Urology Services Inquiry

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

Simon Gibson
Assistant Director of Medical Education and Workforce
Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

29 April 2022

Dear Sir,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

Issued by Urology Services Inquiry on 29 April 2022. Annotated by the Urology Services Inquiry.

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

Chair's Notice

[No 17 of 2022]

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

WARNING

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

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

TO:

Simon Gibson
Assistant Director of Medical Education and Workforce
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **12 noon on 10th June 2022.**

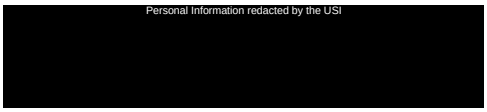
APPLICATION TO VARY OR REVOKE THE NOTICE

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

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by 12 **noon on 3rd June 2022**.

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

Dated this day 29th April 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

Urology Services Inquiry

SCHEDULE

[No 17 of 2022]

General

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

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

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

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out

your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

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

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

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

26. What, if any role did you have in staff performance reviews?

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

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that you were appraised of any concerns generally within the unit?

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

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

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

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

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

    (i) The Chief Executive(s);
    (ii) the Medical Director(s);

(iii) the Director(s) of Acute Services;
(iv) the other Assistant Director (s);
(v) the Associate Medical Directors;
(vi) the Clinical Director(s);
(vii) the Head of Service;
(viii) the consultant urologists.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

    (a) properly identified,
    (b) their extent and impact assessed,
    (c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents. Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:
    (a) outline the nature of concerns you raised, and why it was raised
    (b) who did you raise it with and when?
    (c) what action was taken by you and others, if any, after the issue was raised
    (d) what was the outcome of raising the issue?
    If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

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

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage,

what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

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

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

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

NOTE:

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

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 17 of 2022
Date of Notice: 29th April 2022

Witness Statement of: Simon Gibson

I, Simon Gibson, will say as follows:-

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

1.1 I was involved in matters within the scope of the Public Inquiry covering two time periods, from April 2007 – September 2009 as Assistant Director for Surgery & Elective Care and from April 2016 to now, in my role as Assistant Director to the Medical Director.

1.2 In my role as Assistant Director for Surgery & Elective Care, my responsibility was to lead on all aspects of the service provision under my responsibility, including General Surgery, Urology, ENT, Trauma & Orthopaedics, Oral Surgery and outpatients. I attended Senior Management Team meetings with other Assistant Directors across Acute Services, where a wide range of topics relating to performance, finance, HR and governance were considered. To avoid repetition and ensure all questions are answered as completely as possible, my narrative of detail of issues raised, meetings

held and actions or decisions taken by myself and others to address any concerns are covered within questions 4-72.

1.3 In my role as Assistant Director to the Medical Director, my responsibility was to support the Medical Director by leading on a number of key functions:

- Undergraduate medical education
- Postgraduate medical education
- Medical Revalidation & Appraisal
- Research & Development
- Emergency Planning & Business Continuity
- Supporting doctors in difficulty

1.4 My duties included meeting with the teams within each of these areas to take forward issues and opportunities to improve the services provided. I do not in this role have direct responsibility for managing Urology.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

2.1 This witness statement includes 34 appendices, which include new appendices provided to the USI as the original document request did not cover the period from 2007-2009.

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative**

and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors, or, if you prefer, you may contact the Inquiry.

3.1 The below text answers the remaining questions in this Notice.

Your position(s) within the SHSCT

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

4.1 My qualifications are:

- BSC (Hons) Public Sector Management – 1991 – Sheffield Hallam University
- Post-Graduate Diploma Health Economics & Management – 1999 – Queens University, Belfast

4.2 My occupational history prior to commencing employment with the Southern Trust is summarised in the below table:

From	Until	Role	Organisation
1991	1995	Contracts and Marketing Manag	Rotherham Hospitals NHS Trust
1995	2002	GP Fundholding Manager	Bangor Health Centre
2002	2005	Senior Manager	Lisburn Health & Social Care Group
2005	2007	Senior Manager	Newry Health & Social Care Group

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5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

5.1

From	Until	Job Title
April 2007	September 2009	Assistant Director, Surgery and Elective Care

Duties and responsibilities:

To operationally manage the surgical services and specialties within the Southern Trust. These specialties were:

- General Surgery
- Urology
- ENT
- Trauma & Orthopaedics
- Oral Surgery
- Outpatients

To ensure that all elective targets were achieved and governance issues were managed.

The elective targets were:

- Maximum 9 week waiting time for new outpatient appointments

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- Maximum 13 week waiting time for day case surgery
- Maximum 13 week waiting time for inpatient surgery

The governance issues would have included responding to complaints, IR1's and issues identified on the Risk Register.

Appendix 1 - SEC Job description located in Section 21 17 of 2022 Attachment
The job description is an accurate reflection of my duties and responsibilities in this post.

5.2

From	Until	Job Title
September 2009	November 2013	Assistant Director, Best Care, Best Value and Income Generation

Duties and responsibilities:

The duties and responsibilities were to find new ways to address the financial gap within Acute Services and to explore new ways of delivering Acute Services in accordance with best practice, whilst achieving financial balance in the future.

Appendix 2 - JD Best Care Best Value located in S21 17 of 2022 Attachments.
The job description is an accurate reflection of my duties and responsibilities in this post.

Urology Services Inquiry

5.3

From	Until	Job Title
November 2013	April 2016	Assistant Director, Medicine and Unscheduled Care

Duties and responsibilities:

To operationally manage the medical services and specialties which were under my remit within the Southern Trust. The specialties were:

- Neurology
- Dermatology
- Respiratory
- Nephrology
- Stroke
- Acute Geriatric medicine
- Cardiology
- Gastroenterology
- Endocrine/Diabetology
- Rheumatology

To ensure that all elective targets were achieved and governance issues were managed.

The elective targets were:

- Maximum 9 week waiting time for new outpatient appointments

- Maximum 13 week waiting time for day case surgery

The governance issues would have included responding to complaints, IR1's and issues identified on the Risk Register.

Appendix 3 - AD Acute MUC B.C_ located in S21 15 of 2022 Attachments. The job description is an accurate reflection of my duties and responsibilities in this post.

5.4

From	Until	Job Title
April 2016	Current post	Assistant Director, Medical Directors Office

Duties and responsibilities:

The role of this post is to deliver on the strategic and operational priorities of the Medical Directorate, with a focus on, Medical leadership, Medical revalidation & Appraisal, Medical Job planning, Medical leadership development and delivering on the Medical Directors/AMDs identified priorities. It also has responsibility for Medical education (both Undergraduate training and Postgraduate training), as well as Research & Development and Business continuity & emergency planning.

Appendix 4 - JD Assistant Director - Medical Directorate as at 2022 is located a S21 17 of 2022 Attachments. The job description is an accurate reflection of my duties and responsibilities in this post.

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

Role of Assistant Director, Surgery and Elective Care April 2007 – September 2009

6.1 Within this role, I reported directly to the Director of Acute Services, Jim McCall and his successor, Joy Youart. I had management responsibility for inpatient wards, day case and outpatient activity for the specialities of - General Surgery, Urology, Ophthalmology, ENT, Trauma & Orthopaedics and the Outpatient departments.

6.2 I had line management responsibility for Noeleen O'Donnell (Head of Service for General Surgery, ENT and Urology), Caitriona McGoldrick (Nurse Manager), Roberta Wilson (Head of Service for Trauma and Orthopaedics), Louise Devlin (Head of Service for Outpatients and Ophthalmology) and Sharon Glenny (Operational Support Lead).

Role of Assistant Director, Best Care, Best Value October 2009 – July 2011

6.3 Within this role, I reported directly to the Director of Acute Services, Joy Youart and her successors Dr Gillian Rankin and Debbie Burns. I had responsibility across the totality of Acute Services for achieving financial savings within the Acute Services Directorate. I had no line management responsibility for staff in this post.

Role of Assistant Director, Medicine and Unscheduled Care August 2011 – March 2016

6.4 Within this role, I reported directly to the Director of Acute Services, Debbie Burns and her successor Esther Gishkori. I had management responsibility for inpatient wards, day case and outpatient activity for the specialities of Neurology, Dermatology, Respiratory, Nephrology, Stroke, Geriatric Medicine, Cardiology, Gastroenterology, Endocrinology and Rheumatology.

6.5 I had line management responsibility for the Heads of Services who managed these specialties – Kay Carroll (Cardiology, Dermatology, Neurology), Eileen Murray (Nephrology, Respiratory), Caitriona McGoldrick (Geriatric, rehab and Stroke) and Louise Devlin (Endocrinology, Gastroenterology and Rheumatology). This is detailed in **Appendix 5 - MUSC Organisational Chart 2014 which can be located in S21 17 of 2022 Attachments.**

Role of Assistant Director, Medical Education and Workforce April 2016 – to present

6.6 Within this role, I reported directly to the Medical Director, Dr Richard Wright and his successors, Dr Ahmed Khan and Dr Maria O'Kane. I have management responsibility for Medical Education, Medical Revalidation and Appraisal, Emergency Planning &

Business Continuity and Research & Development. I have line management responsibility for the managers of each of these teams.& Development) as detailed in **Appendix 6 - Medical Directors ORG CHART Dec 2018 - July 2019 located in S21 17 of 2022 Attachments.**

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

7.1 In considering this question, my roles and responsibilities were as per my job description for Assistant Director, Surgery and Elective Care, namely as therein set out to:

a. Ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements

b. Ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework

c. Ensure the division complies with all professional, regulatory and requisite standards

d. Ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness

e. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales

f. Ensure the management of complaints within the division comply with HPSS Complaints and Trust Procedures and are underpinned by transparency and a culture of continuous improvement

g. Lead in the implementation of quality initiatives such as Investors in People and Charter Standards in the division

7.2 In terms of my lines of management, as outlined above, I reported directly to the Director of Acute Services.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

8.1 Having considered the roles of the Medical Director, Clinical Director and Associate Medical Director, I feel that the main difference is that they held responsibility for professional elements of medical management, whereas I had operational responsibility for the performance of the division.

8.2 I feel that the roles and responsibilities of the Head of Urology Services were very similar to my own as Assistant Director, in terms of holding operational responsibility for the performance of the division.

Urology services/Urology unit - staffing

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

9.1 To provide the Inquiry with some context, prior to the formation of the Southern Trust in April 2007, Urology services were provided through the Newry & Mourne Trust, which incorporated Daisy Hill Hospital, and Craigavon Area Hospital Trust, which incorporated Craigavon Area Hospital. When the Southern Trust was created in April 2007, Urology services were carried out in both Craigavon Area Hospital (CAH) and Daisy Hill Hospital (DHH). These services were provided by three consultants in CAH: Mr Michael Young, Mr Aidan O'Brien and Mr Mehmood Ahktar. In DHH, they were

provided by Mr Robin Brown. From April 2007 to September 2009, I managed the Urology service within the Southern Trust.

9.2 Following the publication of the Regional Review in March 2009, a Trust Steering Group was established to review the existing model of Urological Care within the Trust and identify a new cross site service model for Urology. **Appendix 7 - Revised terms of reference with actions located in S21 17 of 2022 Attachments** provides the Terms of Reference for this review. My involvement was a member of the project team undertaking this internal review and included calculating the capacity gap by assessing Urology supply and demand, identifying national service standards, recruiting staff and developing a business case.

9.3 During the time period I was in this role, I was working in the background, establishing the "building blocks" for the new unit, such as starting the process of the team job plan and establishing the activity levels for the unit. In September 2009 I changed roles from AD for Surgery & Elective Care to AD for Best Care, Best Value and handed over this ongoing review and the ongoing operational issues to Mrs Heather Trouton who was taking on the role of AD for Surgery & Elective Care. **Appendix 8 - CX, Directors re BCBV Role in ASD 17.9.09 located in S21 17 of 2022 Attachments.**

10. What, if any, performance indicators were used within the urology unit at its inception?

10.1 The main performance indicators used within the Urology Unit were in relation to inpatient, day case and new outpatient waiting times. The Trust was striving to achieve the 13-week target for inpatients and day cases, and 9 weeks for outpatients, where all patients had to be seen within these timescales. **Appendix 9 - Delivery of Access Targets located in S21 17 of 2022 Attachments** is an example of the focus given to performance targets. There were also performance indicators within the IEAP, such as achieving triage of referral letters within 72 hours, and cancer performance indicators.

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology

consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

11.1 The Integrated Elective Access Protocol (IEAP) was provided to me on 14th May 2008 by Nicky Hayes, the PA to the Director of Acute Services, Mr Jim McCall. On the same day, 14th May 2008, I circulated the IEAP to key staff within Surgery and Elective Care - Noeleen O'Donnell (Head of Service for General Surgery, ENT and Urology), Roberta Wilson (Head of Service for Trauma and Orthopaedics) Louise Devlin (Head of Service for Outpatients and Ophthalmology) and Sharon Glenny (Operational Support Lead). I asked them within this email to ensure that processes within their own span of control were adhering to the parameters laid out within the IEAP. **Appendix 10 - 20080514 - Email - Implementation of IEAP located in S21 17 of 2022 Attachments.** The Heads of Service would have been responsible for cascading this information down to the specialties and consultants.

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

12.1 During the period when I was the Assistant Director for Surgery, the implementation of the IEAP focussed attention on striving to achieve the 13-week target for inpatients and day cases and the 9-week waiting time for new outpatient appointments. Lesley Leeman and Lynn Lappin (Heads of Performance) within the Performance & Reform Directorate provided regular reports of the positions by specialties – including Urology – against the targets within the IEAP. Monthly meetings of the Acute Directorate Senior Management Team, chaired by the Director of Acute Service, were held to consider performance against these target and plans agreed to redress any deviations from the targets. These plans were called "cutting plans" and set out how many additional patients needed to be seen, over and above the established weekly activity, to achieve the regional targets.

12.2 The IEAP was a mechanism by which delays in processes could be highlighted, such as if triaging of letters was being delayed beyond the 72 hours target. It is my

recollection that spreadsheets would have been provided indicating where triaging of letters had not been completed within the 72-hour target. This was periodically an issue with Mr O'Brien within Urology, and staff within the division would have communicated with Mr O'Brien and his secretary to chase up these triage letters. It is my recollection that that the delays were not lengthy in nature at this time and did not prevent the 9-week performance target being met.

12.3 *At this point in my response to the questions raised in this Section 21, I should highlight that many of the following questions specifically relate to the Urology Unit created in 2010, following the Regional Review of Urology Services. Given that I ended my responsibility in relation to Urology in September 2009, I may be unable to fully answer the questions being asked. However, in an effort to provide as much information as possible, I have considered these questions in the context of the time when I did manage Urology, from April 2007 to September 2009 and, if relevant from my knowledge of the period after this date. In undertaking these considerations, I may be limited in my response as I do not have access to all my emails, as the email archiving system was not in place at this time, and there is only very limited documentation which is still available from 15 years ago. Therefore, my responses are based mainly on my recollections from this time.*

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement with this plan?

II. How was it implemented, reviewed and its effectiveness assessed?

III. What was your role in that process?

13.2 This question seems to seek information on two "plans"; the Team South Implementation plan and the Trusts plan to deal with the outpatient review backlog.

13.3 In terms of the Team South Implementation Plan, I had no knowledge or involvement with this plan, as by June 2010 I was not involved within Urology, and so

cannot comment on how it was implemented, reviewed or assessed as I had no role in that process.

13.4 In terms of the outpatient review backlog, I was aware that there was a substantial backlog of patients awaiting review at consultant led clinics. This had been identified by myself and I had led the creation of a plan to address this. I escalated this as a costed plan to address this backlog to the Director of Acute Services, Joy Youart in October 2008 **Appendix 11 - REVIEW BACKLOG PAPER - final 22 oct located in S21 17 of 2022 Attachments.** This plan was implemented during 2009 and was ongoing by the time I left this role in September 2009.

IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

13.5 In relation to both the Team South Implementation Plan and the Outpatient Review backlog plan, as I had moved role and was no longer responsible for this service, I am unaware whether these plans achieved their aims. I believe Heather Trouton, as Assistant Director for Surgery & Elective Care would be best placed to respond to this question.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

14.1 I am unaware as to whether the issues raised in the 2010 Implementation Plan were reflected in subsequent Trust documents. I am unable to answer whether it was on the Risk Register at that time. I believe it would have been the responsibility of Joy Youart as Director of Acute Services to ensure these issues were reflected in Trust documentation, and I am unable to provide an explanation if they were not so reflected.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

15.1 Given that I was not involved in the setting up of the Team South Urology Unit, I am unable to answer this question, as I do not have the knowledge from that period. I believe Heather Trouton, as AD for Surgery & Elective Care would be better placed to answer this question, as this would have been part of her responsibilities at that time.

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

16.1 As the *Implementation Plan* was published in June 2010, I am unable to comment on the issues raised in this question, as I was not responsible for or involved with the operational management of Urology from September 2009 onwards.

16.2 However, from my knowledge of the 2007-2009 period, I am aware from work undertaken in September 2008 that the unit was understaffed from a medical perspective, with a requirement for five consultants to meet the recommendations of the British Association of Urological Surgeons (BAUS). In the 2007-09 period, the unit was running with 2 substantive members of staff and one locum.

16.3 During my tenure, the Urology service created its own vision for Urology; this is reflected in **Appendix 12 - The Future of Urology Service provision – final version 2009 is located in S21 17 of 2022 Attachments**, which laid out a proposed future for Urological Services within the Southern Trust. This vision described that services should be:

a. of the highest quality, demonstrated by clinical outcomes and patient experience

b. sufficient to meet current and future urological need

c. optimally accessible with services as close to home is as possible

d. at minimal inconvenience and cost to patient and family

16.4 All of these characteristics require:-

a. sufficient complements of personnel

b. sufficient infrastructure and facilities, demonstrated by both a local and regional network of urological services

c. investment to ensure the service is capable of keeping pace with technological change

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

17.1 Yes, I was aware of staffing problems. The main staffing problem I was aware of was the issue I was aware of during my tenure and continued after I passed on responsibility which was that one of the three consultant urologists posts was being held by a locum (Dr Mehmood Akhtar) rather than a substantive postholder.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

18.1 As noted above, I am unable to respond to the issue of vacancies for the period beyond 2009. However, from my recollection there may have been periodic staffing challenges within the Urology ward nursing workforce and also within the Urology Nurse Specialist workforce. During the 2007 -2009 period, these would have been managed by the Ward Manager, Shirley Tedford and the Head of Service, Noeleen O'Donnell. Colleagues in HR may have details of staffing vacancies from this period. From my recollection, the staffing vacancies in Urology were not substantially any better or worse than other specialties under my responsibility.

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

19.1 In my view, the main impact of the staffing problems during the 2007 - 2009 period was an inability to fully implement all the recommendations of the British Association of Urological Surgeons. Working with the team in place at that time, it was a challenge for us to deliver on the provision of Urological services, centred around delivering on the

elective targets for outpatients, day cases and inpatients. If we had a team of 5 Consultants, it would have allowed us to provide a wider range of Urological sub-specialisation. In my view, the staffing problems had no impact on management and governance of urology services.

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

20.1 As I left my role in September 2009, there was a new Head of Service for Urology, Martina Corrigan commencing, replacing Noeleen O'Donnell, who had retired. I have no recollection of their being any other significant changes in staffing posts, roles, duties and responsibilities.

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

21.1 During the 2007-2009 period of my tenure, my governance roles and responsibilities remained the same. As detailed in the job description, these were to:

a. Ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements
b. Ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework
c. Ensure the division complies with all professional, regulatory and requisite standards
d. Ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness
e. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales

f. Ensure the management of complaints within the division comply with HPSS Complaints and Trust Procedures and are underpinned by transparency and a culture of continuous improvement

g. Lead in the implementation of quality initiatives such as Investors in People and Charter Standards in the division

21.2 After my tenure ended in September 2009, I no longer had a role in the governance of Urology. In my roles as Assistant Director for BCBV and then Assistant Director for Medicine, I attended Acute SMT meetings and would have been a participant at these meetings when governance issues relating to Urology may have been discussed. However, I did not have direct responsibility for Urology governance. When I moved into my current role in April 2016, I had no direct role in Urology governance.

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

22.1 As noted above, I am unable to fully respond to the issue of how the Urology unit was supported by non-medical staff in the period beyond 2009. However, to assist the Inquiry, I have considered this question as it related to my tenure in the 2007 - 2009 period. From my recollection, administrative support was provided directly through medical secretaries to the consultants, by ward clerks on the wards and more generally by administrative staff in the health records department. Theses duties would have included typing up letters, dealing with discharge letters and organising the scheduling of outpatient clinics. I believe Heather Trouton, who was AD for Surgery & Elective Care would be well placed to answer this question for the period 2009 onwards.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

23.1 As noted above, I am unable to fully respond as to whether there was an expectation as to how administrative staff worked within the unit in the period beyond 2009. However, to assist the Inquiry, I have considered this question as it related to my tenure in the 2007 - 2009 period. From my recollection, medical secretaries were aligned to particular consultants but would have informally covered for each other, in terms of answering phones. They may well have covered for each other in relation to typing letters, but I do not have a firm recollection of this.

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

24.1 Concerns were raised with me on one occasion, in March 2008 **(Appendix 13 - Urology Workplan 110408 is located in S21 17 of 2022 Attachments)** during a workshop held which identified a range of pressures on the Urology Service at that time. Whilst it wasn't recorded as a concern, one pressure noted (page 4) was ensuring triage was undertaken within 4 days. My recollection is that this concern was raised by admin staff. The three consultants in post at that time (Mr Young, Mr O'Brien and Mr Ahktar) committed to undertaking triage within 4 days.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

25.1 Throughout the period April 2007 – September 2009, there was a Head of Service in charge of the day to day running of the Urology unit – Noeleen O'Donnell. In September 2009, the Trust then appointed a Head of Service for the day to day running of the Urology unit, and this was Martina Corrigan. Martina Corrigan commenced at the end of September 2009, at which point I was no longer operationally responsible for the Urological Unit.

26. What, if any role did you have in staff performance reviews?

26.1 During my tenure as Assistant Director for Surgery and Elective Care, I had "1:1" meetings with my Heads of Service and Operational Support Lead on a regular basis to

discuss their roles and how they were delivering agreed objectives, such as achieving the 9 week and 13-week access targets or ward staffing levels. These would have considered their performance reviews. We met as a team and individually. Some of these meetings would have been minuted, but I have been unable to locate these documents from the 2007 - 2009 period.

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

27.1 Yes, my role was subject to a performance review and appraisal. During my tenure as Assistant Director for Surgery and Elective Care, I met with the Director of Acute Services on a 1:1 basis to discuss my areas of responsibility. **Appendix 14 - Completed KSF 08-09 as at 18th August is located in S21 17 of 2022 Attachments** is an example of this appraisal.

Engagement with unit staff

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

28.1 I find it hard to recollect with any confidence the level/frequency of involvement I had with the Urology unit in the 2007 to 2009 period and subsequently in my role as Assistant Director for BCBV. My Microsoft Calendar has not retained details from this period to allow me to identify any meetings held.

28.2 I was regularly involved in discussions with medical staff in relation to achieving elective access targets and workforce planning. This would have predominantly been with Michael Young as Clinical Lead for Urology, but also on occasion with Aidan O'Brien and Mahmood Akhtar. During this period, we discussed the potential of a team job plan with the appointment of a 4th and 5th consultant post. A team job plan is where all members of the medical team work together to deliver on the overall levels of activity

required by the commissioner. I also engaged with the medical staff in relation to agreeing a vision for taking the service forward, in line with recommendations of regional and national bodies, and as described in my response to Question 16.

28.3 I was also involved in discussions with the ward manager Shirley Tedford and Head of Service Noeleen O'Donnell in relation to ward issues and the development of the specialist urological services that we were establishing, for example a nurse led urodynamic service and the creation of the Thorndale Unit, which was a purpose-built unit for the Urology service to facilitate urological procedures to be undertaken.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1 I find it hard to recollect with any confidence from my own memory the details of regular meetings from the 2007-2009 period. As outlined above, my Microsoft Calendar has not retained details from this period to allow me to identify all meetings held.

29.2 I recall meeting with Michael Young as clinical lead for Urology to discuss performance targets, a meeting which would have been taken over by Heather Trouton when she took over the assistant Director role.

29.3 In addition, from documents retained I am aware that we held a workshop in March 2008 to consider the Urology service with a view to agreeing the priorities to take forward. **(Appendix 15 - Urology Future planning March 08 is located in S21 17 of 2022 Attachments).** This led to an action plan **(Appendix 13 - Urology Workplan 110408 located in S21 17 of 2022)** and the publication of a "Southern Trust Vision for the future of Urological Service Provision" in September 2008 **(Appendix 12 - The future of urology service provision - final version located in S21 17 of 2022 Attachments).** As Assistant Director, my recollection is that I worked with the Consultant Urologist team and the Director of Acute Services in agreeing this vision. This vision described that services should be:

a. of the highest quality, demonstrated by clinical outcomes and patient experience
b. sufficient to meet current and future urological need
c. optimally accessible with services as close to home is as possible

d. at minimal inconvenience and cost to patient and family

29.4 All of these characteristics require:-

a. sufficient complements of personnel
b. sufficient infrastructure and facilities, demonstrated by both a local and regional network of urological services
c. investment to ensure the service is capable of keeping pace with technological change

29.5 Following a regional review of Urology performance in September 2008 (**Appendix 17 - Urology Presentation 17th September performance data located in S21 17 of 2022)** the Southern Trust established a Trust Review of Urology **(Appendix 11a Appendix 11a - Revised terms of reference with actions)** which met on a regular basis to take the Urology service forward. I have attached as evidence copies of agendas and minutes where available. **(Appendix 18 - Action notes - 16th February 2009, Appendix 19 - Action notes - 2nd March 2009, Appendix 20 - Action notes - 23rd March 2009, Appendix 21 - Action notes - 30th March 2009, Appendix 22 - Action notes - 6th April 2009, Appendix 23 - agenda - 15th June, Appendix 24 - agenda - 22nd June can be located in S21 17 of 2022 Attachments.** I was a team member of this review group, looking at issues such as:

a. Service standards
b. Capacity and demand
c. Workforce planning
d. Equipment and accommodation

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

30.1 During my tenure, I believe we did work well together. We agreed that there was need to modernise the service and worked together to consider ways of improving this. These included areas such as increasing the workforce, improving the accommodation

and specialist equipment to deliver a wider range of urological services. Their participation in the March 2008 workshop and agreeing priorities for action are an example of us working well together. My recollection from that time is unclear as to how frequently we met, but when we did, I don't recall the meetings as being difficult and actually felt we worked well together, for example when we had to discuss performance targets.

Governance – generally

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

31.1 My role regarding the consultants and other clinicians in the unit was to work with them to deliver on the performance targets set. In relation to matters of clinical governance, from my recollection, I would have discussed issues such as complaints, IR1's and audit results with Michael Young and other clinicians as appropriate.

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

32.1 Clinical governance arrangements were overseen by myself, through consideration of the various governance reports which were presented to the Acute Services Senior Management Team meetings. These would have included an analysis of complaints, summaries of IR1's and would have been reported to the Acute Services SMT meeting. I would have had access to the Directorate and divisional risk register and answered complaints made by patients and/or their relatives. I would have seen relevant incidents summarised through the Incident Reporting system (DATIX) and acted on these as appropriate. I would also have considered any SEA or SAI investigations; from my recollection, there were no SAI's relating to Urology from that period.

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

33.1 I would have overseen the quality of services in Urology by considering documentation such as complaints, SAI's and DATIX reports and acted on these as appropriate. In addition, it is my recollection that at the inception of the Southern Trust, the quality of services in all specialties was defined by the 9 week and 13-week access targets. In essence, performance was a sub-set of quality. I oversaw the delivery of the access targets through the performance metrics as outlined below at Question 34. Adherence to the 72-hour target for triage was another aspect by which quality of services could be assured.

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

34.1 I was responsible for the performance metrics in Urology. There were regular meetings of the Acute Services Senior Management Team (from my recollection called ASSET) regarding performance for all specialties in the Acute Directorate, including Urology Services. There was a particular focus on the elective care targets of 9 weeks for outpatients and 13 weeks for inpatients and day cases. The Acute Services Directorate would be provided with data from Lesley Leeman, Head of Performance within the Performance & Reform Directorate and her team. For example, the Trust would receive correspondence from the Service Delivery Unit at the DHSSPS **Appendix 25 - Letter to Trusts re PTL Plans - December 2008 located in S21 17 of 2022 Attachments** highlighting:

"……. the expectation, that in the majority of specialties, Trusts will achieve the 2008/09 maximum waiting time targets for elective services (including AHP services) by 31 January 2009 and sustain these through February and March"

34.2 Monthly meetings would be held, to consider current performance. I would have attended these meetings. I cannot recall which of my team attended with me at these meetings. (**Appendix 26 - sdp meeting 131108 located in S21 17 of 2022 Attachments.)** If performance was not as expected, remedial plans – known as "cutting plans" – would be agreed to ensure the targets were delivered by 31st March every year. These cutting plans were weekly calculations designed to work out the supply of appointments required to meet the demand from patients whilst ensuring that, by 31st

March, the targets were delivered. Consideration of adherence to the target for delivering triage within 72 hours would have been part of this performance discussion.

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

35.1 In order to assure myself regarding patient risk and safety in urology, in the period 2007-2009, I would have relied on the governance and risk reports which were reported to Acute Services Senior Management Team meetings, such as complaints, Datix & IR1s as well as regular staff meetings. These meetings would have included meetings with the consultants and Head of Service, as well as meetings with the ward manager if required. I have requested patient safety and risk documents from this 2007-2009 period but have been advised by the Southern Trust's Public Inquiry Team that these are not available. These would have assisted me in considering whether appropriate standards were being met and maintained.

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

36.1 Issues of concern could be brought to my attention informally, through meetings with Heads of Service, Clinical leads or service administrators, as well as the more formal mechanisms through Datix and monthly governance reports provide to SMT. I also signed off complaints which provided a useful indicator to issues of potential concern.

36.2 Systems were designed to identify issues, which I would have acted on. The main system was through the complaints mechanism and the Datix system. I have difficulty recalling the efficacy of the systems going back to the 2007-2009 period in the absence of the documentation from that period. I have asked for the Acute Services SMT minutes and Governance documents which summarised concerns being raised from this 2007-2009 period but have been advised by the Southern Trust's Public Inquiry

Team that these are not available. These would have assisted me in considering the efficacy of those systems. From my recollection, I felt that they did raise issues to Acute SMT for me to act on as appropriate.

37. Did those systems or processes change over time? If so, how, by whom and why?

37.1 I am not aware of those systems and processes changing significantly over time.

38. How did you ensure that you were appraised of any concerns generally within the unit?

38.1 I am unable to fully answer this question in relation to the Urology Unit, as it was created in 2010, after I had ended my responsibility for this service. However, considering this question from my tenure 2007-2009, as indicated above, the mechanisms I used to be appraised of any concerns generally were, to the best of my recollection, from complaints, IR1's, meeting with staff and clinicians. I have no recollection of any SAIs from the 2007-2009 period.

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

39.1 I am unable to fully answer this question in relation to the Urology Unit, as it was created in 2010, after I had ended my responsibility for this service. However, considering this question from my tenure 2007-2009, I would have had discussions with my Head of Service and with Michael Young as Clinical Lead to assure myself that governance systems were adequate. I would have considered the outcome of audits and met with staff within the Urology ward and Thorndale unit. From my recollection, I do not recall having any concerns that governance issues were not being identified, addressed or escalated. I relied on the governance systems which were in place.

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

40.1 I am unable to fully answer this question in relation to the Urology Unit, as it was created in 2010, after I had ended my responsibility for this service. However, considering this question from my tenure 2007-2009, I would require documentation from that period. I have requested copies of Acute SMT minutes and Acute Governance minutes from the 2007 -2009 period but have been advised by the Southern Trust's Public Inquiry Team that these are not available. It would have been my responsibility to raise issues onto risk registers or ask for them to be discussed at governance meetings. In the absence of documentation, I have no recollection of raising issues relating to Urology onto any Governance documents.

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

41.1 The main system I recall for collecting patient data was the Patient Administration System (PAS). I cannot recall how PAS helped identify any concerns.

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

42.1 I was not close enough to the PAS system to form a view of whether it was efficacious. The main system which I recall changing was the introduction of the Integrated Elective Access Protocol (IEAP) in April 2008, which brought to the Southern Trust a more performance orientated approach to managing patient waiting times.

