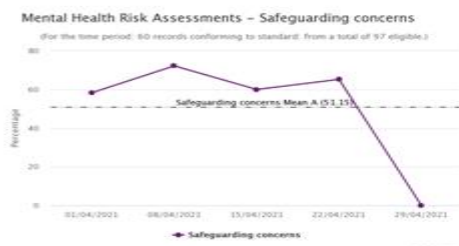
CAH 77.62% vs National 58.4%



6. Documentation of safeguarding concerns



CAH 56.6% vs National 44.59%



2. If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
Re-audit most recent data from 2021 using the RCEM QIP portal	Audit. Dr Hampton suggested that 10 charts could be reviewed monthly.	In progress
Improve documentation compliance	As above	In progress
Sub working group across both EDs (M Perry CAH, C Gaston DHH) with senior nursing representative from both EDs.		

Addendum - NAA Summary Report 2021

To examine areas identified in organisational recommendations such as MH triage (e.g. incorporation of Australian MH scale), observation, risk assessment adjustment etc.		In progress
There are areas of the national standards we may struggle to meet. Consideration of addition to trust risk register if this is the case.		In progress
Search policy. Now a clinical standard for RCEM. Recent SAI recommendation. MH has one for Bluestone. Trust wants an interagency approach from SAI.		In progress

**3. Key areas to raise awareness to SMT/ Governance Committee
- could be an area of concern / unidentified risk / good
practice or barrier to improvement**

- Fundamental concerns with regard to department footprint, patients absconding, exit block, crowding.
- Concerns remain regarding the designation of the ED regionally as “place of safety”, the interpretation of the absconding protocol / involvement of the PSNI and site security.

Addendum - NAA Summary Report 2021

National Audit Title	Society for Acute Medicine's Benchmarking Audit (SAMBA)		
Host Organisation	Society of Acute Medicine		
Clinical Audit Lead(s) Divisional / AMD	Dr Chiara Byrne, Consultant Physician		
Contact details	Personal Information redacted by USI		
Time period	Continuous	Snapshot	YES (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021?		NO
	Please comment: See section 4		
Directorate	ACUTE		
Division / speciality	Medicine & Unscheduled Care - Medicine		
Full Report accessed via	SAMBA 2021 Report - Society for Acute Medicine Login required – for participating Trusts only		
Update provided	NIL Return (complete section 4 to make 'nil' return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.				
2.				
3.				

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced

Addendum - NAA Summary Report 2021

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

4) Update on non-participation if national audit work has been delayed / not progressed.

We did not participate in this audit this year, we didn't receive notice with regard the dates in sufficient time to be able to progress with sufficient clinical audit lead personnel.

Addendum - NAA Summary Report 2021

National Audit Title	UK Renal Registry Report (UKRR)		
Host Organisation	UK Renal Registry / The UK Kidney Association		
Clinical Audit Lead(s) Divisional / AMD	Dr John Harty Dr Philip Murphy		
Contact details	[Redacted]		
Time period	Continuous Snapshot (please specify dates)		
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES / NO Please comment: Data continues to be submitted to the UKRR		
Directorate	ACUTE		
Division / speciality	Medicine & Unscheduled Care - Nephrology		
Full Report accessed via	Annual report The UK Kidney Association		
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.	1 year incidence Survival on dialysis	89.4%		Within 95% confidence limits
2.	1 year prevalent survival on dialysis	82.4%		Within 95% confidence intervals
3.	Percentage of patients on home peritoneal dialysis	12%		NI 7.6 – 13.5)
4.	Percentage of RRT patient with transplant	Increased from 51% in 2015 to 63.8% 2019		
	Percentage of transplant patients with GFR > 30	56%		Above national average

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
See section 3	See section 3	See section 3

Addendum - NAA Summary Report 2021**3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement**

- Our percentage for late presentation to the renal service (i.e. patients who need to start dialysis not referred within either 90 days or 1 year – was consistently higher than other centres in NI.
- We undertook a detailed audit on this and found that only a very small number (3 patients) might have benefited from earlier referral. We concluded that our percentage is higher due to a combination of small numbers (28 – 30) starting RRT each year and chance, for example – in 2020 we only had 1% late referrals with no change in access to the service!

Addendum - NAA Summary Report 2021

National Audit Title	Non-Invasive Ventilation - Adults		
Host Organisation	British Thoracic Society		
Clinical Audit Lead(s) Divisional / AMD	Dr R Convery Dr Philip Murphy		
Contact details	[Redacted] Personal Information redacted by UST		
Time period	Continuous _____ Snapshot: Feb – Mar 2019 (please specify dates)		
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES / NO Please comment: No recent National Audit BTS study for participation		
Directorate	ACUTE		
Division / speciality	Medicine & Unscheduled Care – Respiratory Medicine		
Full Report accessed via	National Adult Non-Invasive Ventilation Audit 2019 British Thoracic Society Better lung health for all (brit-thoracic.org.uk)		
Update provided	Progress Report or NIL Return (complete section 4 to make 'nil' return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.				
2.				
3.				

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress

Addendum - NAA Summary Report 2021

		Not yet commenced
--	--	-------------------

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement

4) Update on non-participation if national audit work has been delayed / not progressed.

- Nil to update
- For any future BTS NIV audit, on-going infrastructure required for adequate clinical audit team support, information requests and access to charts.