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

43.1 From my recollection, I believe performance objectives were well set for consultant medical staff and for specialty teams. From my recollection, the main performance objectives set for consultant medical staff and for speciality teams were the elective access targets as set out in the Priorities For Action documentation. This laid out annual targets for waiting times for various elective specialties. An example of this is the 2009-10 Trust Delivery Plan **Appendix 27 - TDP 2009-06_16 Final**

Version_amended190609 (003) located in S21 17 of 2022 Attachments which laid out the outpatient, diagnostic, day case and inpatient targets which had to be met.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

44.1 During my 2007-09 period of tenure, in relation to annual job planning I felt it worked quite well, as it was a useful mechanism for incorporating levels of activity which were required to hit performance targets. Within a job plan, there are typically 10 blocks of 4-hour periods, within which certain activities were set, such as an outpatient clinic, theatre list, administration tasks or ward rounds. During this period, the Southern Trust was, I felt, a performance driven organisation and so breaking down job plans to constituent fixed sessions was helpful to calculate activity levels. **Appendix 28 - Urology Fixed Sessions with 4 consultants located in S21 17 of 2022** is an example of how job plans were key in discussions regarding the organisation of the Urology team.

44.2 In relation to appraisal, this function was professionally led by the medical line manager, as I did not professionally line manage medical staff and I was not involved in this cycle, I am unable to comment. As noted in my response to Question 26, other staff I managed had appraisals through their 1:1's.

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

45.1 I am unable to fully answer this question in relation to the Urology Unit, as it was created in 2010, after I had ended my responsibility for this service. However, considering this question from my tenure 2007-2009, I would require documentation from that period. I have requested copies of Acute SMT minutes and Acute Governance minutes from the 2007 -2009 period but have been advised by the Southern Trust's

Public Inquiry Team that these are not fully available. Limited documentation from the June – September 2009 period has been provided, but this does not provide detail in relation to processes and procedures.

45.2 From my recollection, the complaints and IR1's from a period (either monthly or quarterly) would have been gathered into a report and summarised into themes by the Acute Services Risk Manager, Beatrice Moonan, and presented to the Acute Services SMT. This report would have been considered and actions taken if appropriate.

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

46.1 Yes, I did feel supported in my role by the medical line management hierarchy. The main relationship I had with the medical line management hierarchy was with Mr Eamon Mackle, who was AMD for Surgery & Elective Care and Mr Robin Brown, CD for Surgery & Elective Care. For the period 2007-2009, whilst I have no personal recollection of specific examples, my recollection is that we worked well together and supported each other. We had regular informal meetings to discuss topics, but I don't recall these being minuted. I felt able to approach my medical manager colleagues, and felt supported by them.

Concerns regarding the urology unit

47. The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with the following staff (please name the individual/s who held each role during your tenure):

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (ii) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

47.1 I am unable to fully answer this question in relation to concerns regarding the Urology Unit, as it was created in 2010, after I had ended my responsibility for this service. However, I have considered this question from my tenure in the period 2007-2009, which is limited to my recollections from that time, in the absence of calendar entries and e-mails from that period.

(i) The Chief Executive(s);

47.2 I do not recall liaising or having meetings with the Chief Executive between 2007-2009 regarding concerns relating to the Urology Unit.

(ii) the Medical Director(s);

47.3 I do not recall liaising or having meetings with the Medical Director between 2007-2009 regarding concerns relating to the Urology Unit.

(iii) the Director(s) of Acute Services;

47.4 I would have met with Jim McCall and his successor, Joy Youart and discussed concerns regarding a range of specialties, including Urology. The only issue relating to Urology would have been in relation to delays in Urology triage, which I would have raised at regular performance meetings, as this could potentially have had an impact upon the 9-week target for new outpatient appointments.

(iv) the other Assistant Director (s);

47.5 When I moved roles from Assistant Director in Surgery to Assistant Director in Best Care, Best Value, I handed over my responsibilities regarding all specialties to Heather Trouton, who was taking on the new role as Assistant Director in Surgery. As part of this handover, I would have raised issues of concern relating to achieving the elective access targets of 9 weeks and 13 weeks, and delays in triage would have formed part of that handover.

(v) the Associate Medical Directors;

47.6 Eamon Mackle would have been involved in the meetings referred to in Question 29 which were being held to modernise the Urology service. Whilst they did not directly

relate to concerns, implicit within the meetings was a need to improve the provision of Urology care within the Southern Trust

(vi) the Clinical Director(s);

47.7 Robin Brown would have been involved in the meetings referred to in Question 29 which were being held to modernise the Urology service. Whilst they did not directly relate to concerns, implicit within the meetings was a need to improve the provision of Urology care within the Southern Trust

(vii) the Head of Service;

47.8 I would have met with Noeleen O'Donnell on a regular basis to discuss day to day issues in relation to Urology.

(viii) the consultant urologists.

47.9 I would have met with Michael Young as clinical lead for Urology, Aidan O'Brien and Mehmood Akhtar to discuss day to day issues in relation to Urology. Whilst I have no direct recollection of any meetings, I assume that we would have discussed delays in triage.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.

48.1 The concerns raised with me related to the period August 2016 to January 2017, when the Medical Director Dr Richard Wright raised with me that there were a number of concerns relating to the administrative practices of Dr Aidan O'Brien. These concerns related to untriaged outpatient referral letters, outpatient review backlog, patients notes

at home and recording the outcomes of consultations and inpatient discharges **(Appendix 29 - Screening report 20160907 located in S21 17 of 2022 Attachments)**

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

48.2 A screening report was completed to risk assess through quantification of the impact of the concerns.

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

48.3 I provided the screening report to allow Dr Wright as Medical Director to consider whether the concerns may have impacted on patient care and safety. I did not consider this myself, as this was not my role; my role was to provide the information to the Medical Director.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

48.4 It was my understanding that monitoring arrangements were put in place to address these concerns. Esther Gishkori as Acute Services Director was responsible for implementing these monitoring systems, which were monitored and implemented by Martina Corrigan as Head of Service and Ronan Carroll as Assistant Director.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

48.5 I did not assure myself that these systems were working, as this was the responsibility of Esther Gishkori as Acute Services Director.

(f) If you were given assurances by others, how did you test those assurances?

48.6 I was not given assurances by others.

Urology Services Inquiry

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

48.7 I don't believe the monitoring arrangements were always successful as there were occasions when the concerns re-emerged.

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

48.8 There was a period between June and October 2018 when the monitoring arrangements did not take place, as the Head of Service Martina Corrigan was off on Personal Information redacted by the USI leave. **(20181018 Email RE Return to Work Action Plan February 2017 FINAL located in Relevant to MDO/Evidence after 4 November MDO/Reference no 77/no 77 Dr Khan and Dr Wright emails)**

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,

(b) their extent and impact assessed,

(c) and the potential risk to patients properly considered?

49.1 In relation to the issue of delayed triage between 2007 - 2009, there was not a formal assessment of this delay. My recollection from that time is that as the delay was only a number of days in duration, I felt that the potential risk to patients was considered by myself when working with doctors to conclude any overdue triage. I would also refer to my answers to Question 48.

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q64 will ask about any support provided to Mr O'Brien).

50.1 I do not recall any support being provided.

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

51.1 During my tenure from 2007 – 2009, I have no personal recollection for any quality improvement initiatives or support.

Mr. O'Brien

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

52.1 I was not responsible for the day-to-day management of Mr O'Brien, I was responsible for working with Mr O'Brien on delivering on agreed activity levels. In relation to meetings, I find it hard to recollect with any confidence from my own memory the details of regular meetings from the 2007-2009 period. As outlined above, my Microsoft Calendar has not retained details from this period to allow me to identify all meetings held. I would have met with Mr O'Brien on occasion to discuss performance issues for example, or the development of the Thorndale Unit during that time. I had no involvement with Mr O'Brien in relation to the provision of Urology services after 2009.

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

53.1 As explained in my response to Question 28, the only role I had in relation to Mr O'Brien's job plan was during 2009 when we were considering a team job plan for Urology **(Appendix 28 - Urology Fixed Sessions with 4 consultants located in S21 17 of 2022).** I am unsure as to whether this team job plan was implemented, as I handed over responsibility of Urology in September 2009.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? What were those issues of concern and when and by whom were they first raised with you? Please provide any relevant documents.

Do you now know how long these issues were in existence before coming to your or anyone else's attention? Please provide full details in your answer.

54.1 As mentioned earlier, my Microsoft Calendar has not retained details from the 2007-2009 period to allow me to identify meetings held. In addition, the Southern Trust email archiving system did not commence until 2009 **(Appendix 30 - 20220505 - Email re Email archive located in S21 17 of 2022 Attachments).** Therefore, in responding to Questions 54-65, I feel obliged to preface these responses with my observation that I have had to rely on retained documents from the 2007-2009 period which I have been able to locate, but which may not be the full set of documents from that time. In addition, I am relying on a small number of emails from this period **(Appendix 31 - 20081003 - Email - Preparing Urology referrals for triage and Appendix 32 - 20081201 - Email Urgent - Urology-ICATS referrals located in S21 17 of 2022 Attachments)**. It appears some emails from my old cahgt (Craigavon Area Hospital Group Trust) email address were migrated to the inbox of my new email account. I have very little personal recollections from this period that have stayed with me.

54.2 The earliest evidence I have available to me that I first became aware of issues of concern relating to Mr O'Brien was in April 2008, at the workshop where the issue of triage was discussed. In October 2008, it was reported to me by my Operational Support Lead, Sharon Glenny, that there were delays in obtaining the outcome for Mr O'Brien's triage of referral letters. This may have been reported to me verbally or by e-mail, I cannot recall. I believe that the reason this issue came to light was due to the implementation of the Integrated Elective Access Protocol during the latter half of 2008. This set quantifiable timescales for the processing of documentation to ensure that a "Partial Booking" system could be implemented and that outpatients would get their new appointment within 9 weeks. This was a new process which centrally recorded outpatient referrals and if there were delays in the triage element of this new process, which should have taken 3 working days.

54.3 In October 2008, there was correspondence with Sharon Glenny, Operational Support Lead and Aidan O'Brien **(Appendix 31 - 20081003 - Email - Preparing Urology referrals for triage located in S21 17 of 2022 Attachments)** to discuss:

54.4 This was followed up with correspondence in December 2008 between myself and Michael Young and Eamon Mackle **(Appendix 32 - 20081201 - Email Urgent - Urology-ICATS referrals)** which evidences a continuing issue with Mr O'Brien's triage.

54.5 There was a new process (GP referrals were scanned and emailed to Consultant staff) being introduced in 2009 within the Referral and Booking Centre which was felt would address these issues. As referrals were now being scanned, they could be tracked and managed easier. **(Appendix 33 - 20090201 - Referral and booking centre)**

54.6 I do recall that these delays in triage of letters by Mr O'Brien were not large in volume or significant in time, as we were able to work with him to get any outstanding letters triaged. As patients were still being seen within 9 weeks during this period, it wasn't viewed as a significant patient safety risk.

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

55.1 With regard to the issue of delayed triage in 2007-2009, other than what is detailed in **Appendices 30, 31, 32 and 33 (as above**) I have no direct evidence or recollection of actions, meetings or discussions relating to this issue. However, the issue of adherence to IEAP in achieving the 9 week target for outpatients was a regular topic at Directorate performance meetings during the 2008-2009 period and would have been escalated by myself to Joy Youart as Director of Acute Services at that time and passed onto Heather Trouton in September 2009 when our roles transferred.

55.2 With regard to the issues of concern highlighted in 2016, these were dealt with through the Oversight meetings held by the Medical Director, Director of Acute Services and Director of Human Resources and Organisational development. These concerns and discussions were as outlined in my response to Question 48.

56. What actions did you or others take or direct to be taken as a result of these concerns? If actions were taken, please provide the rationale for them. You should include details of any discussions with named others regarding concerns and proposed actions. Please provide dates and details of any discussions, including details of any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

56.1 With regard to the issue of delayed triage in 2007-2009, the only action I recall was for my management team (Sharon Glenny and Louise Devlin) to chase outstanding triage letters with Mr O'Brien or his secretary to ensure they were done eventually. I do not recall how frequently this was done and have no records of this.

56.2 With regard to the issues of concern highlighted in 2016, the operational staff responsible for Mr O'Brien, led by Esther Gishkori as Director of Acute Services, were responsible for actions taken.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

(i) what risk assessment did you undertake, and

(ii) what steps did you take to mitigate against this?

If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

57.1 With regard to the issue of delayed triage in 2007-2009, I have no recollection that – at the time – these concerns were impacting on patient safety. From considering ***Appendices 30, 31, 32 and 33*** I do recall that our focus was ensuring that we obtained these triaged letters because they were needed to commence the partial booking cycle. Reviewing the elective targets at that time, within Urology we were pressing to maintain a maximum waiting time of 9 weeks for routine outpatients and of 13 weeks for all day cases and inpatients. My team was involved in ensuring the delivery of these targets. Part of their role was proactively chasing any delayed triage letters, and ensuring they

were returned to the booking centre in a timely manner to ensure elective targets were being met. Therefore, any delay to the patient was minimal and patients were still seen within the regional targets.

57.2 Accordingly, I don't feel that during the 2007-2009 period there was any impact upon patient care and safety as – at that time – there was active management of the booking process and patients were being seen within the regionally agreed targets of 9 weeks.

57.3 In summary my recollection from the time is that this was considered an administrative performance issue, rather than a patient safety issue.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

58.1 With regard to the issue of delayed triage in 2007-2009, from my recollection there was no agreed way forward in relation to Mr O'Brien, other than the regular follow-up of delayed triage letters by my operational team with Mr O'Brien and/or his secretary to ensure the standards within the IEAP were being met in line with practice followed for all other Consultants.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

59.1 With regard to the issue of delayed triage in 2007-2009, there were no specific additional metrics put in place to monitor Mr O'Brien.

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

60.1 I assured myself by considering our performance against the Trusts adherence to the 9-week target for outpatients appointments. Other than delays in triage of outpatients by a small number of days, I was not aware of any other concerns. If required I assured myself of the triage delays by discussing this issue with my operational team. Reflecting back, this arrangement was not sufficiently robust, as the delays continued to be experienced periodically. The response was not comprehensive but was rather more reactive, with staff cajoling and encouraging Mr O'Brien to triage in a timely manner.

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

61.1 It is my recollection that the chasing up of delayed triage letters did not remedy the concerns, as they continued periodically up until I handed responsibility for Urology services over to Mrs Trouton. In terms of what could have been done differently, a more formal approach to Mr O'Brien could have been considered rather than the passive, informal method being used. However, the wider context is that the Southern Trust was still a new organisation and as a new management team attempting to manage the introduction of the complex new procedures within IEAP, it is my view that had I sought a more formal approach, it may not have been accepted by Directors of Acute Services as the best course of action. There were a small number of consultants who were struggling with various elements of the IEAP, and we were trying to bring staff along with us constructively, rather than to be confrontational in our approach. I would reiterate that – at that time – this was the only issue of concern I recall in in relation to Mr O'Brien, and that we were working with him to comply with the IEAP targets. However, in hindsight, I feel that this issue should have been escalated to achieve a more formal approach.

62. Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those

concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

62.1 The only issue that I recall Mr O'Brien raising was discussing his concerns in relation to the lack of a regional target for review outpatient appointments. I recall that this was in CAH, although I don't recall when it was. I recall him describing to me his opinion that, for Urology, the first review appointment was far more important in the patient's clinical journey than the new appointment, as it was the review appointment where results of investigations could be considered and an action plan agreed. I do recall understanding and agreeing with his concern.

62.2 There was no target for review outpatient appointments as it was not a politically agreed target in the same way that 9 weeks was for a new outpatient appointment. As a result, the Department of Health did not give this the same level of priority for Trust attention. By October 2008 there were significant volumes of outpatients who were waiting beyond their expected date to be seen. Urology was not the only specialty where this was the case and a paper was written by myself and other members of the Acute Services team to quantify this problem and presented to Mrs Joy Youart, Director of Acute Services **(Appendix 11 - REVIEW BACKLOG PAPER - final 22 oct located in S21 17 of 2022).**

63. Did you raise any concerns about the conduct/performance of Mr O'Brien. If yes:

(a) outline the nature of concerns you raised, and why it was raised

(b) who did you raise it with and when?

(c) what action was taken by you and others, if any, after the issue was raised

(d) what was the outcome of raising the issue?

If you did not raise any concerns about the conduct/performance of Mr O'Brien, why did you not?

63.1 The only recollection I have relating to Mr O'Brien was the delay in triaging outpatient letters, which we were dealing with as outlined above. I would have raised

this issue at the Acute Services Directorate Performance meetings, but I have no documentation to support this. My recollection is that no additional actions were taken, as we were managing this issue informally, by chasing referrals with Mr O'Brien and/or his secretary.

64. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

64.1 The only concern that I recall Mr O'Brien raising was in relation to the outpatient review backlog, as outlined above. In terms of support, I provided to address this concern, I wrote a paper detailing an action plan **(Appendix 11)** and engaged the Director of Acute Services and Director of Performance and Reform in this plan. There was no involvement of HR in this issue, as this was a performance issue relating to review outpatients.

65. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

65.1 I am not aware that the issue of the outpatient review backlog was raised in Trust governance documents in the 2007-2009 period. I have asked for copies of relevant Acute and Trust governance documents from this time period, but they have not been made available to me.

Learning

66. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

66.1 Having reviewed the various investigative reports by Dr Chada and Dr Khan, I am now aware of a range of governance concerns arising out of the provision of Urology services which I do not believe existed during my tenure from 2007-2009. These concerns relate to untriaged letters, undictated clinic outcomes, charts being kept at home and inappropriate placement of private patients which various investigative reports indicated were apparent from 2012 onwards.

66.2 It may be of benefit to highlight that the concern I was dealing with was not untriaged letters, but a delay in the triage of these letters by a number of days. This was a periodic issue which I would have handed over as an ongoing concern to Mrs Heather Trouton, Assistant Director of Surgery and Elective Care.

67. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

67.1 Reflection provides the benefit of hindsight. In hindsight, looking at my own tenure, I think that a more formal approach, with a formal action plan, would have been a better approach, as the way I dealt with it through an informal manner didn't permanently resolve his behaviour of being slow in triaging referral letters.

67.2 I certainly feel that the management of Mr O'Brien could have been more formally addressed once significant concerns were known in the period 2012-2016 by a wide range of professional, operational managers, Assistant Directors and Directors. In my opinion, what is clear now is that the informal approach of trying to manage Mr O'Brien by a range of staff to change his behaviour during that period was repeatedly unsuccessful, and a formal performance management approach should have been taken. It is my view that the turnover in Acute Directors was not helpful in seeing and challenging the trends in his behaviour, as new Directors "started again" when faced with this problem and were unable to identify this trend.

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

68.1 I think the main learning is that solid monitoring systems and processes should be in place, and in circumstances where there is deviation from an agreed standard of

performance, a more structured formal approach to managing deviation should be put in place if informal approaches are unsuccessful after an agreed period of time. In addition, I agree with the conclusion of the report written by Dr Julian Johnston which stated that clinical staff should be constructively challenged if appropriate, irrespective of their seniority and reputation.

69. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

69.1 Yes, I do feel there was a failure to engage. I think I failed by not formally addressing the concern of late triage when it became apparent that the constructive approach being taken only addressed the issue temporarily. In mitigation, at the time of the introduction of the IEAP there was a small number of medical staff who I recall were not in full agreement with the protocol and were not fully compliant with all aspects of the protocol. Rather than engage in formal processes to force compliance, I felt at the time a more constructive dialogue of persuasion and support was appropriate. In the majority of cases this was successful, but in Mr O'Brien's case, I feel my approach should have changed when it was apparent that his change in behaviour was only temporary.

69.2 Following on from Question 67, I feel that as the issues became more significant, then relevant senior managers should have addressed this issue sooner than September 2016.

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

70.1 I hope my response to Question 69 is clear that Yes, I do feel I made mistakes. Whilst, during my 2007-2009 tenure, the only concern identified which I recall was the delay in triaging referrals by Mr O'Brien by small periods of time, for some patients, I should have taken a more formal approach when attempting to manage this informally failed to sustainably moderate his behaviour. In hindsight, involving Mr O'Brien's clinical manager earlier in the process would have been a better option.

70.2 In the period 2009-2016, as more significant concerns came to the attention of professional and operational Directors, using governance mechanisms to more formally manage Mr O'Brien may have been more appropriate to alter his behaviour in my opinion. This would have been by his professional and operational Directors during that time.

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

71.1 I do not recall having any concerns about the governance arrangements at that time. I think that overall the governance arrangements provided a variety of mechanisms to formally manage Mr O'Brien and support him in managing his patients in line with his colleagues. However, it appears from the various investigative reports that these formal mechanisms were not used early enough in this process and if they had been put in place as early as 2008, then it may have been possible to modify Mr O'Brien's behaviour.

72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 No.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include,

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

Statement of Truth

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

Signed: __Simon Gibson_____

Date: __27th June 2022_____

Section 21 Notice Number 17 of 2022

Witness Statement of Simon Gibson

Attachments

Attachment	Name
1	Appendix 1 - SEC Job description
2	Appendix 2 - JD Best Care Best Value
3	Appendix 3 - AD Acute MUC B.C_
4	Appendix 4 - JD Assistant Director - Medical Directorate as at 2022
5	Appendix 5 - MUSC Organisational Chart 2014
6	Appendix 6 - Medical Directors ORG CHART Dec 2018 - July 2019
7	Appendix 7 - Revised terms of reference with actions
8	Appendix 8 - CX, Directors re BCBV Role in ASD 17.9.09
9	Appendix 9 - Delivery of Access Targets
10	Appendix 10 - 20080514 - Email - Implementation of IEAP
11	Appendix 11 - REVIEW BACKLOG PAPER - final 22 oct
12	Appendix 12 - The future of urology service provision - final version
13	Appendix 13 - Urology Workplan 110408
14	Appendix 14 - Completed KSF 08-09 as at 18th August
15	Appendix 15 - Urology Future planning March 08
17	Appendix 17 - Urology Presentation 17th September performance data
18	Appendix 18 - Action notes - 16th February 2009
19	Appendix 19 - Action notes - 2nd March 2009
20	Appendix 20 - Action notes - 23rd March 2009
21	Appendix 21 - Action notes - 30th March 2009
22	Appendix 22 - Action notes - 6th April 2009
23	Appendix 23 - agenda - 15th June
24	Appendix 24 - agenda - 22nd June
25	Appendix 25 - Letter to Trusts re PTL Plans - December 2008
26	Appendix 26 - sdp meeting 131108
27	Appendix 27 - TDP 2009-06_16 Final Version_amended190609 (003)
28	Appendix 28 - Urology Fixed Sessions with 4 consultants
29	Appendix 29 - Screening report 20160907

30	Appendix 30 - 20220505 - Email re Email archive
31	Appendix 31 - 20081003 - Email - Preparing Urology referrals for triage
32	Appendix 32 - 20081201 - Email Urgent - Urology-ICATS referrals
33	Appendix 33 - 20090201 - Referral and booking centre
34	
35	

Southern Health and Social Care Trust

Assistant Director of Surgery and Elective Care

Band 8c (£49,381 – £60,880 per annum)

JOB DESCRIPTION

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Surgery/Elective Care Division. He/She will be responsible for the operational management of all specialties in the division which will incorporate general surgery, urology, trauma and orthopaedics, oral dentistry and waiting list management in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

- lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's surgery/elective care division.
- ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.
- work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.
- contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

- ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.
- ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.
- ensure the division complies with all professional, regulatory and requisite standards.
- ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.
- ensure the management of complaints within the division comply with HPSS Complaints and Trust Procedures and are underpinned by transparency and a culture of continuous improvement.
- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

Service Planning and Development

- promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.
- assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.
- work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.
- act as a member of the directorate's senior management team and contribute to its policy development processes.
- represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

- responsible for the management of the division's budget and the meeting of all financial targets by each specialty.
- ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.

- participate in contract and service level negotiations with commissioners.
- ensure the effective management, use and maintenance of all physical assets in the division.

People Management

- provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as those relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

Information Management

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.
- adhere to the Trust's corporate planning, policy and decision making processes as a member of the directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

General Management Responsibilities

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Assistant Director of Surgery/Elective Care works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director of Acute Services.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- at all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- comply with the Trust's No Smoking Policy.
- carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- adhere to equal opportunities policy throughout the course of their employment.
- ensure the ongoing confidence of the public in service provision.
- comply with the HPSS code of conduct.

March 2007

Southern Health and Social Care Trust

Terms and Conditions

The NHS terms and conditions (Agenda for Change) will apply to this post.

The salary will be Band 8c, £49,381 – £60,880 per annum.

In addition to 10 public holidays, the annual leave allowance will be as follows:-

- On appointment – 27 days
- After 5 years service – 29 days
- After 10 years service – 33 days

He / she may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. The successful candidate should therefore have access to a form of transport that will permit them to meet the requirements of the post in full and be prepared to travel as required.

Southern Health and Social Care Trust

JOB TITLE: **Assistant Director for Best Care Best Value (BCBV)**

DIRECTORATE: **Acute Directorate**

INITIAL LOCATION: **Craigavon Area Hospital**

REPORTS TO: **Director of Acute Services**

ACCOUNTABLE TO: **Director of Acute Services**

JOB SUMMARY

The post holder will be responsible to the Director of Acute Services for driving forward the BCBV agenda within the Acute Directorate and for identifying and driving forward initiatives to generate income. He/she will provide an embedded challenge function to support Acute Services to utilise information effectively to help highlight and target areas of wastage. They will contribute to corporate and operational strategy, policy and decision making within the Trust by advising the BCBV Program lead (Assistant Director of Performance & Improvement) and the SMT on issues relating to the development, implementation and performance management of BCBV Plans. These Plans will underpin the Trust's achievement of efficiency targets.

The post holder will provide enhanced support and performance improvement expertise and intervention to the Acute Directorate and to corporate projects where required. He/She will provide the organization with a range of intelligent information analyses which demonstrate actual performance against efficiency targets. The post holder will also be required to develop and embed the organization's capacity for continuous improvement including efficiency gains using dynamic leadership and facilitation skills.

KEY RESULT AREAS

1. To work collaboratively with Directors, Assistant Directors, Heads of Service, Senior Managers and Clinicians to determine and agree key areas for productivity and improvement plans.

2. To support the growth of a performance, improvement and efficiency culture within the Trust by assisting staff to maximize use of existing information sources within the Trust, understand and use available performance information, benchmarks and best-practice evidence to inform decision making and the planning of current and future services throughout the Trust. As part of this the post holder will identify gaps in effective management information for the Trust to address.

3. To take the lead in taking forward the following productivity improvement pathway within the Acute Directorate by:-

- An understanding of how resources are currently utilised to generate outputs and outcomes
- Identification/benchmarking of how this performance sits against high performing peer groups of providers nationally and internationally
- Securing agreement on improvement goals aligned to the outcomes from the benchmarking analysis
- Key milestones identified against which to assess progress including actual delivery of cash-releasing savings
- Implementation of improvement processes to deliver against each milestone
- Ongoing review

4. Use expert analytical skills to interpret the broad range of performance information available alongside other relevant data and inform the prioritization of initiatives/ design of new service models that will contribute to maximizing efficiency.

5. To foster good communication and clear lines of accountability relating to productivity and improvement plans within the Acute Directorate including functional support teams (e.g. planning and finance).

6. To provide assistance to directorate teams in diagnosing the issues and factors which are preventing them maximizing the efficiency of all their resources.

7. To provide project management expertise, support, focus and monitoring to ensure specific BCBV project

plans are delivered and result in the intended efficiency saving.

8. To provide project management leadership for specific key projects as required.

9. To provide updates on progress against BCBV plans and keep information systems/processes to support corporate monitoring of progress, updated.

10. To specifically highlight areas of risk/slippage and deviations from expected progress towards efficiency targets, bringing key issues to the attention of the Director of Acute Services / Assistant Director of Performance with recommendations for possible action.

11. To assist in the development of an ongoing and sustainable approach to efficiency gains within the Trust.

12. Assess the outcomes of ongoing projects and facilitate benchmarking exercises and collaborative working across teams, Directorates and other providers.

13. Develop and maintain strong networks with both regional and UK productivity and reform units, keeping up to date with latest thinking and developments.

14. To develop and implement a communication strategy that identifies internal and external stakeholders and establishes appropriate plans for engagement and communication.

15. To secure the information required to support demand assessment and capacity planning.

16. To lead on the analysis of activity, quality and outcome indicators incorporating specifically patient reported outcome measures (PROM'S)

17. To lead on the development of new models of care delivery within the context of regional policy and service frameworks to promote better outcomes, access or value for money.

18. To pursue all opportunities to develop integrated care models involving relevant professional groups in the design and implementation processes.

19. Work collaboratively with Staff Side to ensure they

are fully engaged in all Best Care / Best Value and income generation plans from initial concept through to implementation.

20. Work collaboratively with Clinicians at all levels to ensure clinical engagement and participation in all relevant Best Care / Best Value and income generation projects.

21. Represent the Trust at Service Delivery Unit meetings relating to Definitional Guidance on Discharge and all other processes relating to Patient Flow.

INCOME GENERATION

- To explore opportunities to income generate for Acute Services and report these to Director of Acute Services.
- To research Best Practice in both BCBV Scheme and income generation and provide regular reports to Director of Acute Services.
- To work collaboratively with the Assistant Director providing outcome of research and identifying potential opportunities for BCBV and income generation opportunities.
- To expand the range of information and reports and provide key performance indicators sources for Acute in delivering of BCBV targets.
- To provide update reports to the weekly Acute Services Senior Management Team on progress towards BCBV targets and outcome of research into other potential opportunities.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

- Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
- Maintain staff relationships and morale amongst the staff reporting to him/her.
- Review the organization plan and establishment level of the Acute Directorate to ensure that each is consistent with achieving objectives, and recommend

change where appropriate.

- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

- Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

GENERAL REQUIREMENTS

The post holder will be required to:

Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents / incidents / equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

Adhere at all times to all Trust policies/codes of conduct, including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct
- Standards of attendance, appearance and behaviour

All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximize

his/her potential and continue to meet the demands of the post.

Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

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

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

PERSONNEL SPECIFICATION:

Knowledge, skills and experience required:-

- University degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organization.

OR

- Have worked for at least 5 years in a senior management role in a major complex organization.

AND

- Delivered against challenging performance management programmes for a minimum of 2 years in the last 6 years meeting a full range of key targets and making significant improvements.
- Worked with a diverse range of stakeholders, internal and external to the organization, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- A proven track record of people management,

governance and organizational skills for a minimum of 2 years in the last 6 years.

- A full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extend their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified. Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework. Particular attention will be given to the following:-

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:-

"senior management" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director.

"major complex organization" is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders:

"significant" is defined as contributing directly to key objectives of the organization.

October 2009

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Job Description

JOB TITLE	Assistant Director of Acute Services : Medicine and Unscheduled Care Division
BAND	8C
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Medicine and Unscheduled Care Division. He/She will be responsible for the operational management of all specialties in the division. This will incorporate older people's medicine, endocrinology, rheumatology, neurology, gastroenterology, dermatology, cardiology, A&E department, renal services, rehabilitation, discharge team, hospital social services and bed management in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

KEY RESULT AREAS

Service Delivery

1. Lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's medicine and unscheduled care division.

2. Ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.

3. Work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services

and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

4. Contribute to the development of robust clinical and professional networks within the division and across the Trust.

Quality and Governance

5. Ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.

6. Ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.

7. Ensure the division complies with all professional, regulatory and requisite standards.

8. Ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.

9. Ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.

10. Ensure the management of complaints within the division comply with HPSS and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

11. Lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

12. Ensure that the quality of the patient journey and experience is enhanced and improved by the Patient Support Service, working across all acute services/sites.

13. Provide leadership of the Quality and Patient Support Officer to ensure the Public and Personal Involvement and Health and Wellbeing Strategies are implemented to continually improve the quality of patient/client experience by involving users in shaping services and improving the health of the Trust's clients/patients.

14. Provide an early intervention service in the management of potential patient/client complaints and dissatisfaction by advocating independently on

behalf of the patient/client and enhancing experiential learning by interfacing with the Acute Service Governance system.

Service Planning and Development

15. Promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.

16. Assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.

17. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.

18. Liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.

19. Act as a member of the directorate's senior management team and contribute to its policy development processes.

20. Represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

Financial and Resource Management

21. Responsible for the management of the division's budget and the meeting of all financial targets by each specialty.

22. Ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.

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

24. Ensure the effective management, use and maintenance of all physical assets in the division.

People Management

25. Provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.

Southern Health and Social Care Trust

26. Work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.

27. Ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.

28. Ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.

29. Ensure the effective management of staff health and safety and support in the division.

Information Management

30. Ensure the effective implementation of all Trust information management policies and procedures in the division.

31. Ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

Corporate Responsibilities

32. Develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.

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

34. Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

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

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

Southern Health and Social Care Trust

Human Resource Management Responsibilities

37. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

38. Maintain staff relationships and morale amongst the staff reporting to him/her.

39. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

40. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

41. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

GENERAL REQUIREMENTS

The post holder will be required to:

43. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

44. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

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

46. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

Southern Health and Social Care Trust

47. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

48. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

Southern Health and Social Care Trust

Personnel Specification

JOB TITLE Assistant Director of Acute Services
Medicine and Unscheduled Care Division

Ref No: 73211009 February 2011

Notes to applicants:

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*
2. ***You must clearly demonstrate on your application form how you meet the required criteria – failure to do so will result in you not being shortlisted.*** *Please note that whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable Criteria.* ***Applicants are therefore strongly advised to clearly demonstrate how they meet each element of both the Essential AND the Desirable criteria on their application form.***
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made = if you are unable to provide this, the offer will be withdrawn.*

ESSENTIAL CRITERIA *– these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview.* ***Applicants should therefore make it clear on their application form how they meet these criteria. Failure to do so will result in you not being shortlisted.*** *The stage in the process when the criteria will be measured is stated below;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

ELIGIBILITY

1. Applicants must provide evidence by the closing date for application that they are employed within a Health & Social Care organisation as defined[1]

QUALIFICATIONS / EXPERIENCE

2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant subject[2] AND have a minimum of 2 years experience in a senior management[3] role in a major complex organisation[4]
   OR
   Have a minimum of 5 years experience in a Senior Management[3] role in a major complex organisation[4]

---

[1] *This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the NI Social Care Council*

[2] *'relevant subject' will be interpreted to mean any business, administrative, corporate function or health related qualification*

[3] *'senior management' is defined as experience gained at Head of Service level or equivalent or above in a major complex organisation*

[4] *'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*

Southern Health and Social Care Trust

AND

3. Have a minimum of 2 years experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant[5] improvements.

4. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change[5] initiative.

5. Have a minimum of 2 years experience in high level people management,

6. Have a minimum of 2 years experience in governance related activity

7. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[6].

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS

8. Have an ability to provide effective leadership to enable transformation of services.

9. Demonstrate evidence of highly effective planning and organisational skills.

10. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

11. Demonstrate effective communication skills to meet the needs of the post in full.

12. Have an ability to effectively manage a budget to maximise utilisation of available resources.

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[5] 'significant' is defined as contributing directly to key Directorate level objectives of the organisation concerned.

[6] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Southern Health and Social Care Trust

DESIRABLE CRITERIA *– whilst the Essential criteria sets out the minimum requirements it may become necessary to make this more stringent by the introduction of other job related criteria as set out in the Desirable criteria.* ***Applicants should therefore make it clear on their application form how they meet these criteria****. Failure to do so may result in you not being shortlisted.*

1. Experience in the management of care services within a health and / or social care setting.

2. Experience of Financial Flows in a major complex organisation[7]

PLEASE NOTE:

It is intended that shortlisted applicants will be assessed against the criteria stated in this specification, linked to the qualities set out in the NHS Leadership Qualities Framework. Whilst candidates should be prepared to provide examples of their competence against any of the leadership qualities, particular attention will be given to the following elements;

- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Drive for improvement
- Effective and strategic influencing

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out a Protection of Children and Vulnerable Adults check (POCVA) before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

[7] *'Major Complex Organisation' will be interpreted as per essential criteria 2.*

SOUTHERN HEALTH AND SOCIAL CARE TRUST

JOB DESCRIPTION

TITLE OF POST: Assistant Director – Medical Directorate

DIRECTORATE: Medical Directorate

REPORTS TO: Medical Director

JOB SUMMARY:

The postholder will work closely with the Medical Director, Associate Medical Directors and other Trust Directors to facilitate the implementation of the strategic and operational objectives of the Trust, in line with corporate policies and strategies. In particular the postholder will have lead responsibility on the planning, implementation and progression of specific strategic objectives for which the Medical Director is accountable. The postholder will act on behalf for the Medical Director in all aspects of his role.

JOB ROLE:

The role of this post is to deliver on the strategic and operational priorities of the Medical Directorate, with a focus on:

- Medical leadership
    - Medical revalidation
    - Medical appraisal
    - Medical Job planning
    - Medical leadership development
    - Delivering on the Medical Directors/AMDs identified priorities
- Medical education
    - Undergraduate training
    - Postgraduate training
- Research & Development
- Business continuity and emergency planning
- Financial management within the Medical Directorate
- Staff management within the Medical Directorate

- Organising and participating in the Acute Services Directorate on-call rota

JOB DETAIL AND KEY RESULT AREAS:

Medical leadership

Medical Education, Revalidation and Appraisal

1. Provide managerial support to the designated Responsible Officer for the Trust in the revalidation of the Trust Medical workforce.
2. Development, implementation and on-going management of an effective scheme of medical appraisal which will meet the requirements of revalidation as defined by the General Medical Council.
3. Participation and development of collaborative working channels with regional colleagues, the DHSSPS and the General Medical Council on the development of frameworks to support the implementation of revalidation, including development of MSF, Patient and Client Feedback and on-line appraisal systems.
4. Lead role in the development of corporate responses to consultations linked to professional governance.
5. Lead role in the interpretation of professional regulatory advice in relation to appraisal, revalidation, Good Medical Practice, continuing professional development – and lead responsibility for the development and/or amendment of polices/guidelines to reflect changes.
6. Provide leadership and support for medical job planning within the Trust
7. Work with Medical HR on the development of reports and updates, on behalf of the Medical Director on professional workforce issues to Senior Management Team, Governance Committee and Trust Board.
8. Research and development of audit methodologies that provide assurance to the Responsible Officer on the quality of medical appraisal.
9. Attendance at regional and national conferences to ensure best practice within the field of clinical leadership is applied within the Southern Trust.
10. Where required, lead the development and refinement of in-house bespoke information systems to monitor appraisal processes, professional registration, continuing professional development, study leave and mandatory training of medical staff.
11. Operational responsibility for the undergraduate medical education functions in the Trust.

12. Delivery of the QUB Accountability Framework – including liaison with regional committees, implementation of quality assurance and governance arrangements for undergraduate education.
13. Explore and develop links with other undergraduate suppliers including RCSI where appropriate.
14. Development of appraisal/performance management/response to feedback mechanisms to ensure quality educational experience.
15. Operational responsibility for the Trust postgraduate medical education functions.
16. Ensure that processes exist for effective communication with all junior medical staff, irrespective of working patterns.
17. Work collaboratively with Operational and Medical HR to ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.
18. Work collaboratively with Medical HR in the preparation of business cases for Junior doctor EWTD/New Deal compliance and manage the process of obtaining internal and external approvals in line with local and regional policy and standards.
19. Management of the relationship with NIMDTA in relation to Deanery Visits and the associated remedial actions.
20. Lead responsibility for the analysis of General Medical Council – Trainer and Trainee Surveys and development of supporting action plans.
21. Work collaboratively with NIMDTA and Medical HR to support the revalidation of junior medical staff.
22. Responsibility for the development of e-learning and on-site induction programme for junior medical staff.
23. Operational responsibility for the continuing medical education of Consultant and SAS doctors.
24. Develop a comprehensive programme of supervision for new start Consultants and SAS doctors.
25. Oversee the development of a leadership development programme for Consultants and SAS doctors.
26. Oversee the implementation of the Trust's Specialty doctor Framework.

Research and Development

1. Operational management of Research and Development support staff.
2. Responsible for the implementation of a clear Research and Development strategy for the Trust.
3. Provide Trust representation at regional and national level on Research and development projects, such as ECME

Business Continuity & Emergency Panning

1. Support the Directorate Management teams in their development of processes and systems to embed business continuity management within the organisation.
2. Ensure the Trust business continuity function satisfies the requirements in relation to accountability, governance and assurance requirements as outlined in the in the context of the NI Civil Contingencies Framework (2005).
3. Support the Directorate Management teams in their development of processes, plans and systems across the Trust for emergency planning, including the achievement of compliance with the Emergency Planning Controls Assurance Standards.
4. Co-ordinate Emergency Planning exercises across the Trust and ensure the successful testing of emergency plans at hospital and bronze levels on a regular basis.
5. Co-ordinate and support Trust-wide IFR and ECR requests.
6. Management of ECRs and drug requests for Southern Trust patients and undertaking the necessary liaison with commissioners.

Financial management

1. Responsibility for the Directorate Budget including the SUMDE Undergraduate Medical Education budget, ensuring the appropriate application of financial governance arrangements

Staff management

1. Responsibility for all staff management issues for staff within the Medical Directorate.
2. Review individually, at least annually the performance of immediately subordinate staff providing guidance on personal development requirements and initiate, where appropriate, further training.
3. Maintain staff relationships and morale among staff within the Medical Directorate.
4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
5. Participate in the selection and appointment of staff.
6. Develop and maintain effective communication networks and working relationships with key persons both within and outside the organisation.

Acute Services

1. Participating in the on-call rota for AD/HOS within Acute Services, including organising and ensuring the distribution of the on-call rota

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

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

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own on-going learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

JOB TITLE: Assistant Director – Medical Directorate

QUALIFICATIONS / EXPERIENCE:

1. University degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organisation.
OR
At least 5 years experience in a senior management role in a major complex organisation.

AND

2. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant improvements

3. Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders to achieve successful outcomes.

4. Hold a full current driving license valid for use in the UK and have access to a car or access to a form of transport to meet the mobility needs of the post.

KNOWLEDGE, TRAINING & SKILLS:

5. Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

6. Demonstrate evidence of high level skills in;

a) effective planning and organisation
b) Governance and Risk Management
c) People Management

7. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

8. Demonstrate highly effective communication skills to meet the needs of the post in full.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Barry Conway
Assistant Director, Acute Services

Mary Burke

Specialties:
Acute Medicine
Emergency Medicine, CAH

Ward/Departments:
Emergency Department, CAH
Emergency Dental Service
MAU
Minor Injuries Unit
Winter Ward, CAH

Ruth Donaldson

Wards/Departments:
Social Work, CAH
Social Work, DHH
Social Work, Lurgan

Edel Corr

Wards/Departments:
Patient Support, CAH
Patient Support, DHH
Chaplaincy services

Catriona Kavanagh

Wards/Departments:
Patient Flow, CAH
Patient Flow, DHH
Hospital at night services
Phlebotomy services

Simon Gibson
Assistant Director, Acute Services

Kay Carroll	Louise Devlin	Caitriona McGoldrick **	Eileen Murray
Specialties:	**Specialties:**	**Specialties:**	**Specialties:**
Cardiology	Diabetology	Acute Geriatric	Emergency Medicine, DHH*
Dermatology	Endocrinology	Ortho-Geriatric	Nephrology
Neurology	Gastroenterology	Rehabilitation	Respiratory
	Rheumatology	Stroke	
Ward/Departments:	**Wards/Departments:**	**Wards/Departments:**	**Wards/Departments:**
Cath Lab	1 South, CAH	Level 6, DHH	Emergency Department, DHH
1 North, CAH	DCC, CAH	2 South Medicine, CAH	Female Medical, DHH
Neurology Centre	DCC, DHH	2 South Stroke, CAH	Male Medical, DHH
Dermatology Centre			2 North Respiratory, CAH
2 North Haematology			Renal Unit, DHH

* - Service responsibiity aligned to Barry Conway

** - Location of these specialties within structure for review in spring 2015

MEDICAL DIRECTOR'S OFFICE - STRUCTURE – Dec 2018 - July 2019

MEDICAL DIRECTOR
Dr Maria O'Kane
(commencing Mon 3rd Dec 2018)
Personal Assistant
Laura White
028 375 60117

Assistant Director
Simon Gibson
Admin. Support
Ruth Montgomery

Dr Martin Brown
Consultant
Microbiologist

Assistant Director Clinical and Social Care Governance / Nursing Governance
Margaret Marshall
Admin. Support Paula McCluskey

Executive Director of Nursing
Mrs Heather Trouton
Admin. Support
Maria Witczak

Emergency Planning Manager
Teresa Cunningham
- Mary Markey
- Brenda Greene (Mat leave)

Research & Development Manager
Irene Knox
- Mairead McAreavey
- Catherine McDonald

Medical Education Manager
Kelly Wylie
- Eoin Daly
- Lenore Peile
- Sonia Ferris
- Siofra McSherry

Head of Service M&M and Clinical Audit
To be app.
- Raymond Haffey
- Terri Harte
- Diane Sloane
- Jessica Torley
- Philip Sullivan

Infection Control Lead Nurse
Colin Clarke

Head of Revalidation
Norma Thompson
- **DHH**
  - Roisin Feely
  - Katie Shields (LT S/L)
- **CAH**
  - Diane Davidson
  - Patrick Morrison
  - Liz McCreary
  - Pauline Rooney

Project Manager
Stephen Wallace
- Eileen Shine
  Admin. Support

Patient Safety Manager
Colum Robinson
- Siobhan Edgar

2018 Note:
ADEPT FELLOW
Kathleen Hadden

Note:
CHIEF REGISTRAR
Wendy Baird

Received from Simon Gibson on 27/06/2022. Annotated by the Urology Services Inquiry.

Actions

1. **Chase up MY on locum – EM – set date for interview Simon, Robin and Michael? Test it out with HR.**
2. **Get revised date on workshop - SG**
3. **What are givens in the new service model? – Simon to Catherine**
4. **What is the increase in the flows to the Southern Trust? – Simon to Catherine**
5. **Setting agreed standards for the service E.g x New patients and y reviews at a clinic, and establishing an exception reporting mechanism**
6. **Contact Catherine McNicholl regarding the demand/capacity volumes as part of regional review**
7. **Benchmarking via clinical challenge from a nationally recognized expert in Urology**
8. **Message that if 3 centre model doesn't work, would revert to a 2 centre model**
9. **Get the post out to internal trawl – 8b permanent -**
10. **Date of workshop before 16th February – next week Simon**
11. **Revised paper to SMT**

Teleconference between sites for weekly core group – Monday evenings for 8 weeks – 5pm to 7pm

Robin Brown
Michael Young
Heather Troughton
Mairead McAlinden
Joy Youart
Simon Gibson
Eamon Mackle
Charlie McAllister

Monthly communication meeting

Terms of Reference for Urology Review

The Urology Review will be led by the Director of Acute Services, and will deliver the following project objectives:

- An agreed analysis of the capacity gap in relation to urology services, recognising the impact of the Regional Review.

- Assess the current service against the standards set out in 'Action On' Urology and IOG Guidance and, where standards are not currently met, bring forward agreed plans to address same

- Develop an agreed cross site service model including ICATs to deliver assessed future demand, including potential future business which could be generated from other commissioners, through either:
    - The new model of urology services for NI as recommended by the Regional Urology Review Group
    - Demand from HSE

  and service standards as set out in 'Action On' and IOG guidance.
- The development of agreed team job plans to deliver this model.

- The development of a business case to commissioners to deliver the agreed model of care.
- Developing the sustainability of the service and reducing costs through the urgent progression to recruit funded consultant and other posts on a permanent basis.

Southern Health and Social Care Trust

Acting Director of Acute Services
Administration Floor
Craigavon Area Hospital

Acting Chief Executive
Directors
Assistant Directors, Associate Medical Directors and Heads of Service – Acute Services
Southern Health & Social Care Trust

17 September 2009 **Our Ref:** JY/njh **Your Ref:**

Dear colleague

Best Care Best Value Role – Acute Services Directorate

In view of the increasing importance and significance of the BCBV role within the Trust, I have decided there is a need to raise the profile and to expand the remit of this role throughout the Acute Services Directorate. Simon Gibson has agreed to undertake this key role as Assistant Director for BCBV and Income Generation.

I see this role as critical to our efforts to find new ways to address the financial gap and to explore new ways of delivering Acute Services in accordance with best practice, whilst achieving financial balance in the future.

Heather Trouton has agreed to undertake Simon's current duties and responsibilities as Assistant Director for the Surgical & Elective Care Division, in an acting up capacity to release Simon to undertake this critical role. Handover arrangements will commence on Monday 21 September 2009, with a view to the new arrangements being fully in place by 5 October 2009.

I look forward to your continuing support for Simon and Heather in their new roles.

Yours sincerely

Personal Information redacted by the USI

Mrs Joy Youart
Acting Director of Acute Services

Acute Services Directorate

Surgical and Elective Care Division

Maintaining elective access standards 2009-10

Context

With the restructuring of all divisions into pathways of care, and the appointment of Heads of Services and Service Administrators within the surgical division, it is necessary to clarify what impact the new arrangements will have on the accountability for the delivery of the standards during 2009-10.

Accountability

From 1st April 2009, accountability for maintaining the elective access standards will sit with the relevant Head of Service.

The role of the Operational Support Lead will be to support the Service Administrators in the

Specialties and Access Standards

Specialty	Access Target	Maximum waiting time	Accountability
General Surgery	Out-patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service
ENT	Out-Patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	ICATS	Sustaining 9 weeks until March 2010	Head of Service
	Diagnostics (Sleep studies)	Sustaining 9 week until March 2010	Head of Service

	Diagnostic Reporting Turnaround Times	Urgent within 48 hours Routine within 28 days This is a standard, rather than a target, but monitored by SDU.	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service

Urology	Out-Patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	ICATS	Sustaining 9 weeks until March 2010	Head of Service
	Diagnostics (Sleep studies)	Sustaining 9 week until March 2010	Head of Service
	Diagnostic Reporting Turnaround Times	Urgent within 48 hours Routine within 28 days This is a standard, rather than a target, but monitored by SDU.	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service
T&O	Out-patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service
	Fracture Target	??need to check??	Head of Service
Oral Surgery	Out-patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service
Ophthalmology	Out-patient PTL	Sustaining 9 weeks until March 2010	Head of Service
	Elective PTL	Sustaining 13 weeks until March 2010	Head of Service

Process for Dealing with all PTLs

- Capacity and Demand modelling
- Identification of Gap for SMT
- Maximising in-house capacity for specialty
- Securing and arranging in-house additionality to address gap
- Identification of patients for transfer to Independent Sector to IS team
- Weekly/daily monitoring of PTL reports as required
- Responding to Risk Reports from Performance
- Completion of breach reports

All the above steps in the process will become the responsibility of the Head of Service with effect from: XXXXXX

Until such times as Head of Service are in post for General Surgery, Urology and ENT, OSL will continue to support these specialties.

Performance Management/Accountability

Fortnightly accountability meetings have already been set up with Heads of Service. These will take the format of:

- Key Performance Indicators
- Timetables
- Performance management of internal capacity
- Actions taken to avert breach situations
- Breach reports

Division Structure to Support New Model

The Divisional structure will support a patient pathway model, with each Head of Service having a Service Administrator to support them in the delivery of access targets, however, it will remain the responsibility of the Head of Service to deliver the target.

At present the Operational Support Lead currently meets with the Service Administrators on a weekly basis to discuss areas of risk within each specialty. This will/will not continue????

Reporting arrangements for Service Administrators and their clerical teams will still remain the responsibility of the Operational Support Lead.????

What is my function in PTLs? Is there any now??

Gibson, Simon

From: Gibson, Simon <[redacted]>
Sent: 14 May 2008 10:36
To: Cunningham, Teresa; Mitchell, Clifford; Glenny, Sharon; Meredith, Jane; Wilson, Roberta; Devlin, Louise; ODonnell, Noleen
Subject: FW: IEAP April 2008
Attachments: Integrated Elective Access Protocol Revised 30apr08.doc; IEAP Cover Letter April 08.doc; IEAP April 2008 Training Presentation.ppt; IEAP Executive Summary April 08.doc; Revised IEAP Appendices April 08.zip

Dear all

The IEAP Cover Letter April 08 document gives the context for this issue, which you will all need to be familiar with and ensure that processes within your own span of control are within the IEAP parameters.

Kind regards

Simon

From: Hayes, Nicola
Sent: 13 May 2008 16:41
To: Anita Carroll; Gibson, Simon; McVey, Anne; Ronan Carroll; Stead, Lindsay
Cc: Burrell, Gail; McCullough, Elizabeth; Shauna (Anita's Secretary); Valerie (Ronan's Secretary)
Subject: FW: IEAP April 2008

Hi everyone

For information/action as necessary.

Please note that some of these documents contain pages from 25-80 in total!!!!

Many thanks and kind regards.

Nicky

Nicky Hayes

Personal Assistant to Mrs Joy Youart, Acting Director of Acute Services

Southern Health & Social Care Trust

Craigavon Area Hospital

Personal Information redacted by USI (Direct Line)

_____

From: Grant, Pauline On Behalf Of McAlinden, Mairead
Sent: 12 May 2008 10:31
To: Dillon, Martin; Donaghy, Kieran; Dornan, Brian; Loughran, Patrick; McAlinden, Mairead; McCall, Jim; Rankin, Gillian; Rice, Francis; Hayes, Nicola; Mallagh-Cassells, Heather(Kieran Donaghy's Sec); Morrison, Denise; Rees, Sharon; Taylor, Karen (Older People & Primary Care); Tracy McShane; White, Laura; Wright, Elaine
Subject: IEAP April 2008

Dear All

Please find attached for information and circulation to key staff.

Kind regards

Pauline

Mrs Pauline Grant

Personal Assistant to

Mrs Mairead McAlinden

Director of Performance and Reform

Southern Health and Social Care Trust

Tel Personal Information redacted by USI

Fax: [redacted]

Email: [redacted]

_____

From: Mills, Ursula [mailto: [redacted]]
Sent: 08 May 2008 14:58
To: [redacted]; norma.evans [redacted] john.compton [redacted]; william.mckee [redacted]; colm. [redacted]
Cc: antoinette.gallagher [redacted]; taylor, emma; susan.hogg [redacted]; elaine.wright [redacted]; Sullivan, Dean; Bloomfield, Michael; michelle.irvine [redacted]; Mullen, Hugh; jennifer.thompson [redacted]; hugh.mccaughey [redacted]; Stockman, Denise; sloan, martin; Mairead.Mcalinden [redacted]; Simpson, John; Lusby, Joe; Patricia Donnelly ; Hinton, Catherine; McGoran, Seamus; Margaret.Kelly [redacted]; joy.youart [redacted]; Wright, Maria
Subject: IEAP April 2008

<<Integrated Elective Access Protocol Revised 30apr08.doc>> <<IEAP Cover Letter April 08.doc>> <<IEAP April 2008 Training Presentation.ppt>> <<IEAP Executive Summary April 08.doc>> <<Revised IEAP Appendices April 08.zip>>

Dear All

Please find attached the following documents:

* Cover Letter
* Revised Integrated Elective Access Protocol
* Executive summary
* Appendices
* PowerPoint presentation

Thank you
Ursula

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that any use, dissemination, forwarding, printing, or copying of this email is strictly prohibited. If you have received this email in error please notify the sender.

This email is confidential and intended solely for the use of the individual(s) to whom it is addressed. Any views or opinions presented are solely those of the author and do not necessarily represent those of Southern Health and Social Care Trust. If you are not the intended recipient, be advised that you have received this email in error and that

Southern Health and Social Care Trust

ADDRESSING REVIEW BACKLOGS

Louise Devlin, Head of Outpatients, Ophthalmology, Oral Surgery & Dentistry
Directorate of Acute Services
Date: 27 June 2022

CONTEXT

A large number of specialties within the Southern Trust have considerable volumes of patients whose review appointments are overdue some are waiting in excess of 1 year past the date their review appointment was due. This has arisen due to a number of factors:

- The access targets for outpatients have placed the focus on ensuring that all new routine appointments are seen within maximum waiting times. In order to achieve this additional clinics have been set up to see new routine patients within specialties where there are capacity shortfalls. However, no additional resources were invested in creating review capacity to see the review appointments which converted from additional new appointments. These reviews were added to existing clinic capacity which was insufficient to cope with them.
- The access targets for Red Flag patients have also had an impact on capacity to see review patients. Clinic templates have had to be set such that Red Flag patients, New Routine patients and New Urgent patients have protected appointment slots sometimes at the expense of review patients.
- When doctors are on leave there is no backfill provided to ensure clinic capacity is maintained. Whilst the access targets mean that capacity has to be ensured for new routine and Red Flag patients no provision is made for backfilling review appointment capacity. This has a particularly significant impact following peak holiday periods eg summer.

In order to manage the high volume of outpatient reviews solutions have been developed on a specialty basis. It is recognised that calling all patients for review appointments may not now be clinically appropriate as some reviews may no longer be necessary. Therefore casenote reviews will be undertaken by Consultants in a number of specialties where there may be alternatives to consultant review. During this exercise the Consultant will determine the status of the patients and will determine the most appropriate outcome for the patient from the options being developed.

In addition specialties are developing protocols to ensure consistency within the specialty and that reviews are only undertaken where clinically necessary. For example certain post-op conditions will no longer be routinely reviewed, some may be clinically managed with a telephone review, others will be discharged to the GP with advice.

GPs have been advised that this work is due to commence by the Associate Medical Director for Primary care and an article was placed in their practice magazine with regard to the processes which will be undertaken for casenote reviews. Feedback to date has been positive.

All review appointments will be partial booked, which may reduce the number of appointments required as patients will 'ROTT' through either non response to partial booking letters or may contact the booking office to advise they no longer wish to have an appointment. Unfortunately there is no information available with respect to 'ROTT' rates for review appointments.

SPECIALTY ANALYSIS

Each specialty has agreed on the maximum number of patients to be reviewed per session. These figures vary from specialty to specialty which reflects the fact that some types of patients take longer per consultation.

The costing for Nursing support is Band 5/3. Whilst every effort will be made to ensure least cost per specialty it will not always be possible to provide nursing support at Band 3 level as there are insufficient staff trained to this level and therefore we will have to use resources available ie Band 5 nursing.

Several options have been worked up for each specialty. All of these options will require 'sign-up' from Medical Staff particularly those which incur a risk eg Option 3, discharging all patients whose review appointment is over a year past their due date.

General Surgery

In General Surgery a total of 2838 patients have not received their review appointment on their due date. Some patients have been waiting up to 2 years past their appointment due date. Within this specialty it was acknowledged that it may no longer be necessary for the patient to attend a consultant outpatient appointment due to the length of time their appointment is overdue and alternatives to bringing all patients back to an outpatient clinic were considered. It was agreed that a casenote review would be undertaken dealing with 30 casenotes per session. An outcomes form will be completed for all patients detailing the following outcomes:

- Discharge to GP – write to GP + possibly patient if required
- Add to a Waiting List
- Investigations
- Review by Consultant – either named or any
- Telephone Patient

CASENOTE REIVEWS	
Total Number of Reviews Backlogged	2838
No. of Patients per casenote review	30
Number of Casenote review sessions	95
Cost of Casenote Reviews(Consultant) 95 x £Commercially Sensitive	£Commercially Sensitive information redacted by USI
Cost of Casenote Reviews (Health Records) 2860 x 20 min x £14,33/hr	£Commercially Sensitive information redacted by USI
Total Cost Casenote Review	£Commercially Sensitive information redacted by USI

Two pilot casenote reviews have been completed on 25 patients with 2 consultants undertaking the exercise on the same set of casenotes. The results of these were very different indicating different clinical practice.

Consultant 1 - would discharge 44% whilst 56% would come back to an outpatient clinic.
Consultant 2 - would discharge 24% whilst 76% would come back to an outpatient clinic.

Therefore a protocol has been developed to govern the practice to be undertaken in the casenote reviews. Based on the average of these outcomes it is expected that 34% of the total number of backlogged reviews would be discharge ie 972 patients would be discharged. Approximately 1888 patients would therefore require an outpatient appointment.

Figures for Telephone reviews are not reliable as Consultant 1 would have done 5 telephone reviews out of a sample of 24 patients ie 21% however Consultant 2 did not assign any patients to telephone reviews.

GENERAL SURGERY	
Total Number of Patients	2838
No. Patients per clinics	15

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
	Band 2	4	£58.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£101.88
Goods & Services			£196.40
Total Cost per Clinic			£1,147.28

Additional equipment will have to be purchased to facilitate turnaround of sterilisation and ensure appropriate equipment is available for existing scheduled outpatient clinics.

Equipment List	Number	Cost – Each	Total Cost
IRC Rods	4	£1,000	£4,000
76cm basket	4	£38	£152
76cm Lid	4	£33	£132
Silicon insert	4	£28	£112
Sigmoid heads	4	£188	£752
Cassette for sigmoid head	4	£27.75	£111
		Total Cost	£5,259

Within General Surgery the Consultants recognise that junior staff who see patients at their clinics would tend to bring patients back for review more readily. Therefore processes with respect reviews and the type of patients who are reviewed could be tightened. A protocol is being developed which will be used by all doctors within the specialty and will give guidelines with respect to those patients who should be offered review appointments. One Consultant will pilot a process starting week commencing 20th October whereby junior staff will not be allowed to bring patients back for review unless the Consultant has 'signed off'.

OPTIONS

Option 1: See All backlog Review Patients

2838 patients @ 15 patients per clinic = 189 clinics x £1,147.28 per clinic = £21,836 + equipment cost of £5,259 =

Total Cost = £222,095

Option 2: Undertake Casenote Review + Outcome clinics

2838 patients @ 30 patients per casenote review = 95 sessions = £69,806. 126 outcome clinics x £1,147.28 per clinic = £144,557 + equipment cost of £5,259 = £149,816

Total Cost = £219,622

Undertaking a casenote review + outcome sessions equates to 221 Consultant sessions in comparison to only 189 Consultant sessions if all backlog review patients were seen at clinic.
Therefore not undertaking a casenote review would mean 32 fewer sessions by consultants with an extra cost of only £2,473.

The discharge rate from the casenote reviews is very subjective and as seen above could vary from 24% to 44%. If a discharge rate of only 24% is achieved this would increase the number patients to be reviewed to 2157 with an associated cost of £170,467. Therefore the total cost of the casenote review would be £240,273 ie £18,178 more expensive than seeing all patients at clinic.

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

634 patients are 1 year past their required review appointment date.
2838 – 634 = 2204 @ 15 patients per clinic = 147 clinics x £1,147.28 per clinic - £168,650 + equipment cost =

Total Cost = £173,909

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months of review backlog = 499 patients
2838 – 499 = 2339 @ 15 patients per clinic = 156 clinics x £1,147.28 per clinic = £178,976 + equipment cost £5,259 =

Total Cost = 184,235

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last month of review backlog = 275 patients
2838 – 275 = 2563 @ 15 patients per clinic = 171 clinics x £1,147.28 = £196,185 + equipment cost £5,259 =

Total Cost = £201,444

Option 6: Option 2 + Option 3

2838 – 634 – 499 = 1705 @ 15 patients per clinic = 114 clinics x £1,147.28 = £130,790 + equipment cost £5,259 =

Total Cost = £136,049

Option 7: Option 2 + Option 4

2838 – 634 – 275 = 1929 @ 15 patients per clinic = 127 clinics x £1,147.28 per clinic = £145,705 + equipment £5,259 =

Total Cost = £150,964

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 additional review patient onto all clinics within the specialty on the CAH, STH and BBPC sites where the problems lies x 13 clinics per week x 35 weeks (ie accounting for Surgeon of Week Rota) will increase review capacity by 455 reviews in the year.

Breast Surgery

There are 404 Breast Surgery patients whose review appointments are overdue. These are mainly as a result of the suspension of the Banbridge Polyclinic outpatient clinic being suspended during the period of the Doctor's maternity leave.

BREAST SURGERY	
Total Number of Patients	404
No. Patients per clinics	15

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
	Band 2	4	£58.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£101.88
Goods & Services			£196.40
Total Cost per Clinic			£1,147.28

Recommendations:

- Reinstate Monday morning clinic in BBPC either following return from maternity leave of Doctor - January.
- Convert Daisyhill Hospital Consultant workload to stop doing new outpatients at Daisyhill and do BBPC clinic on Monday morning.
- Associate Specialist undertake BBPC Monday morning clinic in meantime.

Reinstating the BBPC clinic will eliminate the requirement for additional clinics.

OPTIONS

Option 1: See All backlog Review Patients

Total of 404 patients @ 15 patients per clinic – 27 clinics x £1,147.28 per clinic =

Total Cost = 30,976

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months of Review Backlog = 147 patients
404 – 147 = 257 @ 15 patients per clinic = 17 clinics x £1,147.28 =
Total Cost = 19,504

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 month of Review Backlog = 84 patients
404 – 84 = 320 patients @ 15 patients per clinic x 21 clinics =
Total Cost = 24,093

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

If BBPC clinic is reinstated, this equates to 2 clinics per week x 42 weeks equates to an increase in review capacity in this area of 84 patients per year.

Cardiology

Within Cardiology a total of 570 patients have not received their review appointment on their due date. Some of these patients have been waiting up to 1 year past their appointment date. As the consultant sees all patients within this specialty it was felt that processes with respect to review appointments are as tight as they can be and therefore all patients on the review list would require to be seen back at clinic and no value would be gained through a casenote review. It was agreed that 14 patients could be seen in a review clinic.