Addendum - NAA Summary Report 2021

National Audit Title	Adult Community Acquired Pneumonia		
Host Organisation	British Thoracic Society		
Clinical Audit Lead(s) Divisional / AMD	Dr Liam Polley Dr Philip Murphy		
Contact details	Personal Information redacted by USI		
Time period	Continuous — Snapshot: Dec 18 – Jan 19 (please specify dates)		
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES- / NO Please comment: No recent National Audit BTS study for participation		
Directorate	ACUTE		
Division / speciality	Medicine & Unscheduled Care – Respiratory Medicine		
Full Report accessed via	Adult Community Acquired Pneumonia British Thoracic Society Better lung health for all (brit-thoracic.org.uk)		
Update provided	Progress Report or NIL Return (complete section 4 to make ‘nil’ return update)		

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Site specific data	SHSCT compliance	National or regional compliance
1.				
2.				
3.				

2) If appropriate, areas for improvement and actions taken

National, regional, Trust recommendations		
Recommendation	Action taken	SHSCT status as at October 2021
		Complete In progress Not yet commenced
		Complete In progress Not yet commenced
		Complete In progress

Addendum - NAA Summary Report 2021

		Not yet commenced
--	--	-------------------

3) Key areas to raise awareness to SMT/ Governance Committee - could be an area of concern / unidentified risk / good practice or barrier to improvement.

4) Update on non-participation if national audit work has been delayed / not progressed.

- Nil return
- Community Acquired Pneumonia Audit, not applicable due to Covid 19 pandemic and clinical lead time unavailable to national audit programmes.
- For any future BTS CAPA audit, on-going infrastructure required to access charts in real time over a 3 month winter period.

Addendum - NAA Summary Report 2021

National Audit Title	Sentinel stroke national audit programme (SSNAP)
Host Organisation	School of population Health and Environmental Science Kings College London
Clinical Audit Lead(s) Divisional / AMD	Dr Michael McCormick/Dr Bronagh McGleenon/ Dr Pat McCaffrey Dr Pat McCaffrey
Contact details	Personal Information redacted by USI
Time period	Continuous Snapshot April 21 to June 21 (please specify dates)
Data Collection	Did SHSCT contribute data to this study in 2020/2021? YES Please comment: Continuous data entry and 2 yearly organisational audit
Directorate	Acute
Division / speciality	Medicine and Unscheduled Care
Full Report accessed via	Dr McCormick, Dr McGleenon, Dr McCaffrey
Update provided	Progress Report

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

Please include site specific audit results where available and SHSCT compliance against the national / regional compliance where available

		Jan – June 2019			Apr – June 2021		
		CAH	DHH	UK	CAH	DHH	UK
1	Admission to stroke unit within 4hours:	57.8%	52%	56.3%	30.7%	20.6%	51.5%
					Declined by 27.1%	Declined by 31.4%	
	➤ Direct admission to the stroke unit has declined when compared to 2019 and is well below the UK average. Delays in identifying stroke patients means that they are not admitted to the right bed to allow access to the specialist team within an appropriate time period. This ultimately delays investigations, prolongs length of stay and prevents patients benefiting from appropriate interventions. ➤ A stroke bed in DHH has been ring-fenced and a Lysis bed is always available in CAH with an assessment bed in CAH also when bed pressures allow. It is intended to work towards securing this in both sites.						

Addendum - NAA Summary Report 2021

		CAH	DHH	UK	CAH	DHH	UK
2	Applicable patients have a swallow screen within 4hours:	75%	78%	75%	66.4%	48.7%	74.4%
					Declined by 8.6%	Declined by 29.3%	
	➤ Compromised swallow is a risk for pneumonia. When patients are transferred to the stroke unit within 4 hours, their swallow screen is completed. ➤ Training on swallow screening is a recurring need for nursing staff in both stroke wards, sisters in ED and AMU, HDU and night co-ordinators. Ensuring the patient is in the RIGHT location as soon as possible (within 4 hrs) helps improve on this essential intervention. There is a Trust initiative to improve compromised swallow identification which will be subject to evaluation. A Trust wide training initiative in swallow assessment needs to be a competency in all acute admitting wards. Admission to the stroke ward within 4hours and stroke nurse specialist availability to aid identification of stroke patients in the ED is a priority.						
		CAH	DHH	UK	CAH	DHH	UK
3	Applicable patients assessed by a nurse and one therapist within 24 hours and all relevant therapists within 72 hours and rehab goals within 5 days.	28.2 %	25%	64.3%	22.7%	68.4%	63.4%
					Declined by 5.5%	Improved by 43.4%	
	➤ DHH are to be commended on the progress made in accessing therapy within a timely fashion. AHP funded staffing is well below the recommended levels which directly impacts on ability to respond proactively and timely to stroke referrals. Funded Stroke therapists are predominantly ring-fenced to stroke wards however this has been increasingly challenging with the impact of the pandemic as we have had to ensure patient flow across all areas for safety ➤ Across both sites weekend cover is at this stage not stroke specific as it focuses on ward based facilitation of discharges. Availability to input therapy at weekends is dependent on general pressures such as ED and ward discharges. Progress has been made in accessing therapy at weekends. ➤ Therapy staffing is well below the recommended levels and this has been highlighted continuously to management and to HSCB. An Investment case has been presented to the Trust Strategic Investment Committee and is to be presented to HSCB, specific to Stroke service gaps. A significant number of						