These figures include Paediatric Cardiology which has a backlog of 49 patients. This Consultant has been doing additional new clinics to address shortfalls in capacity to see new patients within maximum waiting time targets. However no additional capacity has ever been created to address any resultant review patients.

CARDIOLOGY	
Total Number of Patients	570
No. Patients per clinics	14

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3.5	£50.00
Outpatient Booking Staff	Band 3	3.5	£57.00
Secretarial Support	Band 4/5	5.8	£94.54
ECG	ATO Band 3 or MTO1 Band 5	4	£65.00
Goods & Services			£182.22
Total Cost per Clinic			£1,121.76

Recommendations:

Cardiology should amend the balance of their clinic templates to convert new capacity to review capacity. Amending all clinic templates to convert 1 new outpatient slot to 2 review slots will create an additional 10 review slots over the CAH, STH and BBPC clinics which have the backlogs x 42 weeks equates to 420 additional review capacity in the year.

It should be noted that one Consultant has a much higher backlog than the others which would indicate a different clinical practice which may need to be addressed.

OPTIONS

Option 1: See All backlog Review Patients

570 patients @ 14 patients per clinic = 41 clinics x £1,121.76 =
Total Cost = £45,992

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months backlog = 144 patients
570 – 144 = 426 @ 14 patients per clinic = 30 clinics x £1,121.76 =

Total Cost = £33,653

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months backlog = 92 patients
570 – 92 = 478 @ 14 patients per clinic = 34 clinics x £1,121.76 =

Total Cost = 38,140

Option 6: Option 2 + Option 3

Not Applicable.

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 additional review patient per clinic (including Paediatric Cardiology) equates to 7.5 clinics per week x 42 weeks = an increase in review capacity of 315 patients over the year.
However losing 1 clinic per week to Daycases will reduce this capacity to 6.5 clinics per week x 42 weeks – an increase in review capacity of 273 review patients over the year.

Paediatric Medicine

Within Paediatric Medicine there are 653 patients who have overdue review appointments, some patients have been waiting 11 months past their review date.
It was agreed that casenote reviews would be undertaken within this specialty to determine the following outcomes:

- Review Any Consultant
- Review Named Consultant
- Telephone Review
- Write to Patient/GP
- Refer to AHP eg Dietician

CASENOTE REVIEWS	
Total Number of Patients	653
No of patients per casenote review	20
No. of Casenote Review sessions	33
Cost of Casenote Reviews (Consultant) = 33 x £591	£19,503
Cost of Casenote Review (Health Records) 661 x 20min x £14.33/hr	£3,157
Total Cost Casenote Review	£22,660

A pilot casenote review has been undertaken of 20 patients. The results were as follows:
20% require Telephone Review
10% to be discharged to GP
70% require outpatient clinic review – of these 70% the patients were re-prioritised with respect to urgency.

In order to tighten the processes with respect to which patients receive review appointments it was agreed that no juniors would appoint a review unless they can justify the reason and the consultant agrees.
Based on this casenote review approximately 463 patients will require outpatient clinic appointments.

PAEDIATRIC MEDICINE	
Total Number of Patients	463
No. Patients per clinics	12

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3	£43.00
Outpatient Booking Staff	Band 3	3	£49.00
Secretarial Support	Band 4/3	5	£81.50
Goods & Services			£157.43
Total Cost per Clinic			£1,006.93

OPTIONS

Option 1: See All backlog Review Patients

653 patients @ 12 patients per clinic = 54 clinics x £1,006.93 =

Total Cost = 54,374

Option 2: Undertake Casenote Review + Outcome clinics

653 patients @ 20 patients per session = 30 sessions = £22,660
Outcome clinics = 39 x £1,006.93 per clinic = £39,270 =

Total Cost = 61,930

Undertaking a casenote review in this specialty will require an additional 15 consultant sessions and incur a cost of £7,556 more than seeing all patients at clinic.

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable.

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months review backlog = 307 patients
653 – 307 = 346 @ 12 patients per clinic = 29 clinics x £1,006.93 per clinic

Total Cost = 29,201

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months review backlog = 208 patients.
653 – 208 = 445 @ 12 patients per clinic = 37 clinics x £1,006.93 per clinic

Total Cost = 37,249

Option 6: Option 2 + Option 3

Not Applicable.

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 additional review slot to each clinic in CAH & STH will equate to 13 clinics x 35 weeks (on call rota reduces the normal 42 working weeks

capacity) equates to an increase in capacity in the specialty of 455 review appointment slots over the year.

Gynaecology

In Gynaecology there are 893 patients who have overdue review appointments. Some of these have been waiting over 3 months past their appointment date. Within this specialty it was agreed that it would be more useful and would reduce the clinical risk if all review patients were seen at an outpatient clinic.

In addition this specialty will audit the backlog review clinics to determine the type of patients brought back for review and if they could be managed differently. Also it will inform if all practice is uniform and in line with best practice for the specialty. The outcomes from this audit will then dictate protocols for the specialty to be implemented for all future review practice. It is envisaged that this protocol could be developed before the completion of the all the backlog clinics and implemented to ensure future reviews are managed appropriately and another backlog does not develop.

It was agreed that the maximum clinically acceptable number of reviews per doctor would be 12.

GYNAECOLOGY	
Total Number of Patients	893
No. Patients per clinics	12

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5	4	£91.00
Health Records	Band 2	3	£43.00
Outpatient Booking Staff	Band 3	3	£49.00
Secretarial Support	Band 4/3	5	£81.50
Goods & Services			£155.57.00
Total Cost per Clinic			£1011.07

OPTIONS

Option 1: See All backlog Review Patients

893 patients @ 12 patients per clinic = 74 clinics x £1,011.07 per clinic =

Total Cost = £74,819

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months review backlog = 371 patients
893 – 371 = 522 @ 12 patients per clinic = 44 clinics x £1,011.07 per clinic

Total Cost = £44,487

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months review backlog = 204 patients
893 - 204 = 689 patients @ 12 patients per clinic = 57 clinics x 31,011.07 per clinic =

Total Cost = 57,631

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 additional review slot per clinic across CAH, STH, ACH and BBPC will equate to 8.5 clinics per week x 42 weeks equates to an increase in review capacity over the year of 357 patients.
Including DHH in this action will equate to 11.5 clinics which is an increase in review capacity of 483 patients per year.

General Medicine

General Medicine has 222 overdue review appointments within the specialty, some waiting over 5 months past their due date. However the bulk of these patients (163) lie with one consultant. This is a result of a particular group of patients ie Coeliac patients who require yearly review. It is recognised by this Consultant that alternatives to Consultant review are possible and therefore these options will be worked through to remove the bulk of this group of patients from his list. Alternatives are yearly review by Dietetics or GPs under protocol.

The remainder of the backlog are smaller numbers spread over all other consultants which do not necessarily require additional clinics to address but have arisen due to lack of backfill for clinics over the summer period.

As this specialty has stringent review practices in place it was agreed that it would be necessary for all patients to be reviewed at an outpatient clinic. The maximum number of patients to be seen per doctor per clinic is 12.

GENERAL MEDICINE	
Total Number of Patients	222
No. Patients per clinics	12

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3	£43.00
Outpatient Booking Staff	Band 3	3	£49.00
Secretarial Support	Band 4/3	5	£81.50
Goods & Services			£151.39
Total Cost per Clinic			£1,000.64

OPTIONS

Option 1: See All backlog Review Patients

163 patients @ 12 patients per clinic = 14 clinics x £1006.64 per clinic =

Total cost =£14,009

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months of backlog patients = 50 patients
163 – 50 = 113 @ 12 patients per clinic x £1006.64 per clinic =

Total Cost = £9,006

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 month of backlog patients = 31 patients
163 – 31 = 132 @ 12 patients per clinic x £1,006.64 per clinic =

Total Cost = £11,007

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicble

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 patient per clinic to this clinic x 42 weeks will increase capacity to see 42 review patients.

Urology

In Urology there are 2309 patients with overdue review appointments. A number of these have been waiting up to 1 year past their appointment due date. It was agreed that a pilot casenote review would be undertaken on 30 patients to determine if casenote reviews are a possible solution to the backlog.

The possible outcomes of the Casenote Review are as follows:

- Review appointment
- Determine urgency
- Investigations
- Write to GP/Patient
- Refer to ICATS
- Refer to Stable Oncology
- Discharge

The result of the pilot casenote review on 30 patients indicated that no patients could be discharged and 30% could possibly go to ICATS clinics. However, as the ICATs clinics are already running to capacity this would not be a feasible solution.

Within this specialty there are plans to appoint 2 Research Fellowes. The Research Fellowes would attend existing outpatient clinics and thereby increase their capacity to see reviews by approximately 35 patients per week. It was felt that undertaking casenote reviews would only increase the cost of the specialty solution without little reward. The most productive outcome for this specialty therefore would be expediting the recruitment of the Research Fellows, which over a 3 month period, ie December until the end of March 2009 would increase the capacity to see review patients by approximately 490 patients leaving a balance of 1819 patients to be seen at additional Consultant clinics.

UROLOGY	
Total Number of Patients	2309
No. Patients per clinics	12

Staffing per Clinic	Band	Number of Staff	Cost
Consultant			£656.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3	£43.00
Outpatient Booking Staff	Band 3	3	£49.00
Secretarial Support	Band 4/3	5	£81.50
Goods & Services			£157.02
Total Cost per Clinic			£1071.27

Without the appointment of the 2 research registrars this specialty will require 192 clinics at a cost of £205,684.

Recommendation

New to Review ratios within this specialty are totally out of line with National Averages. As there are considerable backlogs in this specialty the New to Review ratio is not an accurate reflection of actual new to review practice. A locum Consultant Urologist could be employed to undertake a sample of backlog review clinics eg 10 clinics and audit the outcomes to determine if practice should be altered with respect to the number and frequency of reviews offered to patients and the types of patient reviewed.

OPTIONS

Option 1: See All backlog Review Patients

2309 patients @ 12 patients per clinic 192 clinics x £1071.27 per clinic =

Total Cost = £205,684

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months review backlog = 459 patients
2309 – 459 = 1850 @ 12 patients per clinic = 154 clinics x £1071.27 per clinic =

Total Cost = £164,976

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months review backlog = 247 patients
2309 – 247 = 2062 @ 12 patients per clinic = 172 clinics x £1071.27 per clinic =

Total Cost = £184,258

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 extra patient to each clinic equates to 5 per week x 42 weeks will increase review capacity by 210 patients per year.

Option 9: Employ 2 Research Fellowes which will increase capacity to see 35 review patients per week x 42 weeks will increase capacity by 1470 over the year.

December to March 2009 will increase capacity by 490 reviews
2309 – 490 = 1819 @ 12 patients per clinic = 153 clinics x £1071.27 per clinic =

Total Cost = £162,833

Neurology

Within Neurology there are 465 overdue reviews, some of which have waited 5 months past their due date. As stringent processes are currently in place with respect to reviews and as it is the Consultant who normally sees all patients no value would be gained from alternatives to outpatient review. However, it should be noted that approximately 50% of the overdue review appointments are attributable to the fact that there has been a gap in service provision since Dr Esmonde, visiting consultant from RVH left the Trust. Therefore when this backlog is eliminated it is hoped that a backlog would not build in the future. It was agreed that the maximum number of review patients who could be seen by 1 doctor at clinic would be 15.

NEUROLOGY	
Total Number of Patients	465
No. Patients per clinics	15

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£101.88
Goods & Services			£193.67
Total Cost per Clinic			£1086.55

An additional Review clinic has commenced within this specialty whereby Dr Forbes converted a RVH session which he no longer does to do a weekly review clinic. This clinic sees 8 patients which will increase review capacity by 336 (ie x 42 weeks) over the year. The full effect of this may not be realised as this consultant had a practice of overbooking existing clinics with reviews. This practice will cease with the commencement of the dedicated Review Clinic. Started October 2008.

OPTIONS

Option 1: See All backlog Review Patients

465 patients at 15 patients per clinic = 31 clinics x £1086.55 per clinic =

Total Cost = £33,683

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months review backlog = 212 patients
465 – 212 = 253 @ 15 patients per clinic = 17 clinics x £1086.55 per clinic =

Total Cost = £18,471

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months review backlog – 117 patients
465 – 117 = 348 patients @ 15 patients per clinic = 23 clinics x £1086.55 per clinic =

Total Cost = 24,984

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 review patient per clinic x 7 clinics per week x 42 weeks will increase overall review capacity by 294 patients per year.

ENT

In ENT there are 1744 overdue review appointments the oldest of which are 8 months past their due dates. Within this specialty it was considered that all patients should be seen at outpatients clinics and that no value would be gained from casenote reviews as the Consultant and not junior staff see all patients. Therefore it would be more effective to see the patients at clinic, with the maximum number of review patients seen per doctor being 15.

Additional equipment will have to be purchased to facilitate turnaround of sterilisation and ensure appropriate equipment is available for existing scheduled outpatient clinics.

Equipment List	Number	Cost – Each	Total Cost
Flexible Scopes	3	£3,195	£9,585
Rigid Scopes	3	£1,650	£4,950
Storz Sterilisation basket	3	£150	£450
		Total Cost	£14,985

ENT	
Total Number of Patients	1744
No. Patients per clinics	15

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.0
Nursing Staff	Band 5/3	4	£85.00
	Band 2	4	£58.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£102.25
Audiology	Band 6 x 2	4 x 2	£226.00
Goods & Services			£198.07
Total Cost per Clinic			£1,375.32

Some value may be gained from ICATs if these services were to commence.

OPTIONS

Option 1: See All backlog Review Patients

1744 patients @ 15 patients per clinic = 116 clinics x £1,375.32 per clinic = £159,537 + equipment cost ££14,985 =

Total Cost = £174,522

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months Review Backlog = 809 patients
1744 – 809 = 935 @ 15 patients per clinic = 62 clinics x £1375.32 per clinic = 385,270 + equipment cost £14,985 =

Total Cost = 100,255

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 month Review Backlog = 456 patients
1744 – 456 = 1288 @ 15 patients per clinic = 86 clinics x £1,375.32 = £118,278 + equipment cost £14,985 =

Total Cost = £133,263

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 Review patient per clinic x 20 clinics per week x 42 weeks will increase review capacity by 840 patients per year.

Ophthalmology

This specialty is maintained with visiting Consultants from RVH. Within Ophthalmology there are 1255 patients with overdue appointments some waiting up to 1 year past their appointment date. Because of the nature of this specialty it was agreed that all patients should be reviewed by a consultant, with the maximum number of patients being seen per session being 15.

OPHTHALMOLOGY	
Total Number of Patients	1255
No. Patients per clinics	15

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£101.88
Goods & Services			£193.93
Total Cost per Clinic			£1,086.81

OPTIONS

Option 1: See All backlog Review Patients

1255 patients @ 15 patients per clinic = 84 clinics x £1086.81 per clinic =

Total Cost = £91,272

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable.

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months Review Backlog = 565 patients.
1255 – 565 = 690 patients @ 15 patients per clinic = 46 clinics x £1086.81 per clinic =

Total Cost = £49,993

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months Review Backlog = 292 patients
1255 – 292 = 963 patients @ 15 patients per clinic = 64 clinics x £1086.81

Total Cost = £69,556

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 review per clinic x 12 clinics x 42 weeks equates to an increase in review capacity of 504 patients per year.

Rheumatology

Rheumatology has 426 patients with over due appointments. A number of these patients have been waiting 18 months past their review date. Within this specialty it was agreed that there would be no value in undertaking casenote review and that all patients should be brought back to an outpatient appointment. The maximum number of patients to be seen per clinic is 10.

When the backlog patients have been seen within this specialty it is acknowledged that the nature of these patients and their requirements will mean that a large percentage will return for a number of appointments. Therefore there may be a bulge in appointments in the future. Until the patients have been seen it is not possible to determine what the conversion rate will be nor quantify the full extent of future reviews. However it is noted that the appointment of a fourth consultant and the commencement of the new anti TNF clinic may reduce this knock on effect.

RHEUMATOLOGY	
Total Number of Patients	426
No. Patients per clinics	10

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
Health Records	Band 2	2.5	£36.00
Outpatient Booking Staff	Band 3	2.5	£41.00
Secretarial Support	Band 4/3	4.17	£68.24
Goods & Services			£133.33
Total Cost per Clinic			£954.57

Nurse Led Clinic will commence 3rd December 2008 which will increase review capacity by 6 patients per week x 14 weeks until end March will reduce backlog by 84 Review patients making the backlog 342 patients.

OPTIONS

Option 1: See All backlog Review Patients

342 patients @ 10 patients per clinic = 34 clinics x £954.57 per clinic =

Total Cost = £32,455

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months Review Backlog = 123 patients
342 – 123 patients = 213 @ 10 patients per clinic x £954.57 per clinic =

Total Cost = £21,001

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months Review Backlog = 76 patients
342 – 76 = 266 patients @ 10 patients per clinic = 27 clinics x £954.57 per clinic =

Total Cost = £25,773

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 review per clinic x 8 clinics per week x 42 weeks will equate to an increase in review capacity of 336 patients per year.

Option 9: The Nurse Specialist has the capacity within her job plan to work alongside 2 addition clinics per week which will be an additional 12 patients per week x 14 weeks (Dec until end March 2009) which will give capacity to see an additional 168 patients and reduce the number to be seen at consultant clinics to 174 with a resultant cost reduction to £16,228 however additional clinic rooms are required to facilitate this. As there are currently none available at the clinic times rooms will have to be created by displacing non clinical use of rooms in the outpatient department and refurbishing these (costs detailed under sustainability).

Thoracic Medicine

Within this specialty there are 346 patients with overdue appointments all of which are required to be seen at an outpatient clinic. A number of patients have been waiting up to 6 months past their due date. It was agreed that the maximum number of patients who could be seen in a clinic is 12.

When the backlog patients have been seen within this specialty it is acknowledged that the nature of these patients and their requirements mean that a large percentage will be required to return for a number of appointments. Therefore there may be a bulge in appointments in the future which is not possible to quantify in advance.

THORACIC MEDICINE	
Total Number of Patients	346
No. Patients per clinics	12

Staffing per Clinic	Band	Number of Hours	Cost
Consultant			£591.00
Nursing Staff	Band 5/3	4	£85.00
	Band 2	4	£58.00
Health Records	Band 2	3	£43.00
Outpatient Booking Staff	Band 3	3	£49.00
Secretarial Support	Band 4/3	5	£81.25
Lung Function	Band 5/6	4	£91.00
Radiology	Band 6 x 2	4	£226.00
Goods & Services			£156.86
Total Cost per Clinic			£1381.11

An alternative solution would be for a Locum to see all new patients and free up the existing consultants to see their own reviews, therefore the cost per clinic would be £988.86 as a Locum cost is £151 reducing the specialty cost to £28,677.

OPTIONS

Option 1: See All backlog Review Patients

346 patients @ 12 patients per clinic = 29 clinics x £1381.11 per clinic =

Total Cost = £40,052

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months Review Backlog = 128 patinets
346 – 128 = 218 patients @ 12 patients per clinic = 18 clinics x £1,381.11 per clinic =

Total Cost = £24,860

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months Review Backlog = 90 patients
346 – 90 = 256 @ 12 patients per clinic = 21 clinics x £1381.11 per clinic =

Total Cost = £29,003

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 extra review slot per clinic = 4 clinics x 42 weeks will equate to an increase in review capacity of 168 patients per year.

Option 9: Employ a locum to undertake new patients to free up existing consultant to see all review patients will reduce the cost of seeing all patients to £28,677.

Restorative Dentistry

In Restorative Dentistry there are 76 patients who have overdue review/treatment appointments. As these are treatments, some patients may require 1 hour for their appointment therefore it is only possible to do 5 patients per session. This specialty is provided by a visiting Consultant. However, this Consultant is leaving his post and will no longer be with the Trust as from 1st December 2008. It is unclear what cover will be provided for this service and this is currently being progressed with S.E.T.

RESTORATIVE DENTISTRY	
Total Number of Patients	76
No. Patients per clinics	5

Staffing per Clinic	Band	Number of Staff	Cost
Consultant			£591.00
Nursing Staff	Band 5	4	£91.00
Health Records	Band 2	1.25	£18.00
Outpatient Booking Staff	Band 3	1.25	£20.00
Secretarial Support	Band 4/3	2	£34.00
Radiology	Band 6	4	£112.00
Goods & Services			£66.47
Total Cost per Clinic			£932.47

OPTIONS

Option 1: See All backlog Review Patients

76 patients @ 5 patients per clinic = 15 clinics x £932.47 per clinic =

Total Cost = £13,987

Option 2: Undertake Casenote Review + Outcome clinics

Not Applicable

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Not Applicable

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Not Applicable

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 review patient per clinic will equate to 2 patients per week x 21 weeks which will increase review capacity for the year by 42 patients.

Dermatology

DERMATOLOGY	
Total Number of Patients	776
No. Patients per clinics	15

In Dermatology there are 776 patients with over due appointments with a number of patients waiting up to 5 months past their due date. As this specialty is developing an ICATs service it was felt that a nurse led casenote review would be appropriate seeing 30 patients per session. Within this review the following outcomes would be determined:

- Consultant Review
- Nurse Review
- ICATS Review
- Write to patient/GP
- Telephone review.

A pilot casenote review had the following results.
23% patients require Consultant Review
7% require Nurse Review
60% require ICATS Review
10% require telephone Review

Total Number of Patients	776
No. Patients per Consultant clinic	15
No. of Patients per casenote Review	30
No. of patients per ICATS clinic	8
No. of patients per Nurse clinic	15
Cost of Casenote Review (Health Records) 776 X 20 min x £14.33/hr	£3,707

Based on the Casenote Review outcomes the specialty cost will be as follows:

Consultant Clinics	
Total Number of Patients	178
No. Patients per clinics	15
Total Number of Clinics	12

Staffing per Clinic	Band	Number of Staff	Cost
Consultant			£591.00
Nursing Staff	Band 5	4	£91.00
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£102.25
Goods & Services			£212.60
Total Cost per Clinic			£1,113.85

NURSE OUTPATIENT CLINICS	
Total Number of Patients	54
No. Patients per clinics	15
Total number of Clinics	4

Staffing per Clinic	Band	Number of Staff	Cost
Nursing Staff			N/A
			N/A
Health Records	Band 2	3.75	£54.00
Outpatient Booking Staff	Band 3	3.75	£61.00
Secretarial Support	Band 4/3	6.25	£102.25
Goods & Services			£212.60
Total Cost per Clinic			£429.85

ICATS CLINICS	
Total Number of Patients	466
No. Patients per clinics	8
Total number of Clinics	58

Staffing per Clinic	Band	Number of Staff	Cost
Associate Specialist			£248.00
Nursing Staff	Band 5	4	£91.00
Health Records	Band 2	2	£29.00
Outpatient Booking Staff	Band 3	2	£33.00
Secretarial Support	Band 4/3	3.3	£54.00
Goods & Services			£197.71
Total Cost per Clinic			£652.71
Total cost			£37,857.00

The ICATs clinics see fewer patients per clinic as the Doctor is a junior member of staff with less experience. If an associate specialist undertook the clinic the number of patients per clinic would be increased to 15 reducing the number of clinics to 31 with an associated cost of £20,234.

Summary Dermatology	
Casenote Review	£3,707.00
Consultant Clinics	£3,366.00
Nurse Clinics	£1,719.00
ICATS Clinics	£37,857.00
Total Cost – Dermatology	£46,649.00

Under the New ICATs service the Nurse Led Clinics are due to Commence in October 2008. These clinics have the capacity to see 15 patients per clinic x 5 days per week. Clinical practice will change to ensure that any suitable patients from current and future Consultant clinics will be referred to the nurse clinics which will free up future capacity to see those who absolutely need a consultant review.

OPTIONS

Option 1: See All backlog Review Patients

776 patients @ 15 patients per clinic = 52 Consultant clinics x £1,113.85 per clinic =

Total Cost Consultant Clinic= £57,920

52 Associate Specialist Clinics x £652.71 per clinic =

Total Cost Associate Specialist clinics = £33,941

Option 2: Undertake Casenote Review + Outcome clinics

776 patients @ 30 patients per casenote review = £3,707 +
12 x Consultant Clinics = £1,114
4 x Nurse Led Clinics = £1,719
58 x ICATs clinics = £37,857

Total Cost = £44,397

Therefore undertaking a casenote review + outcomes approach will incur 104 sessions whilst seeing all patients at clinic will incur 52 sessions and if using Associate Specialists will be £10,456 more expensive or if Consultant clinics £13,523 less expensive.

Option 3: Discharge All Patients whose Review Is Over 1 Year Backlogged

Not Applicable.

Option 4: Exclude the Last 2 months Review Backlog Patients from the Plan

Last 2 months Review Backlog = 488
776 – 488 = 288 @ 15 patients per clinic = 19 clinics x £1,113.85 per consultant clinic =

Total Cost Consultant Clinics = £21,163

19 clinics x £652.71 per clinic for Associate Specialists =

Total Cost Associate Specialist Clincis = £12,401

Option 5: Exclude the last 1 months Review Backlog Patients from the Plan

Last 1 months Review Backlog = 307 patients
776 – 307 = 469 @ 15 patients per clinic = 31 clinics x £1,113.85 per consultant clinic =

Total Cost Consultant Clinic = ££34,529

31 clinics x £652.71 per clinic for Associate Specialists =

Total Cost per clinic = £20,234

Option 6: Option 2 + Option 3

Not Applicable

Option 7: Option 2 + Option 4

Not Applicable

Option 8: Add 1 Review Patient onto all clinic templates within the specialty

Adding 1 review per clinic x 14 clinics per week x 42 weeks will increase review capacity by 588 patients per year.

PAS Support

Additional support will be required to set all the above clinics onto PAS. There will be a total of 896 clinics maximum required to be set up on PAS. This number will reduce/vary according to the options chosen. This will require on average 30 minutes per clinic. This equates to approximately 448 hours Band 5 PAS Officer (£23 per hour) at a total cost of £10,304.

Administration of the Project

In order to organise all of the additional clinics and outcomes etc it will be necessary to employ 1 WTE Band 4 administrator which will cost £14,279.

Timescales and Risks

To eliminate the review backlog will require a total of 896 clinics if casenote reviews are to be used in those specialties which felt value could be gained from them. Not doing casenote reviews will result in 955 clinics being required. As the majority of the backlog sits on the Craigavon site, it will be necessary to undertake the additional clinics on that site. In addition, Consultants prefer to do evening and weekend clinics on the site which is more convenient for them ie Craigavon. To staff all clinics appropriately it would only be feasible to run a maximum of 3 evening and 2 weekend clinics alongside normal daytime clinics. Therefore based on an average of 5 clinics per week it would take 179 weeks to complete the review if running 896 clinics or 191 weeks if running 955 clinics. However, it should be noted that as these clinics will be in addition to doctors other commitments and would be adhoc it may not be possible to achieve a maximum of 5 clinics per week.

To maximise the number of clinics per week it would be necessary to facilitate additional clinics in any spare sessions during normal working hours which will increase the number of clinics per week. However as there are currently no free clinic rooms during these hours this will not be possible without increasing the number of clinic rooms available in the Craigavon Outpatient Department. It would be possible to create 3 additional clinics rooms if rooms in the outpatient department which are currently used for non clinical sessions ie. the ERMs office and 2 speech and language therapy rooms were refurbished into clinic rooms and the staff relocated to alternative office accommodation. This work would require approval to commence immediately in order to maximise sessions.

The costs of converting the 3 offices to clinic rooms are as follows:

	Per Room	X 3 rooms
Refurbishment	£4,500	£13,500
Examination Couch	£560	£1,680
x-Ray Box	£300	£900
Desk	£120	360
Chair (1 x Doctor + 1 x Patient)	£200	£600
Waiting room seating for all rooms	-	£1,800
PC (including licences) + Printer	£1,300	£3,900
Total Cost	£6,980	£22,740

If this piece of work is to be complete by end of March 2009 ie 6 months it would require 35 clinics per week which in view of the above restrictions will not be possible.
It will also be necessary to recruit any additional administrative and clerical staff immediately to get the work underway. Again if the work is to be complete within 6 months this will mean recruiting:
2.32 wte Band 2 Health Records Staff
2.32 wte Band 3 Outpatient Booking Staff
3.87 wte Band 3/4 Secretaries
2.88 wte Band 5 Nursing staff
1.10 wte Band 2 Nursing staff
1.00 wte Band 4 Administrator.

The recruitment and approval process would therefore need to be fast-tracked as normal processes usually take 2-3 months to complete.

Sustainability

It is recognised that this exercise will eliminate the backlogs, however to ensure that backlogs are not created in future the clinic templates will be analysed to determine if they are in line with regional best practice new to review ratios. Any templates which are out of sync with the region will be amended and clinical practice challenged to bring ratios into line. The table below details the average New to review ratio based on the activity at clinics in the financial year 2007 – 08 and also gives the range from lowest to highest new to review ratio within the specialty for comparison. However it should be recognised that these figures are not an accurate reflection of current practice as the backlogs in each specialty are not factored in. To factor in backlogs would require a vast amount of work for little value as the focus is to eliminate the backlogs and amend templates in line with National Benchmarks and best practice to prevent future backlogs developing.

Specialty	N:R per Activity FY 2007/08	N:R Range within Specialty	N:R Welsh Target Benchmark
Cardiology	1:1.2	1:1.06 - 1:2.4	None available
Dermatology	1:0.9	1:0.1 – 1:1.6	1:1.4
ENT	1:1.6	1:0.1 – 1:6.7	1:1.3
General Surgery	1:1.1	1:0.2 – 1:3.0	1:1.2
Gynaecology	1:1.9	1:0.3 – 1:4.9	1:1.3
Neurology	1:1.8	1:0.8 – 1:3.2	1:0.9
Ophthalmology	1:1.4	1:0.9 – 1:2.7	1:2.3
Pain	1:1.2	1:0.7 – 1:2.0	None available
Rheumatology	1:1.8	1:0.1 – 1:3.8	1:3.1
Urology	1:6.2	12.2 – 1:10.9	1:2.1

It should be noted however that as the calculation of backlogs is a manual exercise the numbers were collated as at 30th June 2008. These figures were updated on 30th September and highlighted that the reduction in capacity over the summer period had the following effect on the backlog numbers.

Specialty	June 2008	September 2008	Increased Backlog
General Surgery	2425	2860	435
Breast Surgery	0	445	445
Cardiology	500	573	73
Paediatric Medicine	329	661	332
Gynaecology	414	893	479
General Medicine	150	222	72
Urology	1879	2309	430
Neurology	310	465	155
ENT	1087	1744	657
Ophthalmology (increase includes 58 patients backlogged from orthoptics who require joint appointment.	877	1313	436
Thoracic Medicine	263	346	83
Dermatology	351	776	425

Monitoring the cost of the Review Backlog Solutions

In order to align all costs to the monies for elimination of review backlogs it will be necessary to ensure that all claim forms for additional sessions etc need to be clearly identified and submitted to one point of contact/cost centre in finance. Currently this is not happening for any new additional clinics as overtime/additional claims for nursing staff, administrative staff, radiology, ECG etc are not aligned to these access monies.

Whilst every effort has been made to ensure that the assumptions in this paper are accurate it must be recognised that final figures may be subject to change. Casenote reviews are subjective and each consultant may have differing percentage outcomes therefore the cost of eliminating this backlog may differ from that listed above. In addition all review appointments will be partial booked which in itself may reduce the number of patients who actually attend clinics as they may either be discharged due to non response to partial booking letters or may decide that they no longer wish to have an appointment.

It should also be recognised that this is a work in progress and that solutions may be refined or changed after working through some of the volumes as experience may dictate more productive or alternative outcomes.

APPENDIX

SUMMARY COSTS

Specialty	Option 1 See All £	Option 2 Casenote Rev + Outcomes	Option 3 Discharge > 1 Year	Option 4 Excl last 2 months	Option 5 Excl. last 1 month	Ooption 6 = Option 2 + Option 3	Option 7 = Option 2 + Option 4	Option 8 Add 1 Rev per Clinic	Option 9
	£	£	£	£	£	£	£		£
General Surgery	222,095	219,622	173,909	184,235	201,444	136,049	150,964	455	222,095
Breast Surgery	30,976	30,976	30,976	19,504	24,093	30,976	30,976	84	30,976
Cardiology	45,992	45,992	45,992	33,653	38,140	38,140	45,992	315	45,992
Paediatric Medicine	54,374	61,930	54,374	29,201	37,249	29,201	37,249	455	54,374
Gynaecology	74,819	74,819	74,819	44,487	57,631	74,819	74,819	357	74,819
General Medicine	14,009	14,009	14,009	9,006	11,007	14,009	14,009	42	14,009
Urology	205,684	205,684	205,684	164,976	184,258	205,684	205,684	210	Research Fellow 162,833
Neurology	33,683	33,683	33,683	18,471	24,984	33,683	33,683	294	33,683
ENT	174,522	174,522	174,522	100,255	133,263	174,522	174,522	840	174,522
Ophthalmology	91,272	91,272	91,272	49,993	69,556	91,272	91,272	504	91,272
Rheumatology	32,455	32,455	32,455	21,001	25,773	32,455	32,455	336	Nurse Specialist 16,228
Thoracic Medicine	40,052	40,052	40,052	24,860	29,003	40,052	40,052	168	Locum 28,677
Restorative Dentistry	13,987	13,987	13,987	13,987	13,987	13,987	13,987	42	13,987
Dermatology	57,920	33,941	44,397	21,163	34,529	57,920	57,920		57,920
PAS Support	10,304	10,304	10,304	10,304	10,304	10,304	10,304		10,304
Band 4 Administrator	14,279	14,279	14,279	14,279	14,279	14,279	14,279		14,279
3 x Clinic Rooms Refurbished + Fruniture	22,740	22,740	22,740	22,740	22,740	22,740	22,740		22,740
Total	**1,139,163**	**1,120,267**	**1,077,454**	**782,115**	**932,240**	**1,020,092**	**1,050,907**	**4,102**	**1,068,710**
Using Associate Specialist not Consultants for Dermatology				**764,591**	**917,945**				

Costing Assumptions

- All posts are costed as additional activity out of normal hours.
- All posts are costed at mid point of the pay scale
- All posts have been costed to 2008/09 pay bands which include the 2.30% funded pay award and not the actual pay award.
- All Consultant clinics have been costed as operating Monday to Friday.
- Payroll costs include 5% for payroll goods and services.
- Nursing staff detailed as split between Band 5/3 were costed on a 75/25 split in line with the qualified/unqualified ratio.
- Staffing requirements detailed as split between pay bands have been costed to the lower pay band.
- The calculations include marginal specialty costs of 20% of general surgery excluding medicAl & trained nursing direct costs.
- The specialty costs for 2006/07 have been uplifted by 2.5% for 2007/08 and 2.7% for 2008/09

Actions

1. **Chase up MY on locum – EM – set date for interview Simon, Robin and Michael? Test it out with HR.**
2. **Get revised date on workshop - SG**
3. **What are givens in the new service model? – Simon to Catherine**
4. **What is the increase in the flows to the Southern Trust? – Simon to Catherine**
5. **Setting agreed standards for the service E.g x New patients and y reviews at a clinic, and establishing an exception reporting mechanism**
6. **Contact Catherine McNicholl regarding the demand/capacity volumes as part of regional review**
7. **Benchmarking via clinical challenge from a nationally recognized expert in Urology**
8. **Message that if 3 centre model doesn't work, would revert to a 2 centre model**
9. **Get the post out to internal trawl – 8b permanent -**
10. **Date of workshop before 16th February – next week Simon**
11. **Revised paper to SMT**

Teleconference between sites for weekly core group – Monday evenings for 8 weeks – 5pm to 7pm

Robin Brown
Michael Young
Heather Troughton
Mairead McAlinden
Joy Youart
Simon Gibson
Eamon Mackle
Charlie McAllister

Monthly communication meeting

Terms of Reference for Urology Review

The Urology Review will be led by the Director of Acute Services, and will deliver the following project objectives:

- An agreed analysis of the capacity gap in relation to urology services, recognising the impact of the Regional Review.

- Assess the current service against the standards set out in 'Action On' Urology and IOG Guidance and, where standards are not currently met, bring forward agreed plans to address same

- Develop an agreed cross site service model including ICATs to deliver assessed future demand, including potential future business which could be generated from other commissioners, through either:
    - The new model of urology services for NI as recommended by the Regional Urology Review Group
    - Demand from HSE

  and service standards as set out in 'Action On' and IOG guidance.
- The development of agreed team job plans to deliver this model.

- The development of a business case to commissioners to deliver the agreed model of care.
- Developing the sustainability of the service and reducing costs through the urgent progression to recruit funded consultant and other posts on a permanent basis.

A SOUTHERN TRUST VISION FOR THE FUTURE OF UROLOGICAL SERVICE PROVISION

Vision

Our vision for the future of all urological service provision, whether local or regional, is that services should be:-

- of the highest quality, demonstrated by clinical outcomes and patient experience
- sufficient to meet current and future urological need
- optimally accessible with services as close to home is as possible
- at minimal inconvenience and cost to patient and family

All of these characteristics require:-

- sufficient complements of personnel
- sufficient infrastructure and facilities, demonstrated by both a local and regional network of urological services
- investment to ensure the service is capable of keeping pace with technological change

Vision for local services; guiding principles

Personnel for a local service

- We believe that modern urological services are best provided by personnel from a growing spectrum of healthcare disciplines. This will result in enhancement of expertise and experience of personnel from individual disciplines. It will enrich services provided and therefore enrich the patient experience. It will ensure cost effective use of staff by ensuring optimal use of their individual skills. It will make the service more accessible in the future, particularly by being able to bring the investigative phase of the service closer to the patient.

- We believe that, in view of the changing age profile and morbidity of the population we serve, that a consultant:population ratio of 1:70,000 or 80,000

should be our aim, reflecting the need for these changing population sizes in the future. This is underpinned by evidence attached as an Appendix to this vision.

- It is appreciated that the service delivery is by a multi-disciplinary team delivering the service in multi-network sites producing an accessible service with adequate sub-specialty facilities. To provide this, adequate Interventionalist Radiology, Nephrology, Oncology, middle grade cover as well as Nurse Practitioners are required. The focus on multi-disciplinary team working is essential. To provide the best service to the patients all team members must be offered the opportunity to work together rather than in isolation.

Infrastructure and facilities for a local service

- Inpatient facilities for the more major complex procedures should be maintained and focused on one site. Craigavon Hospital should also be regarded as the primary urology emergency service provider for the Southern Trust with the full range of back up facilities, operating as a self-sufficient unit.

- We believe that expanding the Day Surgery facilities in South Tyrone and Daisy Hill with the potential for short stay surgery on the Daisy Hill site would provide for the principle of access closer to home as well as broadening the scope of procedures to be performed, whilst maximizing use of infrastructure within the locality. This "hub and spoke" model could offer a number of advantages, especially in areas where rurality is a consideration.

- In our vision, we believe that there is a need to enhance the primary care interface to optimize a seamless patient pathway by broadening the Urology team.

- Despite a move towards more day and short stay surgery, enhanced inpatient facilities are required to meet the future demand predicted for the Urology service. This would require enhanced bed and theatre capacity on the Craigavon site.

Technology for a local service

- It is recognized that modern day urology surgery, if provided at a high level, requires a high technology input. It should be recognized that new modalities

of therapy and a turnover of equipment should be built into the annual budgets.

Regional aspects of service provision

This vision recognizes that the regional service will incorporate all the elements outlined above for the local services. We also recognise that with the recent changes within the health structures of Northern Ireland, this has led to a more flexible culture which means that the provision of future Urology services need not be restricted to existing Trust boundaries.

When considering a regional model, we believe that factors that may have an impact on personnel and infrastructure requirements, such as rurality, need to be carefully considered and factored into a future service model.

We believe that a move towards self sufficiency for urological procedures should be encouraged, conditional upon audit of outcomes. Cumulative surgeon experience should be taken into account with adequacy of team members providing a service and that there should be a critical mass of consultants per hospital with sufficient sub-specialty interest in each area. The principles of the Campbell Report for cancer services in Northern Ireland should be maintained. We also believe that within any agreed model for future urology services, there needs to be consistency of approach when determining the location of services.

Finally, we recognise that the clinical management of those procedures that are low in number should be centralized on one site, following clinical and service review of these clinical conditions. However, in our vision for Urological Services, we believe that there would be significant service and patient benefits in a clinical network model which, following meaningful MDT review and determination of a clinical management plan resulting in surgery, would allow this surgery to take place locally, with clinical outcomes an integral measure of such a model.

Appendix 1

- Though increasingly multi-disciplinary, the ratio of Consultant Urologist or Urological Surgeon will remain the most useful indicator of adequacy of personnel, and of service provision as a whole.

- The first study of urological manpower in Europe reported in 2000 for the year 1998 to 1999. The mean Consultant:population ratio in the 32 member countries of EBU was 1:53,450

- BAUS recommended in 1996 that the UK should aim for a ratio of 1:80,000. This recommendation was accepted by the DHSS for England and Wales in 1997. However the DHSS in Northern Ireland used provinces and a younger age profile to justify a target of 1:100,000 for Northern Ireland by 2007. This target has not been achieved yet.

- The resident population of the Southern Trust area is now 345,000. The appointment of a fourth Consultant would result in a ratio of 1:86,000, not yet reaching the BAUS guideline of 1997. Implementing the BAUS guidelines would require a complement of five Consultants.

- A complement of five Consultants in the Southern Area would transform the Trust's capacity to provide quality, adequate and accessible services. In addition, it would enable such a degree of sub-specialization within the area that any service currently provided could be concentrated in pursuit of consistency and audit.

- A replication of this Consultant staffing throughout Northern Ireland would require approximately twenty-six Consultants, achieving a similar ratio of approximately 1:70,000. Such a complement would transform the range and dynamic of service provision in the province.

Urology : Taking the Service Forward – 20th March 2008

Service area	Pressures and restrictions	Potential solutions	Priority issues and actions required	Leads and dates
Proposed service model	Current service inadequate to meet demands of service	4th consultant post – with all job plans reviewed to expand IP/DC provision across the DHH/CAH facilities 4th and 5th consultant model OR 4th consultant and middle grades with additional ICATS	**Priority rank = 1** Need to clarify future issue of Urology Cancer <u>*Model design:*</u> Look to ENT model – clinic and a list on the same day; list in the morning, clinic in the afternoon. (May need to reschedule existing outpatient facilities within DHH) (Quantify the volume of provision available in DHH) Look at Thorndale model or free space on DHH site	Simon Gibson Michael Young Michael Young Roni McMillan Louise Devlin

Service area	**Pressures and restrictions**	**Potential solutions**	**Priority issues and actions required**	**Leads and dates**
Ward facilities	Not enough beds even for existing service	Move out 2 South medical to vacated psychiatric service 13 beds Or move 2 South back to 2 North and move Haematology to Psychiatric Unit. Would solve storage and office accommodation.	**Priority rank = 2**	Simon Gibson and Noleen O'Donnell, Eamon Mackle and Michael Young
		Note: issue of DHH recovery space, plus problem of additional nursing and anaesthetic space and size of DPU in DHH and size of OP facility – add in to the future of overall surgical service	**Priority rank = 3**	Robin Brown supported by Estates and Simon Gibson and Eamon Mackle

Service area	Pressures and restrictions	Potential solutions	Priority issues and actions required	Leads and dates
Proposed Service Model		We need to quantify the service requirements to ensure we meet the targets IP DC OP New OP Review	**Priority rank = 4** Capacity within OP templates Capacity within IP/DC sessions IP in CAH DC in DHH	Sharon Glenny Louise Devlin Michael Young
Ward staff issues	High proportion of junior staff Senior staff leaving the ward Volume of throughput and acuity of patients is heavy, Staff leaving to do other duties Issue around authority of bed manager needs resolved in terms of responsibility for ward issues. Need to address shortfall in nursing – stone service, urodynamics, immuno	Simon to go to ward to speak to staff regarding concerns - 17th April	**Priority rank = 5** Outcome of Telford review requires action Need for in house training for nurses for Urology training – time needs set aside	Simon Gibson, Shirley Tedford and Noleen O'Donnell

Service area	Pressures and restrictions	Potential solutions	Priority issues and actions required	Leads and dates
ICATs issues	Access – corridor	Revised costs available – need to re-look at these for bed issues	Review costs (Simon Gibson to find)	Roni McMillan
	ICATS staffing admin – what is there? What is funded? What is co-ordinator?	Grade 4 part-time needs reinstated		Roni McMillan
		Need to look forward to what ICATs would look like in the future	Review initial ICATS model and funding levels	Roni McMillan
Emergency volumes	Issue of patients outlying in DHH awaiting Urology beds in 2 south		Quantify the size of the problem	Roni McMillan supported by Robin Brown
Outpatients targets	Capacity problems within consultant clinics	Locum consultant has outpatients within job plan	Include within Priority 1 work	
	Booking timelines for partial booking at 6 weeks	Ensure consistency of staff to attend all clinics, backfilling if necessary	9 week target will require a rolling weekly cycle – take up with Department	Louise Devlin
	Scheduling meeting hinders this timetable as scheduling meeting determines numbers of doctors at outpatient clinics		Move scheduling meeting	Michael Young
	Delays in triage	Ensuring triage is undertaken within 4 days	Each Consultant to commit to 4 days triage	Aidan O'Brien Michael Young Mahmood Ahktar

Service area	Pressures and restrictions	Potential solutions	Priority issues and actions required	Leads and dates
Inpatients targets	Model of pre assessment is unclear Yellow form and blue form causes confusion Problems with consultant capacity	Undertake some pre-op assessment within OP Ensure pre-op assessment model has flexibility to allow patient choice *Separate issue but for noting: afternoon DC services within the DHH site*	Try a combined form which allows shared waiting list Just use yellow form Look to revise form for sharing patients Use of more formalised shared waiting list for appropriate patients Knowledge of junior staff and admin staff on how patients are streamed onto waiting lists	Michael Young
Clerical staff issues	Audiotypist issues Additional clinics workload laid upon ward clerk Removal of notes from ward without reference to ward Turnover of ward clerk staff Ward clerks slaughtered due to filing of bloods	Train staff to access PAS	Review of ward workload	Noleen O'Donnell

Service area	Pressures and restrictions	Potential solutions	Priority issues and actions required	Leads and dates
Clinical staff issues	Loss of staff grade – Vincent Koo in August		Need for immediate locum	Michael Young
	Junior medical staff issues after 5pm – 1 JHO covering wide range of areas	Hospital at Night designed to look at workload		Simon Gibson
	Junior staff issues – no trust grade level	Prash and Funsco made more substantive posts		

Simon Gibson
Assistant Director of Acute Services – Surgery and Elective Care
Personal KSF Dimensions and indicators 2008-09

Dimension	Level	Indicators for the level	Evidence of personal achievement against the indicators	Areas for development
Seizing the future	4	Looks to the future and is able to see current opportunities and linkages that others may struggle to see; acts on these. Generates, tests and implements a range of innovative approaches to move a situation on, understanding the broader trends in health improvement and service delivery. Thinks and acts with a long-term, futuristic perspective.	Saw opportunity that merging of Trust created for improving efficiencies within General Surgery. Organised Trust wide general surgery meeting which led to joint working on STEEEP programme Recognised opportunity for modernizing clinical practice – led on work to move Varicose veins from IP to OP	
Self belief	3	Rises to, and relishes, a range of challenges. Feels able to succeed and is prepared to stand up for what they believe in. Has the confidence to involve others in support of a particular goal.	As AD for part of the Southern Trust with the largest number of, and the most visible and tangible, access targets, I have been unstinting in my pursuit of the achievement of these targets. I identified interim targets which were adopted by all divisions, and ensured these were met. After recognizing organizational neglect, I have been relentless in highlighting the clinical risks in the backlog of review and planned patients, resulting in obtaining £1.1m to address this issue. Stood against the proposed model of 4WTE 10 PA job plan for Ophthalmology, working with wide range of partners to evidence need for 11PA model, to ensure demand could be met	
Self management	3	Manages their own energy, pacing their efforts for the long haul. Recognises others' anxieties and problems, and encourages them to find ways of dealing constructively with their stress; models a healthy work/life balance. Is able to absorb and deal constructively with criticism, seeking support as necessary.	I have continually taken positive steps to give my all to the organization, whilst recognizing the need to "switch off" and focus on life outside work to ensure burn out is avoided. Personal Information redacted by the USI [redacted] Constantly remind staff of the importance of work/life balance, particularly children. Set example by maintaining reasonable office hours	

Drive for results	3	Sets self and others stretching goals, over and above those required to meet national standards and targets, where these will help to improve local services. Takes the necessary actions to meet these goals; identifies and applies measures to track and quantify achievement. Overcomes obstacles to achieving goals and uses failure as an opportunity to learn.	I recognised benefits to patients in achieving access targets ahead of regionally imposed deadlines, and ensured these were accepted across all divisions and all sites across the Southern Trust. I created an internal action plan and implemented monthly monitoring against these to ensure achievement. With Urology and T&O, I came up against significant obstacles to achieving initial reductions. I identified that there was a need to recognise the inherent difficulties in these specialties and modified the plans accordingly.	
Dimension	**Level**	**Indicators for the level**	**Evidence of personal achievement against the indicators**	**Areas for development**
Effective and strategic Influencing	3	Uses subtle influencing tactics, such as lobbying before a meeting, which fit with the particular situation. Understands the need to use informal persuasion and provision of information to influence others over whom they have no formal authority. Takes the time to build critical mass or support for a position, with the end aim of getting results by working in partnership.	I identified the potential risk of adhering to a timetable laid out for the implementation of an Ophthalmology service, which was too short and potentially incorrectly calculated. I worked hard with colleagues on an informal basis to persuade them that it was the right thing for the patient, in the long term, to delay this service development and eventually won the support of the project group in my vision for the development of this service.	
Holding to account	3	Challenges and confronts conflict, especially where this is impacting on service delivery and standards, and contributes to brokering agreement. Intervenes swiftly and consistently when performance is slipping, using the appropriate processes. Holds others directly accountable for delivering	On a number of occasions, I have had to get into conflictual situations with consultant colleagues who were behaving in a way I felt was inappropriate.	I need to develop my skills in people management, in particular dealing with difficult staff and holding them to account by clarifying roles and expectations.

		what has been agreed, both within and outside the organisation.		
Leading change through People	5	Gets buy-in and commitment to the vision within the organisation and across the local health context, involving diverse groups. Inspires people to contribute to and lead change initiatives. Creates momentum and excitement about what needs to be done. Gives people a sense that change is achievable and that their contribution matters.		
Empowering others	3	Coaches others, challenging and asking questions to help them work out the answers for themselves. Provides space for others to be creative and to take risks so that they can develop their own capabilities and approaches. Shares power within the organisation, and across networks; and, develops constructive relationships with patients and stakeholders which are focused on their true involvement in, and consultation on, service decision-making.		
Dimension	**Level**	**Indicators for the level**	**Evidence of personal achievement against the indicators**	**Areas for development**
Collaborative working	3	Works with other stakeholders where conflict impedes progress to create the conditions for successful partnership working in the longer term. Is informed on the current priorities of partners, and responds appropriately to changes in their status or circumstances. Ensures that the strategy for health improvement is developed in a cohesive and 'joined up' manner.		

Communication	3	Identifies the range of people likely to be involved in the communication, any potential communication differences and relevant contextual factors. Communicates with people in a form and manner that: – is consistent with their level of understanding, culture, background and preferred ways of communicating; – is appropriate to the purpose of the communication and the context in which it is taking place; – encourages the effective participation of all involved Recognises and reflects on barriers to effective communication and modifies communication in response. Provides feedback to other workers on their communication at appropriate times. Keeps accurate and complete records of activities and communications consistent with legislation, policies and procedures. Communicates in a manner that is consistent with relevant legislation, policies and procedures.		
Dimension	**Level**	**Indicators for the level**	**Evidence of personal achievement against the indicators**	**Areas for development**
	3	Reflects on and evaluates how well s/he is applying		

Personal and people development		knowledge and skills to meet current and emerging work demands and the requirements of the KSF outline for his/her post. Identifies own development needs and sets own personal development objectives in discussion with his/her reviewer. Takes responsibility for own personal development and maintains own personal development portfolio. Makes effective use of learning opportunities within and outside the workplace evaluating their effectiveness and feeding back relevant information. Enables others to develop and apply their knowledge and skills in practice. Contributes to the development of others in a manner that is consistent with legislation, policies and procedures. Contributes to developing the workplace as a learning environment.		I need to pick a coach to ensure sustainable personal development I need to be stronger in accepting the value that holding to account has, even if it entails confrontational and difficult situations
Health, safety and security	3	The worker identifies: – the risks involved in work activities and processes – how to manage the risks – how to help others manage risk Undertakes work activities consistent with: – legislation, policies and procedures – the assessment and management of risk Monitors work areas and practices and ensures they: – are safe and free from hazards – conform to health, safety and security legislation, policies, procedures and guidelines		

		Takes the necessary action in relation to risks. Identifies how health, safety and security can be improved and puts this into effect.		
Dimension	**Level**	**Indicators for the level**	**Evidence of personal achievement against the indicators**	**Areas for development**
Service improvement	3	Identifies and evaluates areas for potential service improvement. Discusses and agrees with others: – how services should be improved as a result of suggestions, recommendations and directives; – how to balance and prioritise competing interests; – how improvements will be taken forward and implemented Constructively undertakes own role in improving services as agreed and to time, supporting others effectively during times of change and working with others to overcome problems and tensions as they arise. Maintains and sustains direction, policies and strategies until they are firmly embedded in the culture inspiring others with values and a vision of the future whilst acknowledging traditions and background. Enables and encourages others to: – understand and appreciate the influences on services and the reasons why improvements are being made; – offer suggestions, ideas and views for improving services and developing direction, policies and strategies;		I need to visualize how change can take place in short timescales by visiting units in England and challenging my own pre-conceived ideas

		– alter their practice in line with agreed improvements; – share achievements; – challenge tradition Evaluates with others the effectiveness of service improvements and agrees that further action is required to take them forward. Appraises draft policies and strategies for their effect on users and the public and makes recommendations for improvement.		
Dimension	**Level**	**Indicators for the level**	**Evidence of personal achievement against the indicators**	**Areas for development**
Quality	3	Acts consistently with legislation, policies, procedures and other quality approaches and promotes the value of quality approaches to others. Understands own role in the organisation and its scope and identifies how this may develop over time. Works as an effective and responsible team member and enables others to do so. Prioritises own workload and organises and carries out own work in a manner that maintains and promotes quality. Evaluates the quality of own and others' work and raises quality issues and related risks with the relevant people. Supports the introduction and maintenance of quality systems and processes in own work area. Takes the appropriate action when there are persistent quality problems.		

Equality and diversity	2	Recognises the importance of people's rights and acts in accordance with legislation, policies and procedures. Acts in ways that: – acknowledge and recognise people's expressed beliefs, preferences and choices; – respect diversity; – value people as individuals Takes account of own behaviour and its effect on others. Identifies and takes action when own or others' behaviour undermines equality and diversity.		

SOUTHERN HEALTH AND SOCIAL CARE TRUST

"Taking Urology Forward"

Date: Thursday 20th March 2008
Venue: Seagoe Hotel
Time: 12:30pm (Lunch) – 1:00pm Welcome

Agenda

1/ Introduction
2/ Priorities of the Organisation
3/ Service Vision
4/ Existing pressures and restriction
5/ Organisation priorities
6/ New Service model Construction options
7/ Consensus on service model
8/ Priority actions

1:00pm Welcome Jim McCall, Director of Acute Services

Purpose of afternoon:

- To appreciate the future demands in the urological service within the Southern Trust, in terms of structure and capacity.
- To establish plans to meet these demands.'

Desired outcome Simon Gibson

By the end of this afternoon we will have:

- An awareness of the priorities this organisation is signed up to achieve
- Agreement on the broad service model we wish to deliver
- A shared understanding of the pressures facing the existing service in meeting these priorities
- Agreement on the top five actions needed to address these pressures
- An identified action plan, with names and dates, to start moving towards the service we want to provide

1 / Priorities organisation has signed up to :
what are they? What is the time frame?

1. PFA, ALOS, PBR.

2. Inpatient

3. Day Case

4. Outpatient - General
- Specific

5. Cancer - Outpatient / diagnostic
- Inpatient priority

6. ICATS - Existing
- New

2 / What service does the urology Department suggest it offers in the next five years:
what and where?

3 / Existing pressures / restrictions and solutions

1. Outpatient Waiting List
2. Inpatient/Day Case Waiting List
3. Emergency volumes
4. Population predictions
5. Inpatient capacity
6. Personnel
    - Consultant
    - Junior
    - Nursing
    - Clerical
    - Administrative

7. Administration
8. Facilities

2.20pm New Service Model Construction

3:00pm Consensus on service model

3:15pm Tea/Coffee

3:30pm Identification of actions

4:00pm Consensus on priority actions

Options

- Who
- When
- Where
- How

4:30pm Conclusion

Urology Review Steering Group

Wednesday 17th September 2008

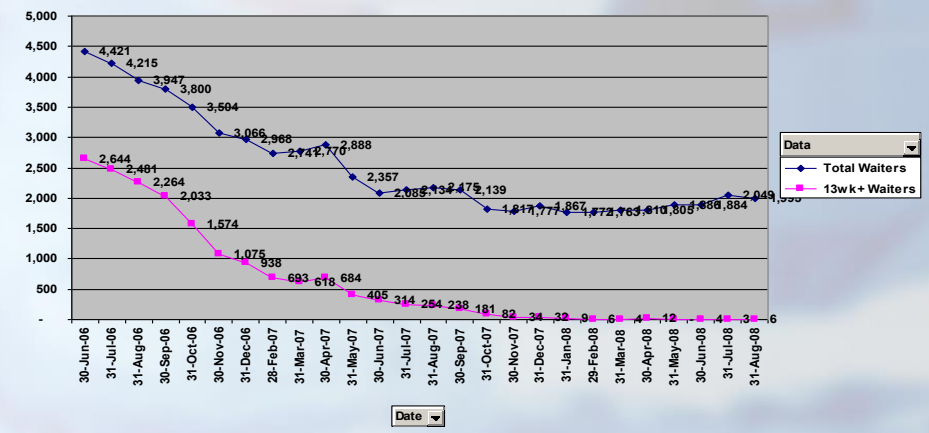
Priorities for Action

- Trusts should ensure that, from April 2008
  - No patient waits longer than 13 weeks for a first outpatient appointment,
  - No longer than 13 weeks for a diagnostic test,
  - No Longer than 21 weeks for inpatient or day case treatment,
  - Reducing to 9 weeks for outpatients, 9 weeks for diagnostics and 13 weeks for treatment by March 2009. Commissioners and providers should work towards a total journey time of 25 weeks or less by March 2011.

Outpatient Performance 2008/09

Outpatient Waits - Region

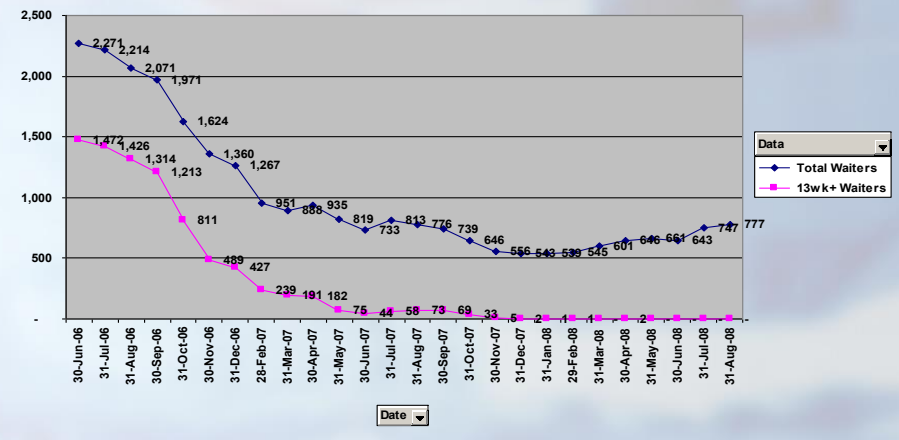
Site: Regional



Outpatient Waits - Belfast

Site: Belfast

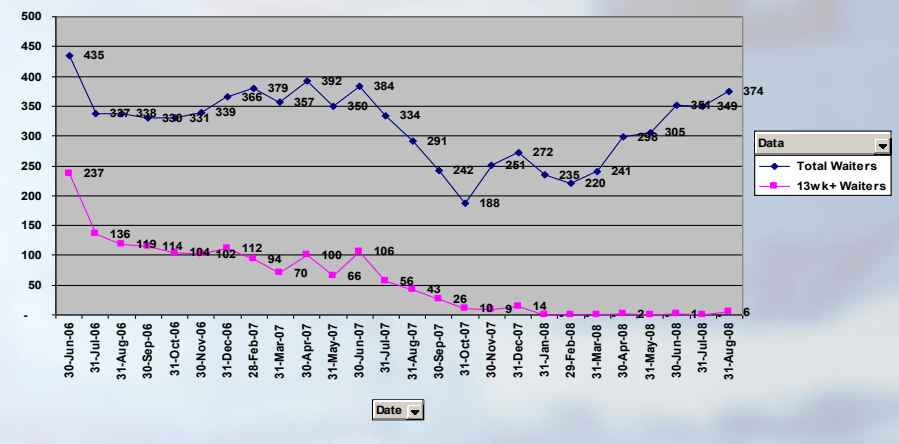
Trust Level - OP Urology waiters by timeband from June 2006 - August 2008



Outpatient Waits - Northern

Site: Northern

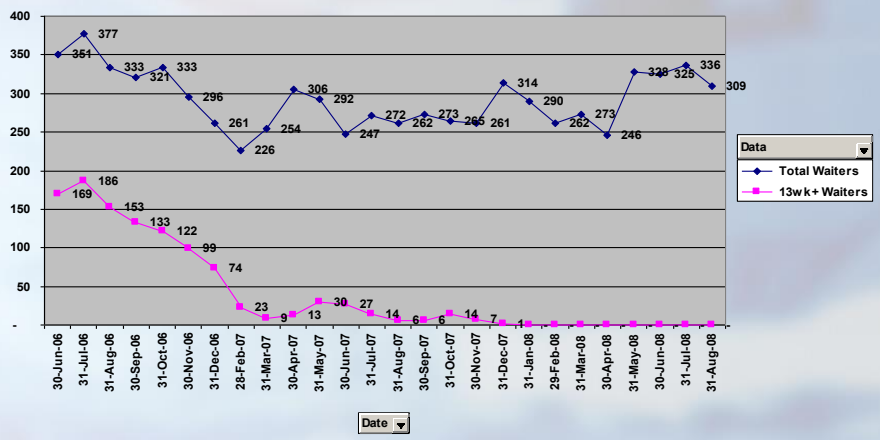
Trust Level - OP Urology waiters by timeband from June 2006 - August 2008



Outpatient Waits – South Eastern

Site: South Eastern

Trust Level - OP Urology waiters by timeband from June 2006 - August 2008



Outpatient Waits - Southern

Site: Southern

Trust Level - OP Urology waiters by timeband from June 2006 - August 2008

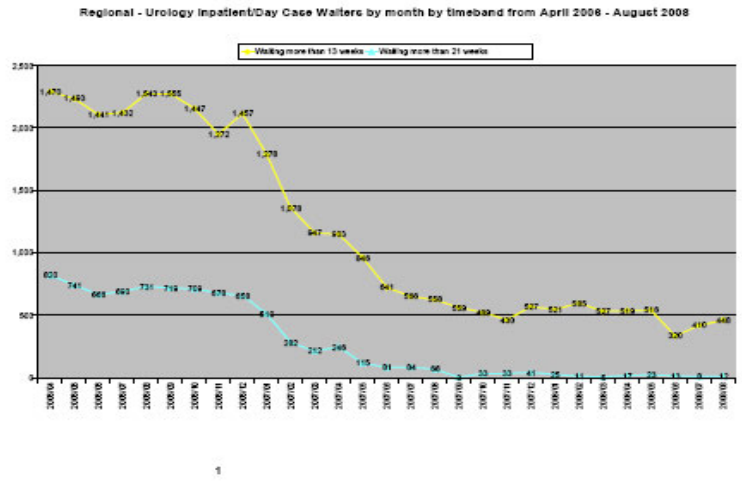
Outpatient Waits - Western

Site Western

Trust Level - OP Urology waiters by timeband from June 2006 - August 2008

Inpatient Performance 2008/09

Inpatient Waits - Region



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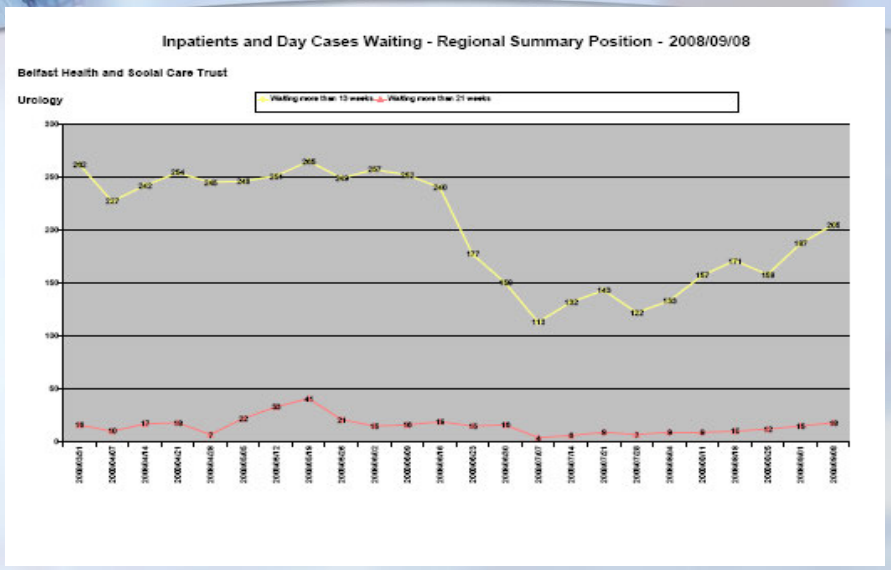
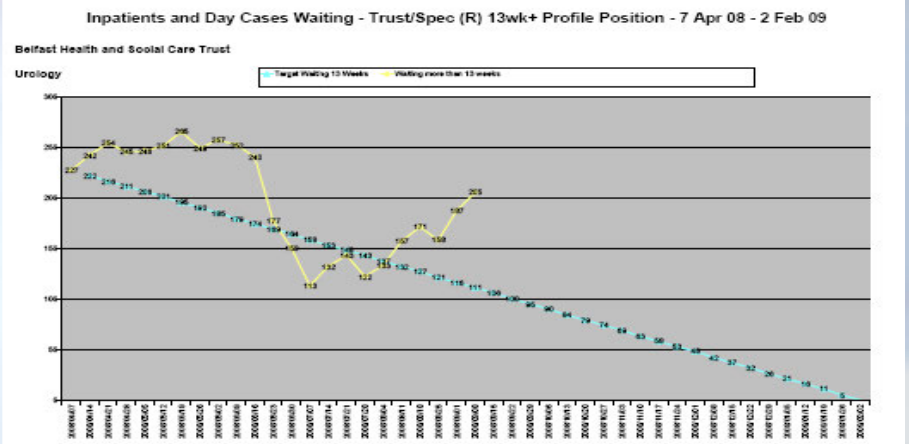
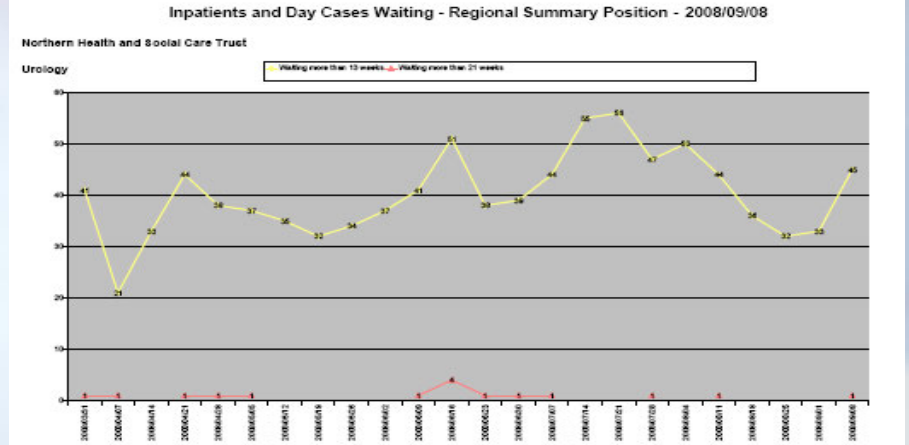
Inpatient Waits - Belfast



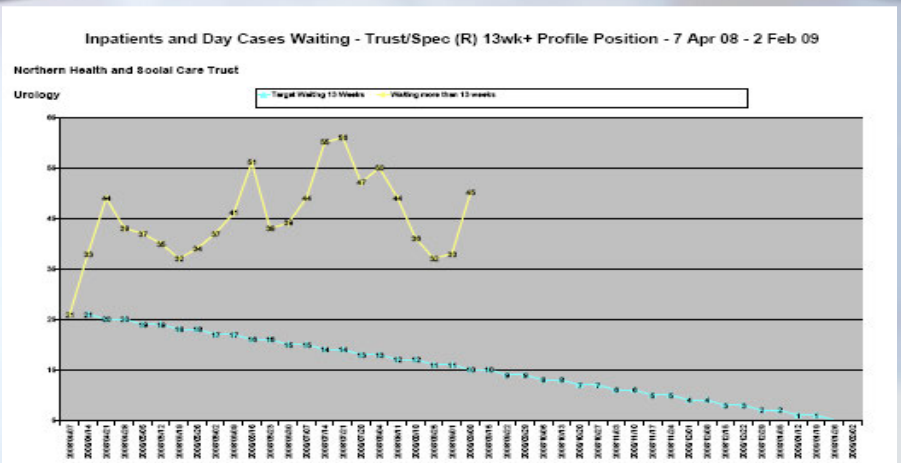
Inpatient Target Profile - Belfast



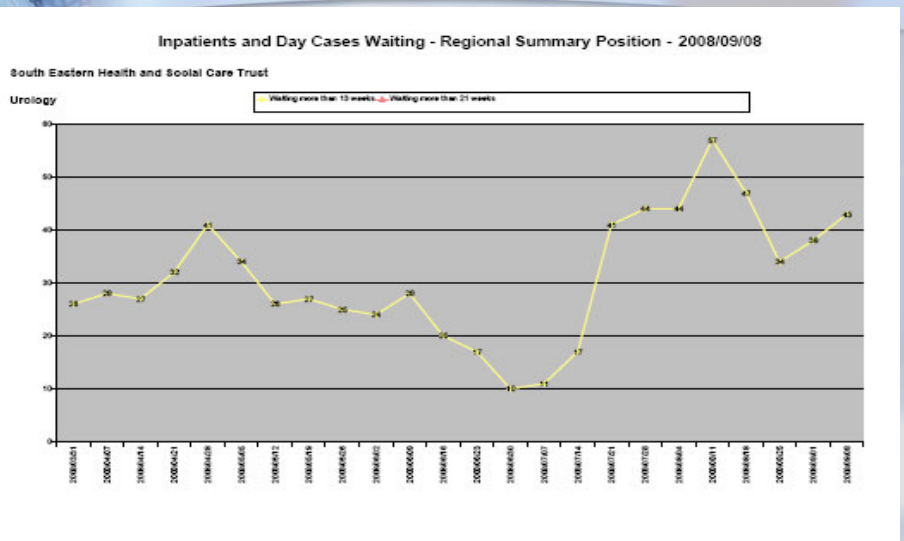
Inpatient Waits - Northern



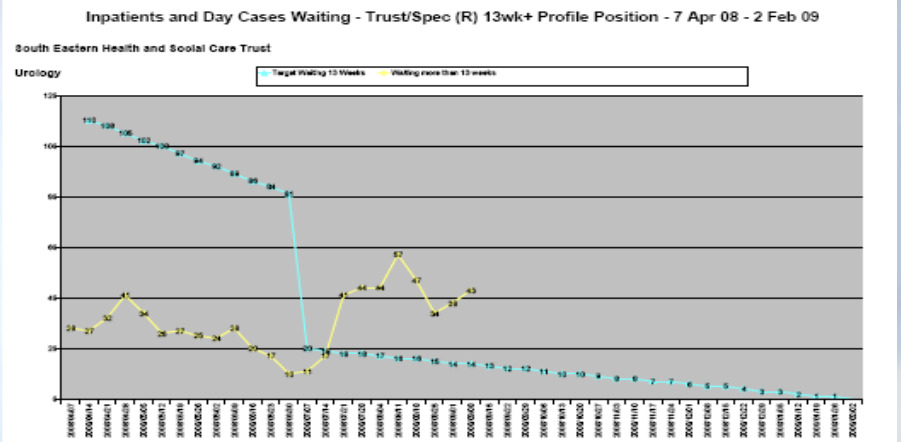
Inpatient Target Profile - Northern



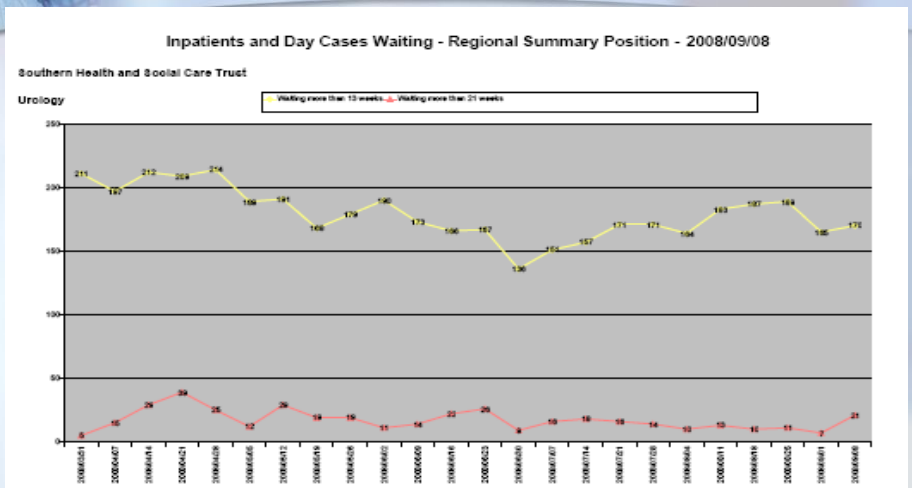
Inpatient Waits – South Eastern



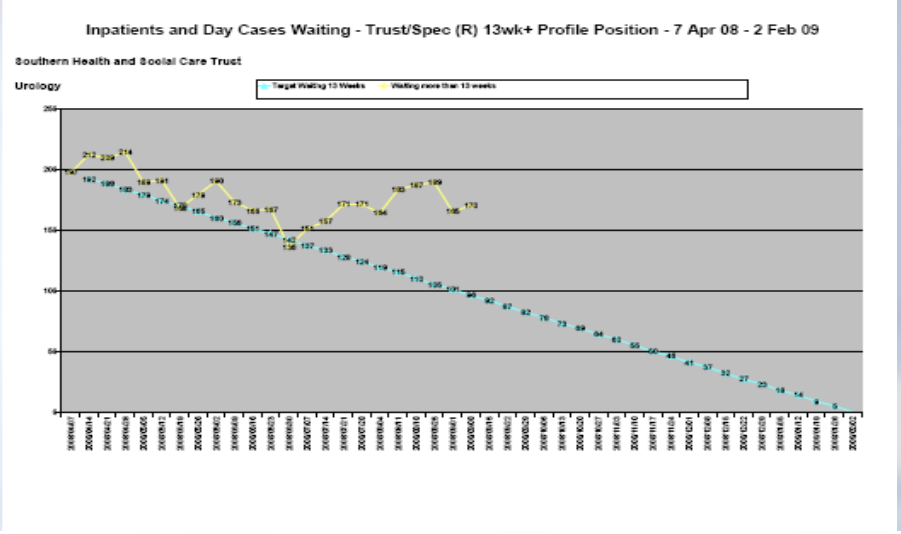
Inpatient Target Profile – South Eastern



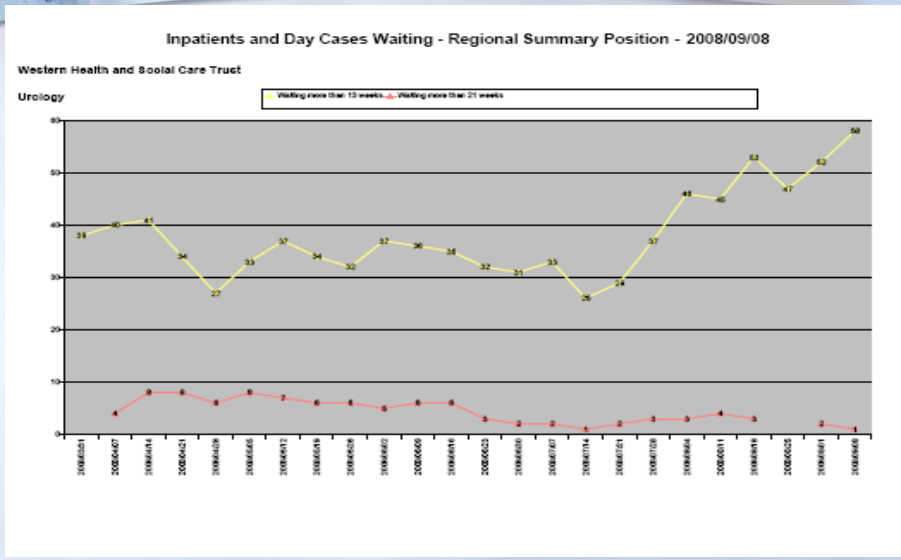
Inpatient Waits - Southern



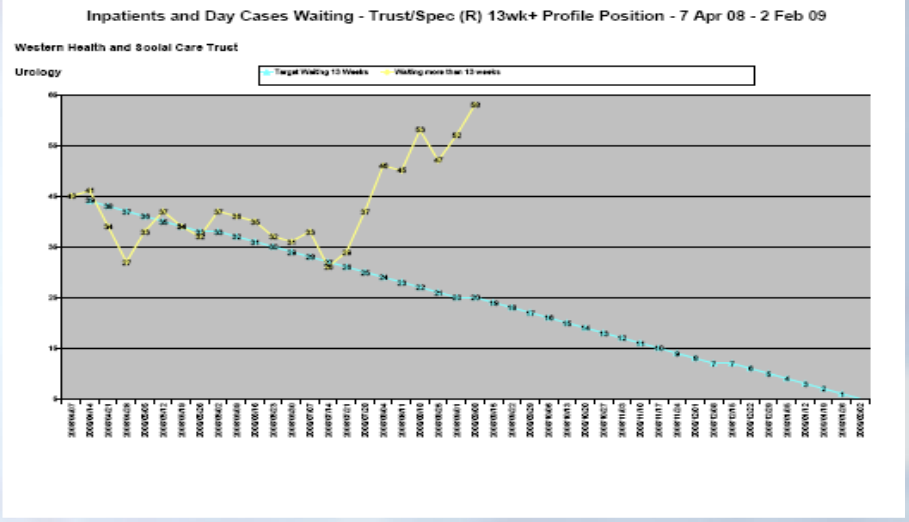
Inpatient Target Profile - Southern



Inpatient Waits - Western



Inpatient Target Profile - Western

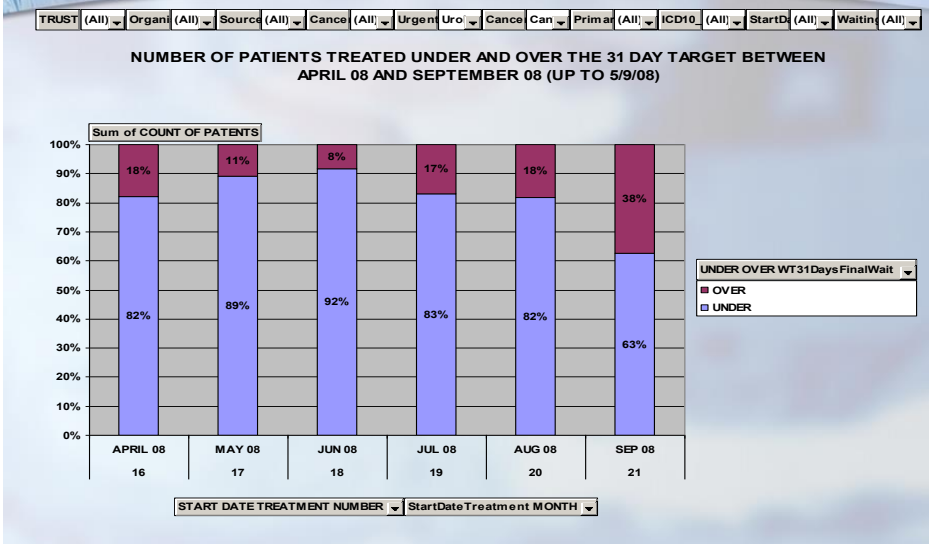


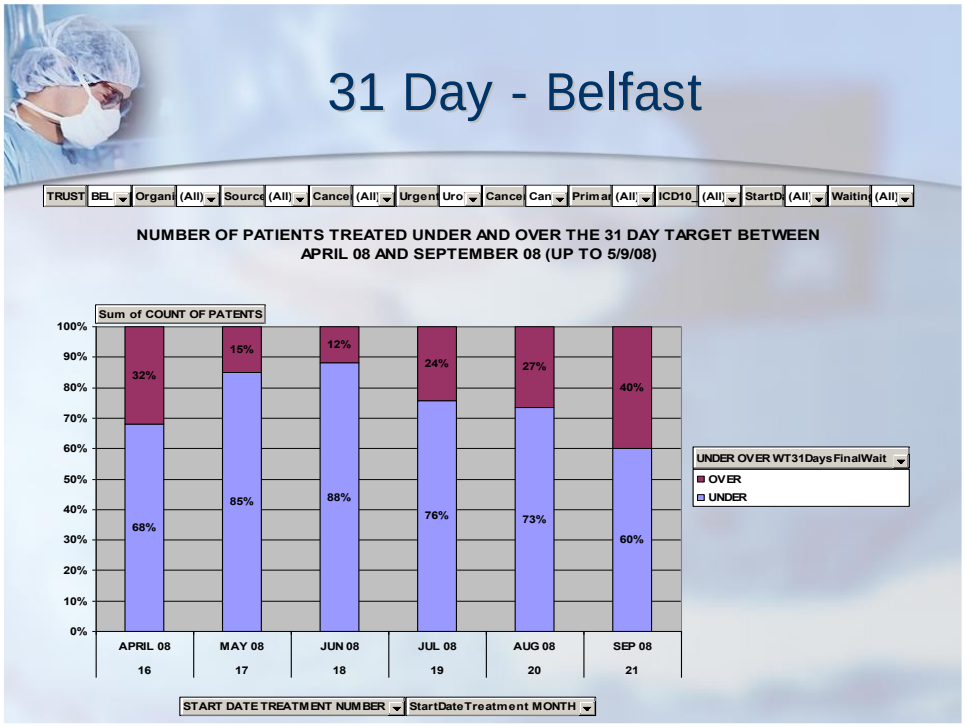
Cancer Waiting Times

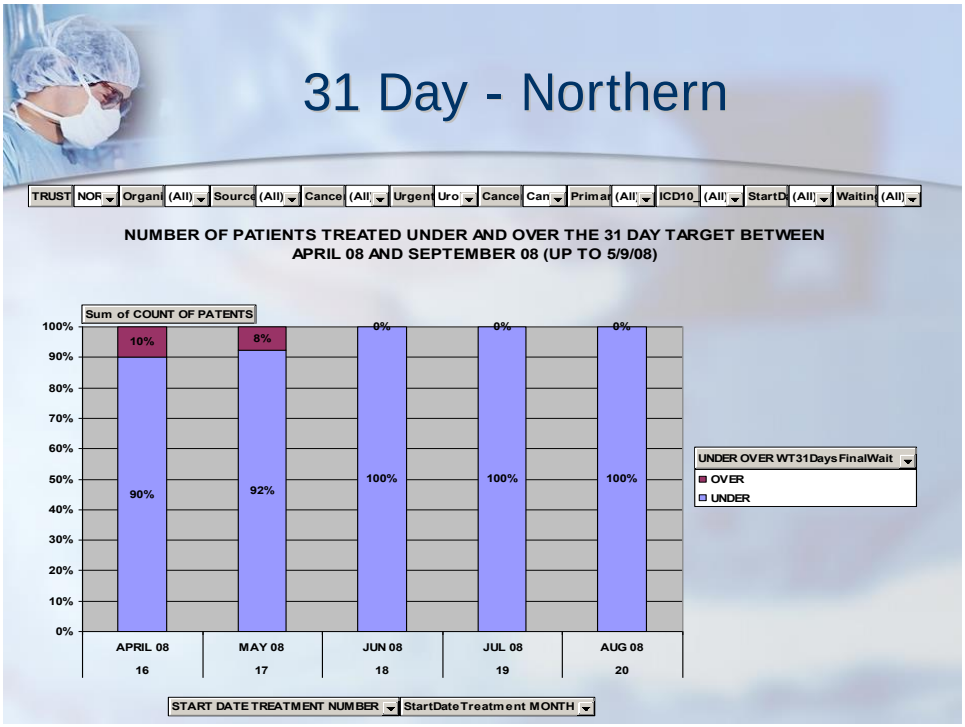
Priorities for Action

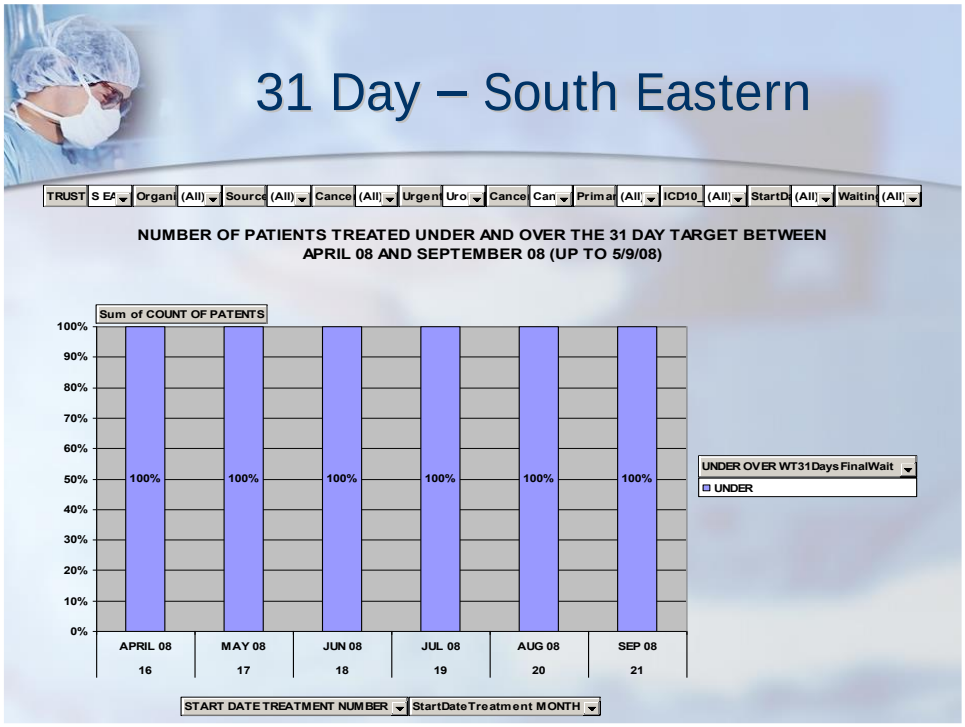
- Trusts should ensure that, from April 2008, 98% of patients commence treatment within 31 days of the decision to treat; from April 2008, 75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days, increasing to 95% by March 2009.

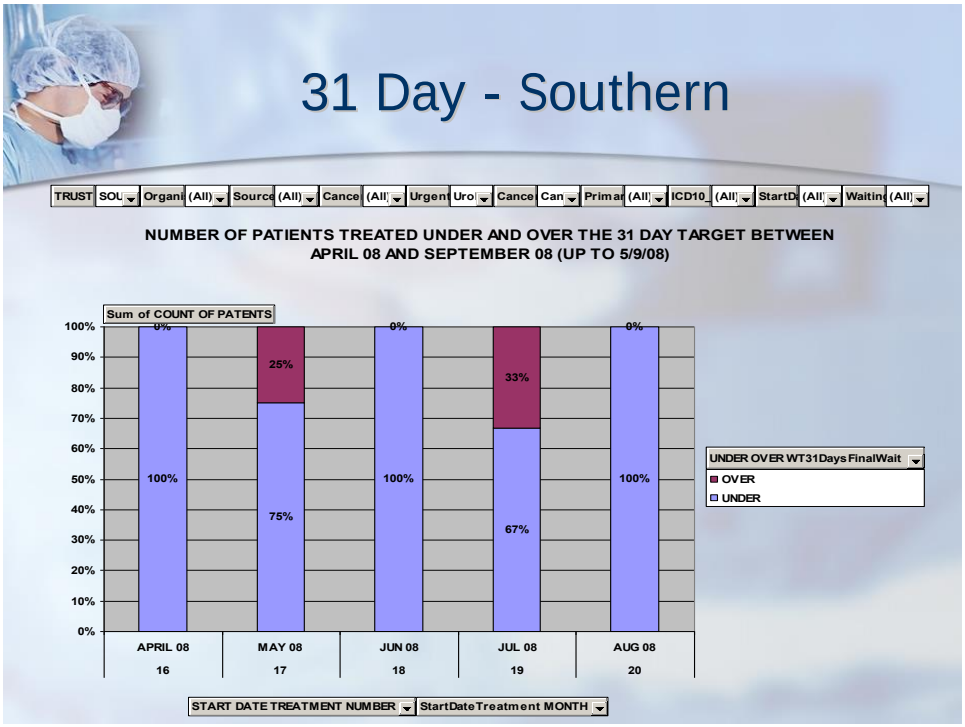
31 Day - Region

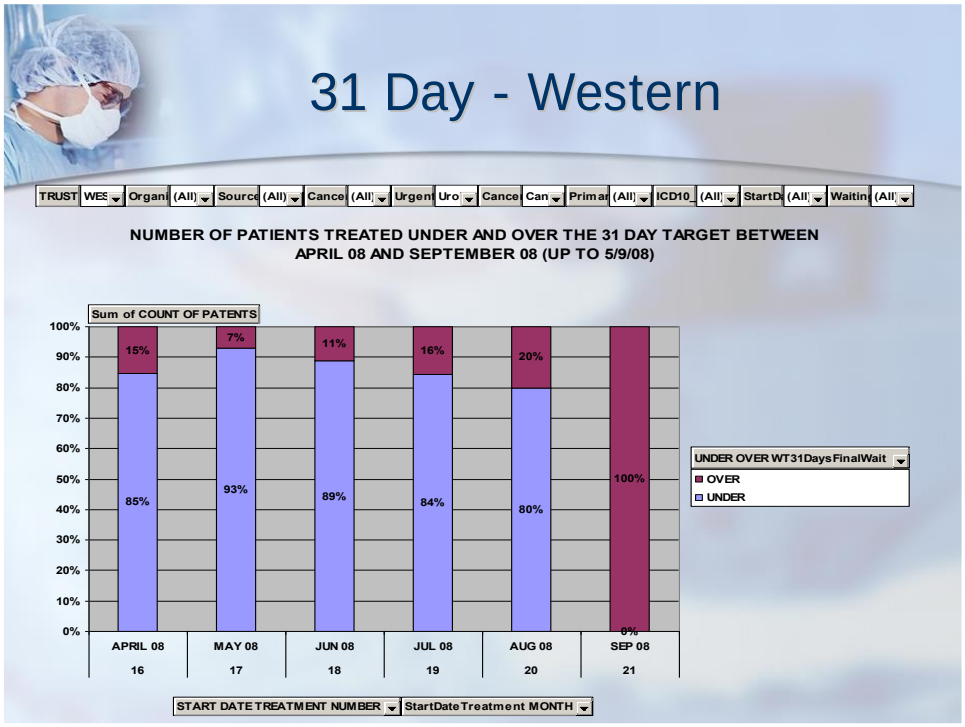


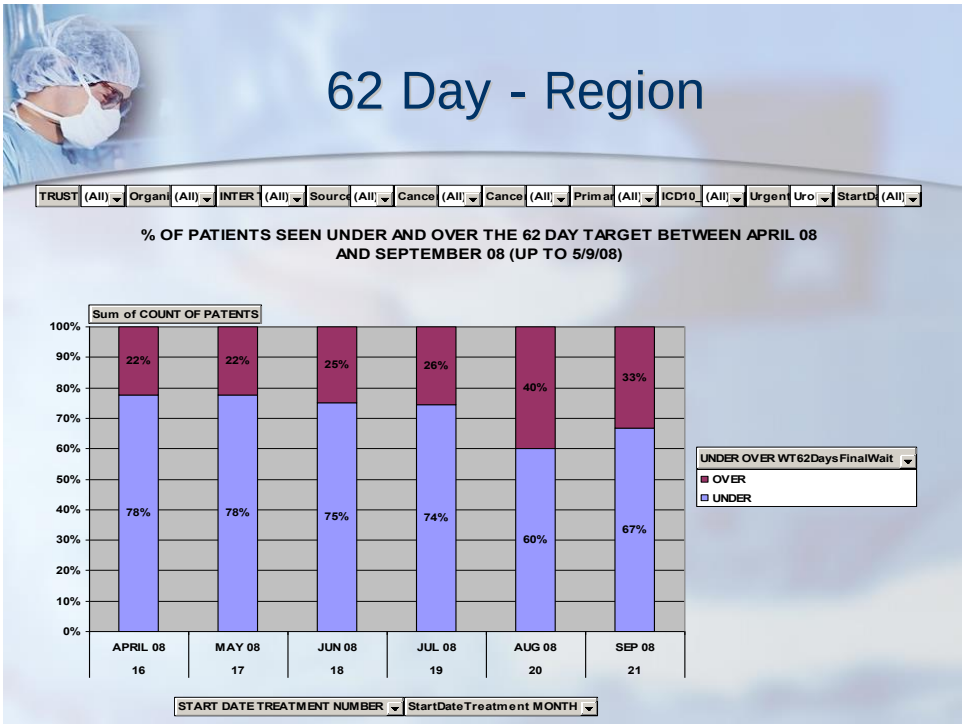


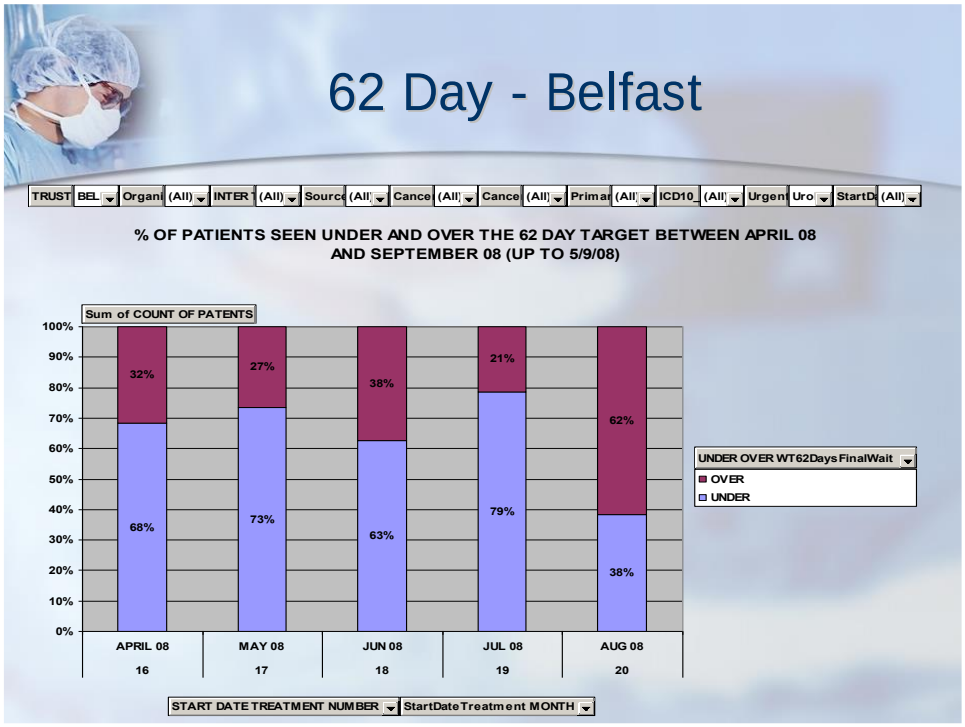


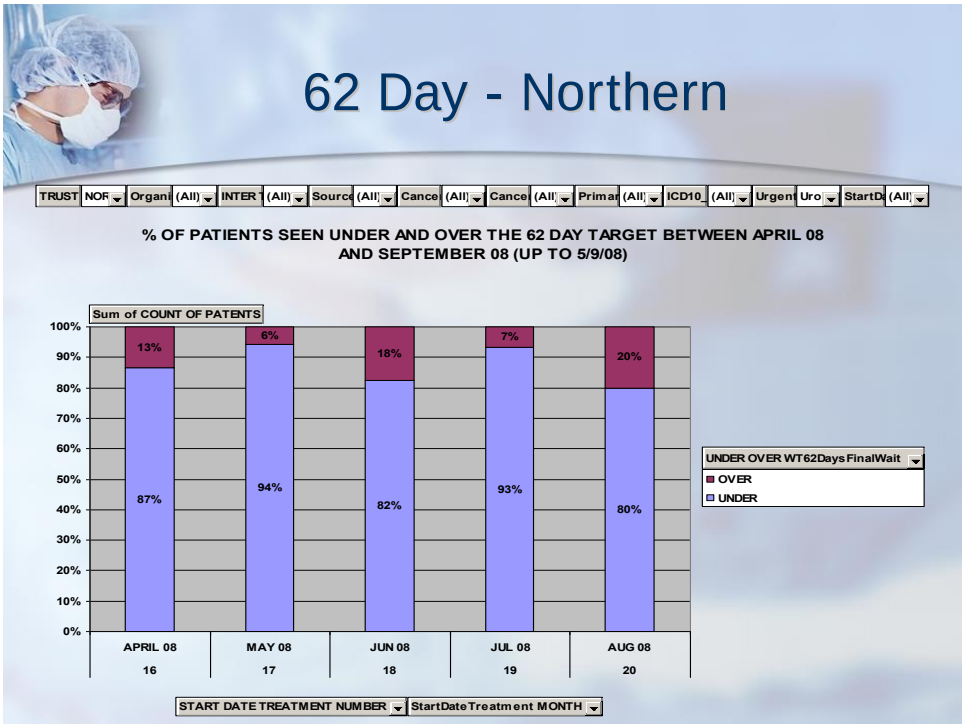


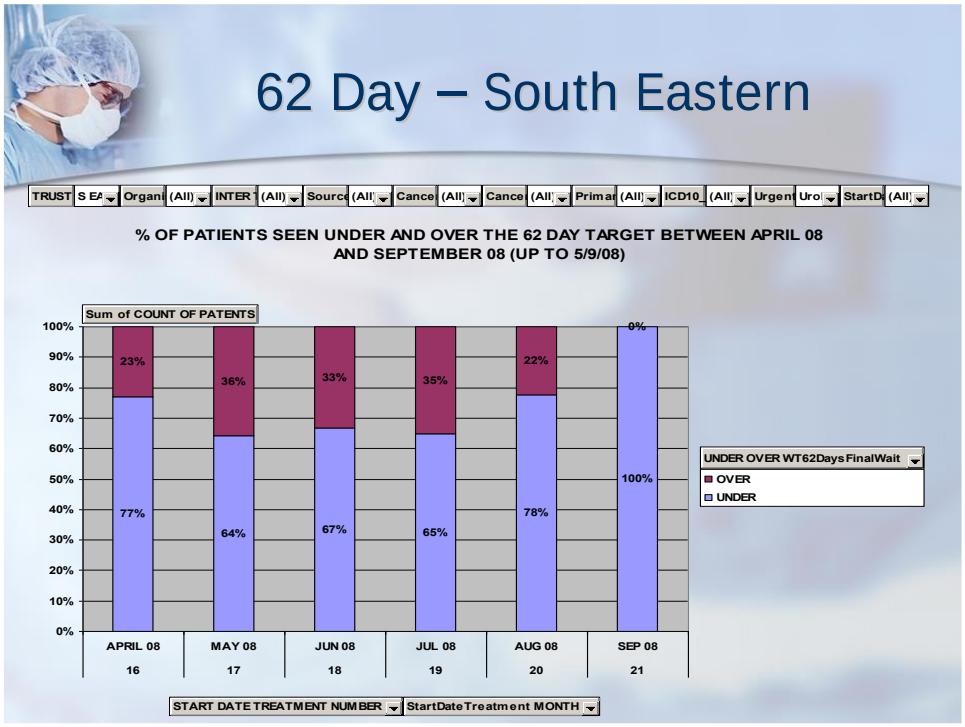


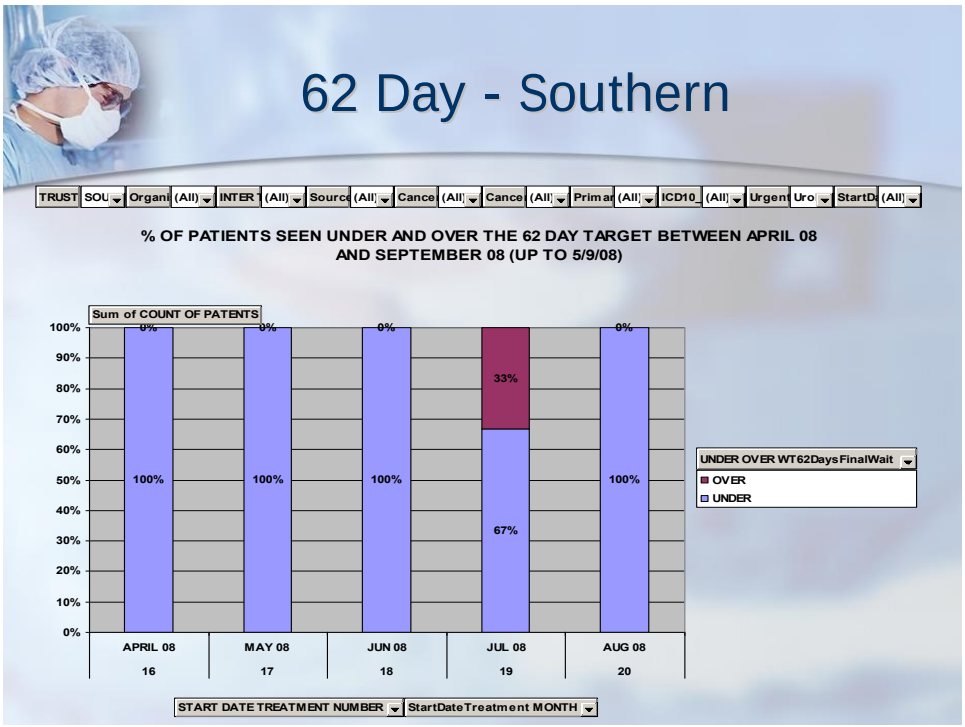








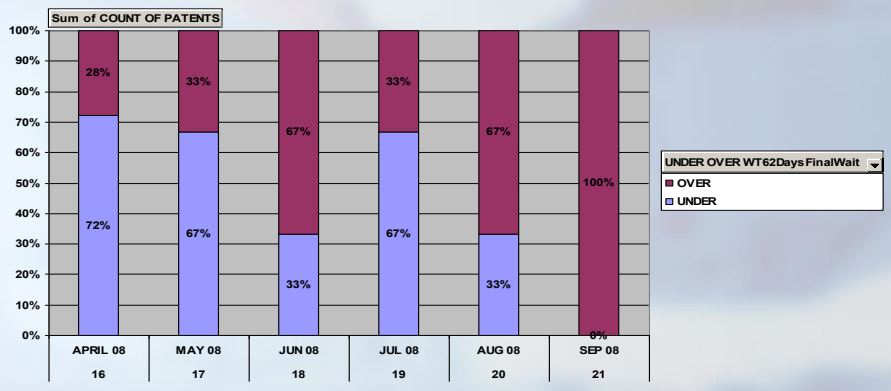




62 Day - Western

TRUST | WES | Organi | (All) | INTER | (All) | Source | (All) | Cance | (All) | Cance | (All) | Primar | (All) | ICD10_ | (All) | Urgent | Uro | StartD | (All)

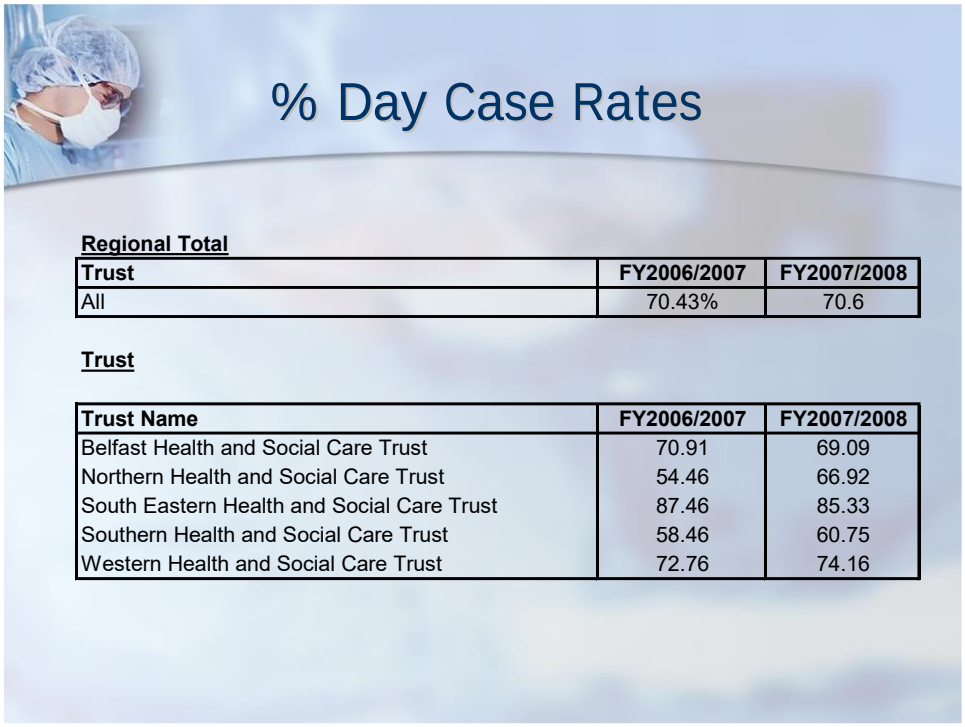
% OF PATIENTS SEEN UNDER AND OVER THE 62 DAY TARGET BETWEEN APRIL 08 AND SEPTEMBER 08 (UP TO 5/9/08)



START DATE TREATMENT NUMBER | StartDateTreatment MONTH

Other Performance Indicators

- Diagnostic Testing
- % Day Case Rates
- Outpatient New : Review Ratios



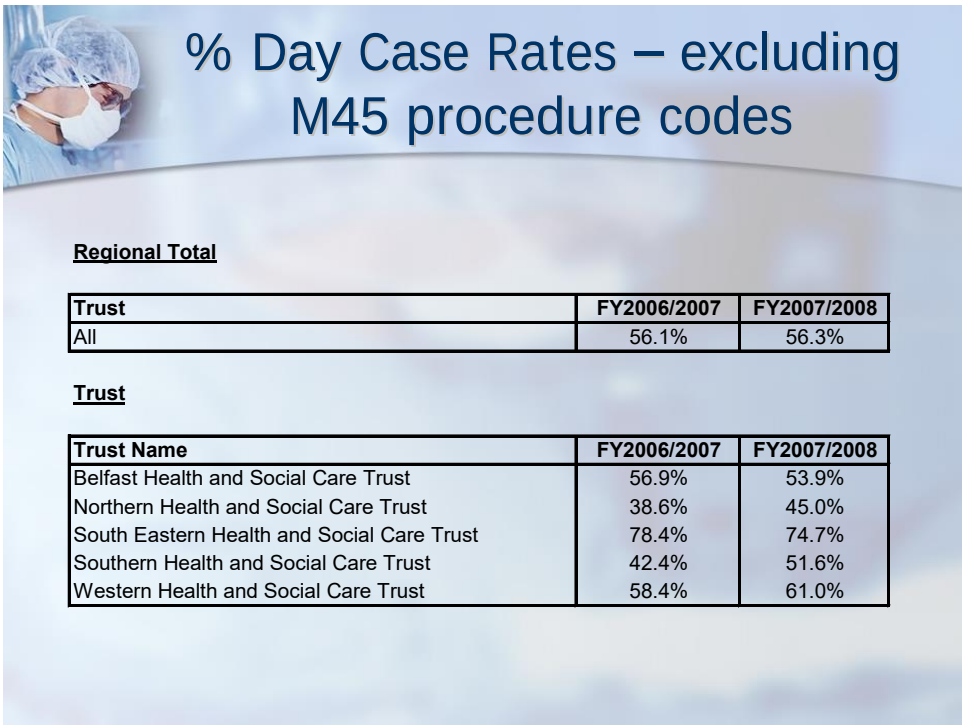
% Day Case Rates

Regional Total

Trust	FY2006/2007	FY2007/2008
All	70.43%	70.6

Trust

Trust Name	FY2006/2007	FY2007/2008
Belfast Health and Social Care Trust	70.91	69.09
Northern Health and Social Care Trust	54.46	66.92
South Eastern Health and Social Care Trust	87.46	85.33
Southern Health and Social Care Trust	58.46	60.75
Western Health and Social Care Trust	72.76	74.16



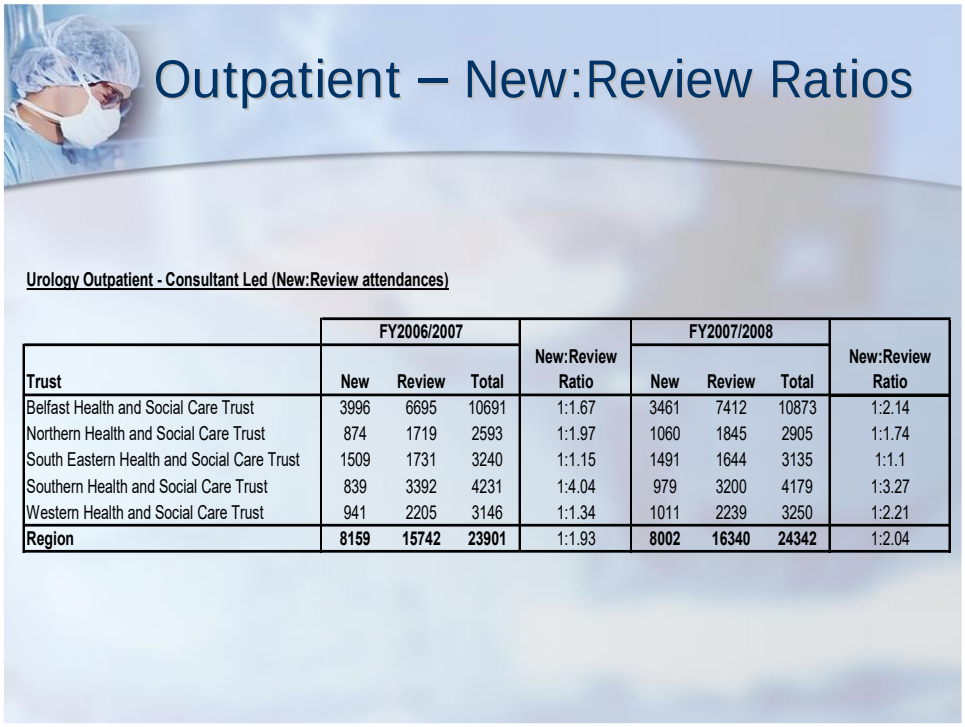
% Day Case Rates – excluding M45 procedure codes

Regional Total

Trust	FY2006/2007	FY2007/2008
All	56.1%	56.3%

Trust

Trust Name	FY2006/2007	FY2007/2008
Belfast Health and Social Care Trust	56.9%	53.9%
Northern Health and Social Care Trust	38.6%	45.0%
South Eastern Health and Social Care Trust	78.4%	74.7%
Southern Health and Social Care Trust	42.4%	51.6%
Western Health and Social Care Trust	58.4%	61.0%



Outpatient – New:Review Ratios

Urology Outpatient - Consultant Led (New:Review attendances)

	FY2006/2007				FY2007/2008			
Trust	New	Review	Total	New:Review Ratio	New	Review	Total	New:Review Ratio
Belfast Health and Social Care Trust	3996	6695	10691	1:1.67	3461	7412	10873	1:2.14
Northern Health and Social Care Trust	874	1719	2593	1:1.97	1060	1845	2905	1:1.74
South Eastern Health and Social Care Trust	1509	1731	3240	1:1.15	1491	1644	3135	1:1.1
Southern Health and Social Care Trust	839	3392	4231	1:4.04	979	3200	4179	1:3.27
Western Health and Social Care Trust	941	2205	3146	1:1.34	1011	2239	3250	1:2.21
Region	**8159**	**15742**	**23901**	1:1.93	**8002**	**16340**	**24342**	1:2.04

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
16th February 2009

Present

Joy Youart (chair)
Mairead McAlinden
Charlie McAllister
Michael Young
Simon Gibson
Robin Brown
Eamon Mackle

Apologies

Paddy Loughran

Membership

Additional membership – Jerome Marley

Terms of reference

Joy Youart gave a context to the discussions and outlined the terms of reference. Mairead McAlinden informed group of need for detailed business case to submit against £8.5million being held regionally for elective access for 09/10 – Urology will be the first call against this money. Joy Youart outlined the issues raised by Catherine McNicholl with regard to the current regional view:

Simon

I am currently writing up the report and its going to take another couple of weeks before the draft goes out.

The issue about beds is not based on any model-- (I was told not to allow for beds!) However I do believe trusts will be able to modernise and reform service provision to free up capacity. Have just looked at average LOS across all sites and Craigavon has the highest for elective at 4.14 in 07/08 with a regional average of 3.37.

There is also an opportunity for you to reduce LOS in non elective- emergency and with your volumes (the same as belfast at 780 per annum) 1/2 to 1 day reduction would free up considerable capacity. Western, Northern and SouthEastern only have about 200. I understand why Belfast is so high but I cannot understand Craigavon's activity. In your last review it said that it was because of long waiting times for elective and that it would reduce once the 3rd Consultant was employed and waiting times fell-- but it hasn't. Daycase rates are also the lowest at 60% with belfast sitting at 69%, Altnagelvin 74% and Southeastern at 85%. When M45'S (cystoscopies) are excluded your daycase rate drops to 52% but so does everyone else's.

Cystoscopies is not really day surgery and therefore should be excluded. In a specialty you should expect to see a daycase rate of at least 60-65%. A few of the procedures are in the "basket" for which performance should be 75%. More admission on the day of surgery, pre-op assessment and LOS of less than a day (23hr) are all clearly going to help.

As a separate issue the volume of elective work per Consultant appears lower than elsewhere (Particularly AOB) and compared with recommended levels of activity and therefore you may not actually require a 5th Consultant.

Hope you are well

Catherine.

-----Original Message-----
From: Gibson, Simon [mailto Personal Information redacted by USI
Sent: 15 February 2009 22:14
To: McNicholl, Catherine
Cc: Youart, Joy; McAlinden, Mairead
Subject: RE: Trust review of Urology

Dear Catherine

Thanks for this - are there any data files breaking down the demand/capacity figures from the regional review you could share with us?

One point I would like to explore is the assumption you make that the removal of 20 radical cancers per year and increasing DC% and decreasing ALOS would balance out the bed requirements which would come with an additional 2 WTE surgeons. Is there any modeling you have undertaken which would evidence this expectation that you refer to?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
Personal Information redacted by USI
Personal Information redacted by USI

-----Original Message-----
From: McNicholl, Catherine [mailto: Personal Information redacted by USI **]**
Sent: 10 February 2009 08:09
To: Gibson, Simon
Cc: Youart, Joy; McAlinden, Mairead
Subject: RE: Trust review of Urology

Simon, apologies for not responding sooner-I hope this is in time for your meeting.

Thank you for asking me these questions as it has made me think about some aspects of the service that I had yet to consider-- Mairead had a quick chat with me on the same issue last week and that also made me think.

I have begun to write up the Review Report but I still have some unanswered questions and outstanding issues to be clarified. (The 3 team model still isn't definitely signed off yet!) Currently the 3 team model assumes a Southern (south/west) team which includes your current resident pop along with fermanagh only at 61,291 bringing your resident pop up to just over 400,000. Based on a consultant ratio of 1:80,000 we are assuming you will have a team of 5 wte.

Team North and West will still serve omagh and surrounding areas-- western currently provides a small outreach service to the Tyrone County with any subsequent inpatient work going to Altnagelvin. It is likely that our proposals will include strengthening OP/DAYCASE provision in Omagh as an outreach from team north and west.

The West doesn't currently provide any out reach service in the Erne. I suspect a small section of this community are already coming to Craigavon for treatment-- you should be able to get this info internally. Equally small numbers from cookstown currently go your direction and we do not envisage this changing-- it would be impossible to draw strict demarcation lines on a map and expect GP's to follow them rigidly.

With a team of 5 consultants it would be wise to look to the future and plan to provide some services outreached to the Erne which will be an enhancement for that population making assessment and diagnostics more locally accessible.

I will try to obtain more info on flows of patients and activity numbers for OP/Ins/Days currently within the Western Trust and in particular the activity generated from Fermanagh. Please also remember that your current resident population is not the same as catchment as some patients flow to belfast/southeastern and to a lesser degree northern. Adlele Graham presented actual catchment for southern elective inpatients and days as 305,000 and 287,000 respectively.

Remember to factor in the transfer of about 20 radical pelvic ops per year to belfast--they take up considerable theatre time/ ICU requirements and probably have the longest length of stay and therefore will release bed days. The costings for the review will not include anything for extra beds/ward staff regardless of additional activity as Trusts will be expected to reduce LOS, do higher % of day surgery and look at 23hr models which are suitable for some/many urology cases.

As part of your review could I suggest you specifically look at emergency admissions to Urology-- I am not going to focus on it in my review but Craigavon's appear unusually high-- is it a recording issue? Can you put systems in place to avoid admission? How many of them go on to have surgical intervention during admission? Can you break them down into conditions e.g. renal colic, acute retention, acute obstruction? With this info you will see what you are dealing with and makes plans to avoid admission, if appropriate, and free up bed and other capacity.

Hope this is enough info to get you started.

Regards

Catherine.

-----Original Message-----
From: Gibson, Simon [mailto: Personal Information redacted by USI Personal Information redacted by
Sent: 03 February 2009 11:31
To: McNicholl, Catherine
Subject: Trust review of Urology

Dear Catherine

We are commencing an internal Trust Review of Urology - I have attached a draft terms of reference, for information. There are also some initial actions we need to pursue, a number of which I am hoping you can help with:

- **What are givens in the new service model?**
- **Specifically, what expectations will there be in relation to Outpatients and Daycase demand generated in the Fermanagh area?**
- **Are there any other expectations in any new service model?**
- **Would you have available the broken down demand/capacity volumes undertaken as part of your regional review which could inform our new service model?**
- **What is the increase in the flows to the Southern Trust? Looking at the map, my assumption is that a 3 centre model will see patient choosing to attend CAH for Urological care from the districts of Cookstown, Fermanagh and the lower quarter of Omagh. Certainly our recent experience of ENT IP services withering in Tyrone County has been these localities flowing to ourselves.**
- **This would equate to roughly 111,711 patients - is this your expectation, or do you have a different view?**

Simon

Work streams

The following workstreams were agreed:

First strand - Need to have an agreed service design model, built on standards we will base our new service model on, and then describe how we deliver it across the 3 sites within a business case to be submitted at the time of the Ministers announcement**. Action : Michael Young and Simon Gibson to define standards we want to base our service model on**

Second strand - need to map out capacity demand model, based upon agreed service model and new catchment area**. Action** : **Simon Gibson to send out existing demand and capacity analysis.**

Third strand will be around workforce planning – team job plans of 3 consultants, done in conjunction with review of clinical support teams, to be incrementally built upon by 4th, 5th and ?6th post. Need central agreement of phasing of 4th post and then a 5th post to ensure equity across the province in line with consultant appointments within other units.

Fourth strand will be around equipment and accommodation – both outpatients and theatres for IP/DC sessions, across all sites

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
2nd March 2009

Present
Joy Youart (chair)
Mairead McAlinden
Michael Young
Simon Gibson
Robin Brown
Eamon Mackle
Heather Troughton

Apologies
Paddy Loughran
Jerome Marley
Charlie McAllister

Work streams

The following workstreams were discussed:

First strand – Service standards

These were agreed at the last meeting.

Second strand - Capacity and demand model.

It was agreed that we need to define what can be done where, on what day of the week, based on combining capacity and demand and the list of procedures defined, against the facilities available across the Southern Trust. (What has to be done on CAH against what can be done in DHH and STH). Would need to be case-mix specific.It would also need to separately include activity coming from Fermanagh and feed this into the capacity and demand calculations
Action: Heather Troughton

Simon Gibson to contact Rosaleen (Belfast Trust) to consider Belfast Trusts proposal.
Action: Simon Gibson

Third strand – Workforce planning

Locum – obtain interview dates just prior to Easter.
Action: Michael Young - Simon Gibson to contact Zoe Parks

List all areas of the service which require cover, and map these against the clinical staff. Recognition that the funding for the fourth post will partially come from the 41PA's which exist in the current service. It was agreed that a team job plan was required. Simon Gibson to bring forward work already undertaken on team job planning to the next meeting
Action: Simon Gibson

Action: Simon Gibson to chase up service administrator and senior manager

Fourth strand - equipment and accommodation – both outpatients and theatres for IP/DC sessions, across all sites

This strand will naturally develop as other strands of work complete.

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
23rd March 2009

Present
Joy Youart (chair)
Michael Young
Simon Gibson
Robin Brown
Eamon Mackle
Heather Troughton
Aidan O'Brien

Apologies
Charlie McAllister

1. Action Notes from previous meeting – 2nd March

These were agreed.

2. Matters arising from previous meeting

Capacity and demand – It was agreed to re-look at the consequences of Fermanagh patients flowing to CAH
Action: Heather Troughton

Service Administrator and Service Manager – It was noted that the Administrator post had been shortlisted, and the Service Manager post was also being processed.
Action: Simon Gibson

3. Activity Data

It was agreed to allow an additional week for reflection on the activity levels proposed as IP/DC
Action: Michael Young, Aidan O'Brien, Mehmood Ahktar

It was agreed for Heather Troughton to contact Lynn Lappin to meet with the clinical team to share with them the capacity and demand model.
Action : Heather Troughton

It was agreed that the service standards would be amended to reflect comparison with peer groups.
Action: Simon Gibson

4. Recommendations from regional review

It was agreed to use the 24 regional recommendations to populate a formal Trust project plan
Action: Simon Gibson

5. 4th post – job plan process

An initial team job plan was tabled, for consideration by the clinical team in advance of the next year.
Action: Michael Young, Mehmood Akhtar, Aidan O'Brien

It was agreed to QA this timetable with existing theatre timetable with Ronan Carroll.
Action: Simon Gibson

6. Creation of formal project plan

It was agreed to create a formal project plan, with timescales and responsibilities for the next meeting.
Action: Simon Gibson

7. Any other business

None

Date of next meeting

Monday 30th March at 4pm

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
30th March 2009

Present
Joy Youart (chair)
Michael Young
Simon Gibson
Eamon Mackle
Lynn Lappin
Mairead McAlinden
Robin Brown
Mehmood Akhtar
Aidan O'Brien

Apologies
Charlie McAllister

1. Action Notes from previous meeting – 23rd March

These were agreed.

2. Matters arising from previous meeting

Service standards
It was agreed to identify any concerns with service standards and finalise these at the next meeting. **Action: Michael Young, Aidan O'Brien and Mehmood Akhtar**

Activity data

Outpatients
Lynn Lappin explained the principles underpinning the model and circulated the demand and capacity model, indicating the shortfalls in capacity. It was noted that there was a need to benchmark these rates. It was agreed to examine the current outpatient review practice, broken down to:

- the different types of ICATS clinics.
- Consultant clinics (by identifying patients with N codes and reviewing their journey through the Urology system to look at their pathway by pathology)

Action: Lynn Lappin

It was agreed to audit why current patients were returning for their review apointments, and also to identify pathways which exist in other centres which allow patients to be discharged.
Action: Heather Troughton

It was noted that this piece of work could also identify patients to be discharged into the care of GPs, following discussions with GP colleagues. It was noted that under Payment By Results, only a set number of reviews would be paid for by commissioners.

(Mairead McAlinden and Joy Youart left the meeting)

Inpatients/Daycases
It was agreed to adjust the demand-capacity gap by operative procedure time.
Action: Lynn Lappin

It was agreed to confirm whether or not any funding would come from the Regional Review of Urology for additional capital build for theatres and beds.
Action: Simon Gibson

(Lynn Lappin left the meeting)

Following a full discussion on changes in service configuration, it was noted that another meeting was commencing at 6pm. In light of this, it was agreed to defer discussion on the following until the next meeting:

- Initial draft of team job plan
- Service standards
- Trust Urology Project Plan

Date of next meeting

Monday 6th April at 4pm

Southern Health & Social Care Trust

Trust review of Urology

Steering Group meeting
6th April 2009

Present
Joy Youart (chair)
Michael Young
Simon Gibson
Mairead McAlinden
Robin Brown
Mehmood Akhtar
Aidan O'Brien
Jerome Marley
Heather Troughton

Apologies
Charlie McAllister
Eamon Mackle

1. Action Notes from previous meeting – 30th March

These were agreed.

2. Matters arising from previous meeting

Following a lengthy discussion, it was agreed to spend time at the next meeting looking at how Urology care could be delivered at a meeting on Monday 20th April at 11am.

Service standards
There was extensive discussion around the service standards tabled. It was agreed to consider day case rates on a procedure basis, following a review of main theatre lists to consider which patients currently listed onto the main theatre would be suitable to managed as a day case.

Activity data

Outpatients
Lynn Lappin explained the principles underpinning the model and circulated the demand and capacity model, indicating the shortfalls in capacity. It was noted that there was a need to benchmark these rates. It was agreed to examine the current outpatient review practice, broken down to:

- the different types of ICATS clinics.
- Consultant clinics (by identifying patients with N codes and reviewing their journey through the Urology system to look at their pathway by pathology)

Action: Lynn Lappin

It was agreed to audit why current patients were returning for their review apointments, and also to identify pathways which exist in other centres which allow patients to be discharged.
Action: Heather Troughton

It was noted that this piece of work could also identify patients to be discharged into the care of GPs, following discussions with GP colleagues. It was noted that under Payment By Results, only a set number of reviews would be paid for by commissioners.

(Mairead McAlinden and Joy Youart left the meeting)

Inpatients/Daycases
It was agreed to adjust the demand-capacity gap by operative procedure time.
Action: Lynn Lappin

It was agreed to confirm whether or not any funding would come from the Regional Review of Urology for additional capital build for theatres and beds.
Action: Simon Gibson

(Lynn Lappin left the meeting)

Following a full discussion on changes in service configuration, it was noted that another meeting was commencing at 6pm. In light of this, it was agreed to defer discussion on the following until the next meeting:

- Initial draft of team job plan
- Service standards
- Trust Urology Project Plan

Date of next meeting

Monday 20th April at 4pm

Trust Review of Urology

AGENDA

Monday 15th June at 4.30pm
in Tutorial Room 1, 1st Floor, MEC, Craigavon Area Hospital

1. Apologies
2. Stocktake – review objectives
3. Service standards
4. Workforce planning
    i. 4th Consultant post
    ii. Team job plans
5. Trust project plan
6. Any other business

Trust Review of Urology

AGENDA

Monday 22nd June at 4.30pm
in Tutorial Room 1, 1st Floor, MEC, Craigavon Area Hospital

1. Apologies
2. Stocktake – review objectives
3. Workforce planning
    i. 4th Consultant post
    ii. Team job plans
4. Trust project plan
5. Any other business

Department of
Health, Social Services and Public Safety
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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Directors of Planning and Performance
HSC Trusts

Service Delivery Unit
Templeton House
411 Holywood Road
BELFAST BT4 2LP
Tel: Personal Information redacted by USI
Fax: Personal Information redacted by USI
Email: Personal Information redacted by USI

Our Ref: MB204
Date: 10 December 2008

Dear Colleague

ACHIEVEMENT OF 2008/09 ELECTIVE WAITING TIME TARGETS – PTL WEEKLY REDUCTION PLANS

You are aware of the expectation, that in the majority of specialties, Trusts will achieve the 2008/09 maximum waiting time targets for elective services (including AHP services) by 31 January 2009 and sustain these through February and March.

At the recent elective care operational performance meeting and at the individual Trust performance meetings on 3 December, it was clear that there are still a significant number of patients across all of the elective care areas who still need to be seen and/or treated to meet the targets within this timescale. In addition, some Trusts highlighted a number of areas where they are unlikely to achieve the elective targets by the end of January.

In order to monitor progress and minimise the need for detailed discussion at future performance meetings, I would ask you to arrange for the attached pro-forma to be completed for any specialties where you expect, at the end of January, to have patients waiting longer than 9 weeks for a first outpatient appointment; 9 weeks for a diagnostic test; 13 weeks for inpatient or daycase treatment or 13 weeks for AHP services. The pro-forma should detail the total number of patients who need to be seen by 31 March 2009 (the PTL) and the estimated weekly reduction in the PTL until all patients have been seen and/or treated. It should also provide details of both in-house and independent sector activity. From our recent meetings I understand that Trusts already have plans in place from which this information should be readily available.

Completed pro-formas should be returned by email to Jill Young at [redacted] by no later than **Friday 9 January**. Any queries on the completion of the pro-formas should be addressed to Jill by e-mail or on [redacted].

Thank you for your co-operation with this matter.

Yours sincerely

MICHAEL BLOOMFIELD
Assistant Director of Performance
Service Delivery Unit

cc Directors of Acute Services
Directors of Mental Health
Assistant Directors of Performance
Hugh Mullen
Catherine McNicholl
Jill Young

SDP MEETING

Thursday, 13 November 2008

Cancer and Clinical Services Division (Wendy/Louise)

Audiology ** RISK **

- 2 audiologists due to retire in next 6 to 12 months – putting in plan for recruiting/training assistant audiologists

Imaging

- By the end of November there will be 5 patients booked that will be past 9 weeks – these are specific ultrasound examinations that only certain consultants undertake – all other patients are in partial booking process

Nerve Conduction Studies

- All going to IS – no risk
- Not as much IHA used – may need some additionality for EEG due to temporary staff shortage – which could be offset against NCS

Pain Management DC

- Discussions have been had with Paul McConaghy in respect of the spinal cord stimulators – Paul happy to proceed if he receives correspondence from Finance confirming funding for the 8 Southern Health and Social Services Board patients and the 4 WHSSB patients – Wendy has spoken to Clodagh in respect of this – Mary McGeough will do a call-off order so that all supplies are in place once the correspondence is received

  Action – Clodagh to forward correspondence

Pain Management OP

- Peter Wright is underperforming in respect of clinical sessional commitment
- Committed to 84 OP sessions a year – to date has only undertaken 30
- Ronan addressing with Peter – will be escalated to Charlie McAllister if required and then to Paddy Loughran
- Requirement for these clinics ASAP – booking needs to be commenced to stop any further use of IHA or IS as already in excess of SDP

  Action – Ronan to address with Peter and feedback ASAP

Theatres ** RISK **

- Issue regarding refurbishment of Daisy Hill Hospital obstetric theatres – will have an impact on general surgery and gynaecology theatre sessions in December – will have an impact on both cutting plans as this has not been factored in
- Urgently require potential impact on the general surgery and gynaecology sessions
- Meeting on Friday, 14/11/08 to discuss

  Action – Wendy to advise of impact following this meeting

Action – Cutting plans to be reworked if required

- 6 new nurses have started, 3 are to start and 4 are going through occupational health – Wendy to confirm timescales for availability of additional sessions through the additional nursing staff

Action – Wendy to confirm timescales of availability of additional sessions at next meeting

- 12 theatre nurses on Craigavon Area Hospital out sick – 10 long-term sick – potential for 3 lists to be cancelled next week – confirmation needed urgently – Wendy to advise ASAP

Action – Wendy to advise of potential list cancellations ASAP

Integrated Maternity and Women's Health Division (Anne/Pauline)

Gynaecology IP/DC

- Very positive and productive meetings held on the Craigavon Area Hospital and Daisy Hill Hospital sites – agreement for creation of pooling for certain procedures amongst Craigavon Area Hospital consultants – agreement from Daisy Hill Hospital consultants in respect of pooling also but some differences in clinical practice – awaiting agreement for transfer of LLETZ biopsies to Daisy Hill Hospital – Noel Heasley leading on the Craigavon Area Hospital site – David Sim leading on the Daisy Hill Hospital site – once agreements confirmed Pauline and Lynn to develop into numerical cutting plan

Action – Pauline and Lynn to develop numerical cutting plan

Gynaecology OP

- Very positive and productive meeting held with David Sim on Wednesday, 12/11/08 – agreement has been reached to pool cross-site – issues highlighted in respect of turnaround time for triage of referrals – Pauline to work with David Sim in respect of this – Louise to sort out PAS and booking staff – Pauline to raise awareness of this agreement and way forward with team leaders and staff

  Action – Louise to sort out PAS changes required and booking staff awareness
  Action – Pauline to work with David in respect of triage times
  Action – Pauline to raise awareness with team leaders/staff

- Problem has arisen in respect of colposcopy slots on the Daisy Hill Hospital site – Louise had advised that these slots were not to be booked up and that they were to be used for Craigavon Area Hospital patients – Daisy Hill Hospital consultants heard of this via booking staff and are not happy – Louise to speak with the relevant consultants as a matter of urgency to sort out

  Action – Louise to speak to relevant Daisy Hill Hospital consultants

- David Sim raised the issue of the referral and booking centre at the meeting on Wednesday – not happy that no-one has spoken to the consultants about this – would like explanations on how the centre will work, how partial booking works, how the review waiting list works etc. Lynn to raise with Siobhan Hanna and Catherine Weaver

  Action – Lynn to raise with Siobhan and Catherine

- Interim agreement has been reached with Consultants, who are affected by the 10 PA/additional payment rule

Medicine and Unscheduled Care Division (Lindsay/Phyllis/Louise)

Cardiology Diagnostics

- Concern in respect of waiting list figures/weeks waiting against cutting plan
- Lorraine Adair speaking to Gwyneth McClintock in respect of booking etc
- Issue in respect of differences in TOMCAT and Pathfinder which leads to difficulties in pooling of lists
- Phyllis and Lynn meeting on Tuesday, 18/11/08 to re-examine the plan, booking etc

Action – Lorraine to talk to Gwyneth
Action – Phyllis and Lynn to meet on Tuesday, 18/11/08

CPAP ** RISK **

- New service had been planned to commence in December – issue with physical location and associated works – Lindsay to speak to Joy
- New service will start ? January/February – will have impact on cutting plan – talking to MTOs in respect of adding additional payments on to their Saturday evening sessions (3 instead of 2)
- May need to push the 13 weeks cut back to January

Action – Lindsay to speak to Joy in respect of physical location/associated works
Action – Phyllis to revise cutting plan

Dermatology DC

- 2 sessions required for 11 patients – patients are only suitable for David Eedy to undertake (10 BCCs and 1 rewedging) – two theatre sessions available in South Tyrone Hospital on 21st and 26th – David not available on 21st, available on 26th but equipment differences on South Tyrone Hospital with associated governance issues in respect of training – only option to get treated in month is to go to Dundonald (issues in respect of short notice, costs and difference in treatment)
- Going to carry these 11 patients forward to December and pull forward some of the December patients for Paula Reid to undertake in November

Dermatology OP

- Plan submitted
- Issue of 37 patients due to suspended/cancelled clinics – meeting held this AM (13/11/08) with resolution achieved for these patients

Gastro-enterology DC

- Lindsay meeting with Philip Murphy this PM (13/11/08) to discuss pooling
- Potential impact from access times requirements in respect of GRS targets (2 weeks for urgent and 6 weeks for routine) – meeting to be held on Friday, 14/11/08 in respect of establishment of a GRS Executive Board and progression of GRS – Wendy to provide feedback at next meeting

Action – Wendy to provide feedback at next meeting
Action – Lindsay to report back to next meeting

General Medicine OP

- Louise spoke to Charles O'Brien
- There is an issue for 20 patients in November
- Charles O'Brien returned 5 patients from a batch that had been sent to him – Louise to discuss with him
- Lindsay meeting with Philip Murphy this PM (13/11/08) to discuss pooling, increasing templates etc

Action – Lindsay to report back to next meeting
Action – Louise to speak to Charles

Neurology OP

- Anticipated 131 in excess of SDP
- Discussions held with Dr Forbes in respect of Dr Nwe undertaking additional sessions within her job plan – Dr Forbes has confirmed that Dr Nwe is unable to undertake any additional sessions within her job plan
- Commitment secured from Raeburn Forbes and John Craig to undertake additionality

Paediatric Cardiology OP

- Current shortfall in RVH also – births increased in Southern Area which is impacting on demand for this service – RVH to go back to Commissioners
- No contract shortfall

Respiratory OP

- Shortfall problem on Craigavon Area Hospital site – Alexander John willing to undertake additional sessions but only sees 6 new patients in a session - ? is this acceptable level – Lindsay to discuss with Philip Murphy
- Look into potential of Nurse-Led seeing some new patients – Lindsay to speak to Eileen O'Rourke to investigate this

Action – Lindsay to discuss with Philip
Action – Lindsay to speak to Eileen to investigage

Rheumatology OP and DC

- The consultants are considering changed OP sessions to DC sessions – cannot afford to sacrifice one for the other – Phyllis to have discussion with Nicola Maiden – Lindsay to raise with Philip Murphy

Action – Phyllis to meet with Nicola
Action – Lindsay to raise with Philip

Surgery and Elective Care Division (Sharon/Louise)

ENT IP/DC

- Plan forwarded for monitoring
- All IH patients scheduled to reach 14 weeks
- 4 IS ENT and 3 IS paediatric ENT patients to be scheduled to reach 14 weeks – in partial booking process
- 6 CPAP patients not scheduled – awaiting capacity from Medicine and Unscheduled Care Division

- Sharon has re-examined December's IS requirements – had planned to send out 208 – actually sending out 80

ENT OP

- Audiology cover confirmed for all day Saturday and alternative Friday PM

Action – Louise to advise Wendy when the Friday PM clinic will commence

General Surgery IP/DC

- 4 IH general surgery and 1 IH paediatric surgery patients to be scheduled to achieve 14 weeks in November – being discussed with Robin Brown to have patients undertaken in Daisy Hill Hospital
- 8 IS patients to be scheduled to achieve 14 weeks in November – in partial booking process

- Sharon has re-examined December's IS requirements – had planned to send out 412 – actually sending out 160

- Locum Consultant has retracted his resignation and will remain until substantive post is filled – Sharon to rework cutting plan

Action – Sharon to rework cutting plan

General Surgery OP

- Predicting overspend of 286 – No further additionality required

Oral Surgery DC

- Scheduled to meet 14 weeks in November

Oral Surgery OP

Action – update required from Lesley in respect of discussions with Southern Health and Social Services Board re: contract

Ophthalmology OP

Action – update required from Lesley in respect of discussions with Southern Health and Social Services Board re: contract

Orthopaedic IP/DC

- 1 IH patient to be scheduled to achieve 21 weeks in November – patient been seen at OPD to ? displace another patient who is waiting a shorter time period for the same procedure
- Costings received for IS orthopaedics – Barry Conway, Lesley Leeman and Sharon meeting on Tuesday, 18/11/08 to progress

Orthopaedic OP

- Slowed down cut – still shortfall of 10 patients in November for upper limb – Barry working on solution for patients to be seen in the last week of November

  Action – update required from Barry

OP Review Backlog

- Expressions of interest have been received from administrative staff for overtime to type and undertake associated administrative tasks for these clinics
- Recruitment request forms to be submitted for temporary A & C staff
- The Project Manager post is being interviewed on Tuesday, 18/11/08

  Action – Louise to submit recruitment request forms for Personal Secretaries

  Action – Update required from Simon in respect of conversations with Clinical Directors/Lead Clinicians re: addition of 1 extra review per senior doctor onto clinic templates and commitment/availability for additional clinics

- Concerns raised by Wendy in respect of the impact of these additional sessions on laboratories and radiology as no costs or additionality has been included for these departments

- Concerns raised by Sharon in respect of conversion from OP to IP/DC and the practicalities associated with post-clinic administration

- Concerns raised that staff are not aware of what to tell patients when they query why they have not had their review appointment on time – would be beneficial to have a standard phrase that all staff could use

  Action – development of standard phrase for staff to use

- Louise reported no further progress in respect of the potential relocation of staff within the OP area to facilitate conversion of rooms into clinic rooms

  Action – update required from Simon in respect of room conversions and associated estates work

Paediatric Medicine OP

- Louise factored in ROTT to the cutting plan
- Anticipated 189 in excess of SDP
- Dr Aljarad ? on leave – Louise to go ahead and meet Grace Hamilton without Dr Aljarad

  Action – Louise to meet Grace Hamilton

Planned Scopes

- Plan is on track

Urodynamics

- Suggestion to transfer patients to Daisy Hill Hospital service and cease any further additionality
- Sharon Glenny has spoken to Connie Connolly in respect of this. Connie feels that there is a difference in the urology and gynaecology urodynamics – they are not trained to do men and the tests that are undertaken are different for urology than what they are trained to do for gynaecology patients
- Were sitting at 9 weeks – now to achieve 9 weeks for December there is a total of 29 patients require to be seen which requires 7.5 all day sessions – only have 3 all day sessions for December – concerns re: consultant and nursing willingness to undertake further additionality for this service

  Action – Escalate to Joy - decision required on way forward ASAP

- Only showing as 40% booked – all other patients are in partial booking process

Urology IP/DC

- Plan forwarded for monitoring
- 30 patients sent to the Belfast clinic to achieve 21 weeks in November – 10 patients removed through validation – 4 patients undergone POA – 16 patients to undergo POA (Monday, 17/11/08) – further cohort of patients to be sent to achieve 14 weeks
- Capacity has been confirmed with the Belfast Clinic for all patients
- POA outcomes are being fed back
- 3 people on PTL for 14 weeks who need an in-house solution

  Action: Update required from Simon re: discussions with Paddy

- Sharon has re-examined December's IS requirements – had planned to send out 234 – actually sending out 75 day cases with some more to go

Urology OP

- Overspend on SDP continuing until Mr Aktar's job plan sorted

Urology OP Review

Action: Update required from Simon re: discussions with Eamon

Southern Health and Social Care Trust

TRUST DELIVERY PLAN

2009-10

Mr Colm Donaghy,
Chief Executive
16th June 2009

Southern Health and Social Care Trust

Contents

Southern Health and Social Care Trust

1.0 Local Context

The Trust's Vision is to deliver safe, high quality and responsive health and social care services, respecting the dignity and individuality of all who use them. This Vision is underpinned by the Trust's values which shape what we do and how we do them. These values are:

- *We will treat people fairly and with respect*
- *We will be open and honest, and act with integrity*
- *We will put our patients, clients, carers and community at the heart of all we do*
- *We will value and give recognition to staff, and support their development to improve our care*
- *We will embrace change for the better*
- *We will listen and learn*

We want to be very clear about what is important to us as a Trust, and what we want to achieve. The Trust's priorities are:

- *Providing safe, high quality care*
- *Maximising independence and choice for our patients and clients*
- *Supporting people and communities to live healthy lives and to improve their health and wellbeing*
- *Being a great place to work, valuing our people*
- *Making best use of resources*
- *Being a good social partner within our local communities*

The Trust is committed to change services for the better and has set out in this document how it intends to develop and transform the services it provides over the next 5 years.

Southern Health and Social Care Trust

Underpinning our development plans and service changes are our 6 priorities for change.

Southern Health and Social Care Trust

Where we are now	Priorities for Change	Where we want to be in 5 years
A commitment to continually improve the quality of the services we provide.	Improved safety and quality of care, and reduced waiting times	Providing safe, high quality care, by the right person, in the right place at the right time
Some users feel they have limited choices for care, and too many people are living in institutional care.	Person-centred planning for all our users and development of 'Own Front Door' solutions	More people living independently with care that is tailored to their needs and choices
Too many of our users experience preventable physical and mental ill health	Increased health promotion and prevention services and empowerment of users and communities	A healthier population with improved wellbeing and quality of life
Many people with long term health care needs unable to manage their condition and dependent on our services	Develop new services and technologies to help people better understand and manage their condition	People with long term care needs are informed and helped to be 'expert patients', self managing their condition
Users, staff and partner organisations – public, voluntary and private sector - are not fully engaged in our planning	Enabling the views of users to inform our care, better engagement with staff, improved partnership working to improve care	Services are driven by the 'voice of the user', staff feel informed and engaged, and services are 'joined up' across organisations
Our voluntary sector partners are not funded in a way that sustains and develops the care they provide	Developing long term funding arrangements with voluntary sector partners with agreed contracts for care	Strong, sustainable partnerships which improve the range and quality of care to our users and communities.

The Trust is consulting on a 5 year Strategic Plan "Changing for the Better" which sets out key service strategies, developments and changes. The Trust's TDP provides detailed plans for the implementation of "Changing for the Better" in 2009/10.

Southern Health and Social Care Trust

2.0 Detailed Delivery Plans - Public Service Agenda & Ministerial Targets

2.1 Introduction

The Trust's response to the 2009/10 targets have been set in the context of the Southern HSS Board's HWIP and are presented in the Department's proposed template. A copy of the Trust's response to each of the Public Service Agreement and associated targets is attached as Appendix 1. Baseline data has been presented where available.

Each target has been assessed from the Trust's perspective and coded. A summary of the achievability of the targets across all programmes of care is included in Table 1 overleaf:

Southern Health and Social Care Trust

Table 1: TDP Summary of PSA & Associated Targets.

TDP Summary of Planned Outcomes Targets 2009/10.

Targets	A1	A2	A3	A4	N/A	Total Applicable	Total
Priority Area 1: Improving Health and Well-being	**1**					1	1
Priority Area 2: Ensuring Safer, Better Quality Services	4					4	4
Priority Area 3: Improving Acute Services	**9**					9	9
Priority Area 4: Ensuring Fully Integrated Care and Support in the Community	6					6	6
Priority Area 5: Improving Children's Services	7					7	7
Priority Area 6: Improving Mental Health Services	6					6	6
Priority Area 7: Improving Services for People with a Disability	6		1	1		8	8
Priority Area 9: Improving Productivity	7					7	7
Priority Area 10: Modernising the Infrastructure	1					1	1
Total	45		3	1		49	49

A1 - Target assessed as fully achievable

A2 - Achievable depending on regional action

A3 - Achievable if additional resources agreed

A4 - Likely to be achieved with some delay/partially achieved

N/A - Not achievable

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3.0 Workforce Strategy

3.1 Staff Engagement and Communication

The Trust continues, as a key goal, to develop communication mechanisms and seeks to encourage staff participation and involvement. It is currently developing a Staff Involvement Policy in conjunction with Staff Side.

Trust Business Plans and key objectives are communicated to staff through the Senior Team and embedded through Directorate team meetings and effective performance management methods including KSF development Meetings.

The Trust places value on effective communication with all its partners and is committed to the principles set out in its Partnership Agreement. The Trust continues to develop communication with staff and places emphasis on building supportive and constructive relationships with Staff Side colleagues through the Joint Negotiating and Consultation Forum and its Joint Operational Forums.

The Trust has recently introduced its “Best Care, Best Value Initiative. The key aim of this is to encourage staff participation and involvement in working with the Trust to generate innovative ideas in improving the services the Trust delivers against a background of strict financial constraints.

3.2 Recruitment and Retention

The Trust continues to complete RPA restructuring through the agreed Process for filling posts below Tier 4. Vacancy Controls remain in place in line with RPA Requirements as relevant. The Trust aims to identify retention problems in specific areas through improved information provision and to target problem areas through robust

strategies such as exit interviews and performance management systems.

The Trust continues to develop innovative approaches to the internal recruitment process and to this end has recently introduced an electronic system through which managers can raise recruitment requests. This ensures a robust audit trail is available in terms of approval to fill posts or indeed where requests are turned down. This system will create a database of information which will contribute to the information requirements related to savings. In addition to this, the first quarter of 2009 will see the availability of an "e-shortlisting" facility. This approach to shortlisting has the potential to bring significant time savings to managers involved in panels in the pre-interview phase, reduce travel expenses and ultimately speed up the recruitment process.

Further developments within the area of recruitment are being planned particularly with the goal of finding innovative approaches to advertising and the onward recruitment methods to ensure that we continue to attract high calibre applicants and ensure that the Trust is promoted as "an employer of choice".

In terms of retention, the Trust seeks to support its staff by creating healthy work-life balance measures and has in place a range of provisions which will enable staff to reconcile the competing demands of family and working life. The Trust will continue to keep these provisions up to date in light of legislative developments e.g. extension of Work and Families (N.I) Order 2006 which will extend current provision to include parents of older children.

3.3 Workforce Modernisation

The Trust remains committed to the realisation of benefits associated with the modernisation agenda and continue to support its managers in delivering innovative approaches to workforce development to respond to service needs.

Directorates continue to develop structures to deliver high quality services aligned to regional Policy Direction and service developments.

The Trust continues to work towards realising cost efficiencies through specific proposals which rely on service remodelling and role redesign. Specific initiatives include nurse rostering aimed at eradicating inefficiencies and promoting a more cost effective use of management time.

The Trust continues to develop proposals to extend the working week. The Hospital at Night service continues to be developed within the Acute setting and extensions to working hours are also being introduced as relevant and appropriate within the Community setting for example within reform of Domiciliary Care services .

3.4 Workforce Planning and Development

The Trusts Corporate Workforce Planning and Modernisation Group continue to meet to support the Trust aim of embedding workforce planning as an ongoing management activity. The Deloitte MCS Workforce Planning report has now been received in draft and is nearing completion and will form the basis for the development of a Corporate Workforce plan for the Trust.

The Trust will continue to participate in Regional Workforce Planning initiatives as agreed with the Department.

The Trust continues to develop its information systems and reporting mechanisms to fully support effective workforce development and decision making to meet defined targets. The Trust aims to ensure the continued availability of an appropriately skilled and trained workforce to meet the requirements of Trust corporate objectives and service delivery in future years. It will continue to develop its links with education and training organisations to effectively plan for those future needs.

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3.5 Improving Working Lives

The Trust continues in its major objective of creating a sense of value amongst staff and in protecting the mental and physical health of its workforce, in a demanding environment of ongoing change and challenge. The Trust will be launching its Workplace Health and Well-being Strategy which provides a focus on achieving a happy, healthy workforce.

The Trust has recently undertaken an attitude survey, which has highlighted a number of key issues which the Trust intends to address in improving the working lives of staff. These include aspects from hygiene and prevention of infection to morale building and stress management. The Trust is developing a Stress Management policy with the key aim of promoting mental health and offering staff simple measures for addressing and lowering stress which can be incorporated in to the daily routine.

The Trust is also finalising a Change Management Policy which is hoped will offer staff support in a climate of ongoing change in how services are provided and the personal impact of such change on staff working lives.

The Trust sickness absence rates are presently below Regional target. It continues to focus on reducing sickness absence by improved access to early intervention strategies, counselling services and robust and consistently applied attendance management arrangements together with awareness training for managers which will assist in addressing issues at an early stage.

3.6 Promoting Education, Learning and Development

An Education Learning and Development Strategy is being drafted with a view to planning activity in future years. The Trust is cognizant of the need to develop both the capacity and capability of staff to make the shift towards new models of care. In support of this the Trust brings together all its Workforce Development & Training Leads and Learning & Development Lead on a regular basis to provide an

overarching view of learning and development across the organisation.

The Trust continues to foster a culture of Lifelong Learning. The Trust seeks to support, develop and promote the contribution of all grades of staff in realizing its key objectives.

The Trust has established a Widening Participation Partnership Forum with representatives from Education providers, Staff Side and Directorates across the Trust with a view to identifying and promoting learning offers for junior staff to 'unleash their potential' through development.

The Trust's NVQ management Board continues to promote and develop occupational NVQ to ensure appropriate skills development and recognition within Health and Social Care.

In 2008 the Southern Trust commissioned the Beeches Management Centre to develop a Southern Trust Leadership Competency Framework in recognition of the need to provide additional support to Managers, particularly for professionals who have progressed into management positions within the Trust.

The Southern HSC Trust Management Competency Framework is based on the Management Standards published by the Management Standards Centre (MSC). The competencies have also been cross-referenced to the Knowledge and Skills Framework and the Leadership Qualities Framework.

These competencies were then used to develop a Trust Tier 4 Leadership Management Development Programme. The aim of the programme is to provide tier 4 managers with the knowledge and skills to do their job leading to improved job satisfaction for managers and staff and improved services to patients and clients.

A pilot Tier 4 Leadership Management Development Programme for 15 managers commenced in December 2008 and will be completed in 2009. Once an evaluation is carried out, it is hoped that this

programme will be extended to more managers over the next three years.

The Trust continues to place emphasis on the importance of identifying development needs. The Trust has established a KSF Project Group with representatives from Staff Side and Management from each Directorate. It is envisaged that during 2009/10 KSF Outline harmonisation (and development for new posts) will take place.

To facilitate the Southern HSC Trust's on-going development of the use of e-learning it is envisaged that a central Virtual Learning Environment (VLE) that all staff can access will be developed and implemented during 2009.

During 2009 it is envisaged that the Trust will implement a Training Administration System to ensure all in-house training is advertised, maintained and attendances recorded centrally on one system and can be accessed by users at various levels therefore improving the organisation's ability to produce management reports.

3.7 Arrangements for Reducing the Proportion of Administrative and Clerical Staff

The HSC target for Administrative and Clerical staff as a proportion of all staff is 18.4% by 2010. The Trust target is 19.3% by that date. The Trust continues to operate vacancy control measures and grade mix to effect this target.

3.8 Skill – Mix

The Trust continues of work within Directorates to effect suggested skill-mix ratios. RPA restructuring and CSR arrangements have allowed for revisions in management arrangements and supporting structures which are contributing to this.

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3.9 Agency Staff

The Trust pays particular attention to Bank/Agency usage which is regularly monitored. An Agency Protocol has recently been introduced which promotes effective monitoring and control of Agency usage and the reasons therefore in order to source out effective alternative solutions.

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4.0 Resource Utilisation

4.1 Income and Expenditure

Strategy

The Financial Strategy of the SHSCT is to achieve and maintain financial balance through sound financial management in order to create the space to allow the organisation to be innovative and forward looking in terms of driving forward Reform and Modernisation.

Corporate Finance Objectives

The corporate financial objectives of the Southern Health & Social Care Trust are to achieve the following statutory targets:

- A balanced position between income and expenditure in-year and recurrently
- A capital cost absorption rate of 3.5%
- Remain within the annual Capital Resource Limit (CRL) set by the DHSSPS (capital expenditure by the Trust is limited to the level in respect of which cover has been agreed by the Department of Health)
- Achieve Value for Money (VfM) in the delivery of services

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The Trust, in common with all other HPSS organisations, is expected to fully adhere to the principles set out in circular HSS (F)29/2000 entitled 'Promoting Financial Stability within HPSS Organisations'. In particular the Trust is required *inter alia* to:

- Break even and

- is required, in conjunction with Commissioners, to ensure that existing services are placed onto a sound financial footing before expansion is envisaged

The allocation letter issued to Boards on the 15 February 2008, covering the years 2008/09 – 2010/11 sets out (paras 13 and 14 refer) the DHSSPSNI's expectation that HSC organisations will continue to focus their efforts on containing costs within the income levels established at the beginning of the year. Deficits, the letter states, are not permitted to develop and if a deficit position threatens to arise, the Trust will be required, after contact with Commissioners and the Department, to put in place, where appropriate, contingency arrangements designed to counter a threatened deficit position.

The Trust is also expected to manage cost pressures within the funding indicated to it at the beginning of the year. The Trust has (as have Commissioners), been requested to draw up its financial plan in this context and been asked to ensure that sufficient recourses are set aside to meet unplanned cost pressures arising in-year. The Trust has therefore carefully reviewed all allocations so as to identify slippage to be held as reserves to assist with the in year management of cost pressures.

Detailed financial proformas setting out the Trust's financial plans for 2009/10 and 2010/11 are attached (FP1T-FP7T) as part of Appendix 2 to this TDP.

Financial Background and Context

Southern Health and Social Care Trust

Opening Recurrent Deficit Position

A fresh assessment of the opening recurrent deficit position for 2009/10 has been prepared. This assessment indicates that the Trust is faced with a potential recurrent gap of some £8.2m between projected income and spend. This assessment has been logged with the Trust's host Commissioner as a bid against the capitation funding gain of £12.5m allocated to the SHSSB in 2009/10 because as the regional allocation letter makes no provision for maintaining existing services funding, the SHSSB's capacity to help close baseline gap is limited to its own baseline funding and in particular to the capitation gain funding. A summary, by POC, of the opening recurrent gap is shown below in Table two. Details of some of the main pressures are shown in Table three.

Table 2 – Opening Forecast Recurrent Deficit 2009/10

Potential Recurrent Gap by Service Provision	**£'000s**	**£'000s**
Programme of Care		
Elderly & Primary Care	2,508	
Learning Disability	1,023	
Children & Young Peoples Services	156	
Acute Services	1,306	
Physical Disability	718	
Mental Health	203	**5,914**
Other MES		
General Cost Pressures		**2,279**
Opening Forecast Recurrent Deficit		**8,193**

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Table 3 – Main Pressure Areas

Main Areas	Acute £'000's	OPPC £'000's	MH&D £'000's	CYPP £'000's	General £'000's	Total £'000's
Acute Nursing	393			156		549
District Nursing		640				640
Voluntary Drivers/Taxis		140	505			645
Domiciliary care		1,228	200			1,428
High Cost Community Care Packages/Placements			847			847
Aids & Appliances		500				500
Miscellaneous					500	485
Pay Reform/Shortfalls	533					533
Pharmacy	624					
Equipment Maintenance					925	

The above sets out the main areas of spend without financial cover and is not intended to be exhaustive. As can be seen, some of the greatest pressure areas are pressures on domiciliary care budgets and high cost community care placements within the Older People's and Mental Health and Disability Programmes of Care. In addition to the above pressures, there are significant pharmacy and equipment maintenance cost overruns.

These areas of spend are considered by the Trust to be a valid part of its cost base and the Trust indicated, in its 2008/09 TDP, that it would look towards the capitation funding to be allocated in 2009/10 and 2010/11 to the SHSSB to help close these funding gaps. In this context, it should be clearly noted that the most recently published Reference Costs Index[1] shows the SHSCT to be the lowest unit cost provider amongst the five Trusts. Circular HSS (F) 29/2000 requires the Trust, in conjunction with commissioners, to ensure that existing

[1] An index published annually by the DHSSPSNI which shows the relative efficiency (as measured by benchmark unit costs) of the HSC Trusts.

services are placed onto a sound financial footing before any expansion is envisaged.

It is important therefore, if this requirement is to be met, that as many of the Trust's baseline gaps are closed before services are expanded. It should also be noted that the Southern Trust has continued to deliver and improve services and balance financially, (albeit with an over reliance on non recurring support), against a backcloth of its host Commissioner being under funded on a fair share basis which results in the Southern Area population receiving £25m less than the needs based capitation formula indicated is required. The gap, which is growing, is partially addressed over the three years 2008/09 – 2010/11 by the allocation of an additional £22.5m (£5m/£12.5m/£5m) to the SHSSB.

Bridging the Opening Baseline Deficit

Capitation funding to be allocated by the Southern Board in 2009/10 will address some of this baseline deficit on a recurrent basis. In the run up to the preparation of this TDP a figure of £2m has been notified by the SHSSB. The remainder will have to be bridged via corrective and contingency measures.

Investment of Capitation Funding

In addition to the Ministerial priorities for Service Investment for 2009/10-2010/11, the Southern Board will receive additional funding to address historic under funding against its capitation share of HPSS investment.

Over the CSR period the Southern Board will receive £22.5M to help close the gap between its current allocation and its fair share, as indicated by the Capitation Review Formula.

The Board will use this funding to respond to a number of service pressures and to enhance services to the Trust's population.

The Trust welcomes the support from the Southern Board and the HWIP allocations include the following:

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Programme	Service	Value
Family & Child Care	Enhanced gateway, family support and outreach services	£1.5M
Maternal & Child Health	For enhanced midwifery staffing levels, increased Midwifery Led Unit capacity and increased neo-natal capacity	£1.5M
Elderly	Enhanced domiciliary care, dementia community support, Carer support, community nursing and additional long term care	£3.2M
Learning Disability	Enhanced domiciliary care, intensive domiciliary support and forensics	£10.9M
Children with Complex needs	Enhanced AHPs, additional care packages, staffing	£0.3M
Physical Disability	Area brain injury service and improved staffing levels	£0.5M
Mental Health	Liaison service, antenatal/perinatal, enhanced child and adolescent services, autism, community support, respite services	£1.3M
Acute	T&O outpatients, investment in DHH, HCAI services, critical care, enhanced acute medical services, enhanced A/E services, enhanced nursing levels, diagnostics carer services	£2.8M

Reform and Efficiency Plan 2008/09 – 2010/11

Over the three year CSR period 2008/09 – 2010/11, the Trust will be required to generate cumulative recurrent efficiency savings of some £36.1m equating to some 9% of its total income. As this funding will

actually be physically removed from the Trust's baseline funding, it will be critical for the Trust's future financial stability prospects that commensurate cash releasing efficiency savings are actually delivered upon. **The scale of this challenge is unprecedented and it represents a real risk to the future financial stability of the Trust**.

The Trust has prepared a Reform and Efficiency Plan covering the three years 2008/09 – 2010/11. The Plan is in two phases, phase one covers the financial year 2008/09 and the other covers the subsequent two years, 2009/10 – 2010/11. A two-phase approach was required because it was acknowledged that year one plans would likely be different in nature from the subsequent years plans (i.e. contain many short term/bridging measures) because of the lead time required to both formulate and implement major service redesign proposals. The 2009/10 cumulative savings requirement is some £22m (about 6% of Trust income). Approval to the Trust's overall plan has been received and the process of implementing the specific measures contained therein is underway other than for a small number of proposals currently out to public consultation.

Decisions on these proposals will be made in late March. The development of robust mechanisms to monitor delivery of the required savings are also required. However, it is clear that, a number of one-off bridging measures (including the application of stringent workforce controls) will require to be implemented in 2009/10 to bridge the gap between the total savings requirement and the expected yield from the specific measures to be implemented in 2009/10.

With regard to the years 2009/10 – 2010/11, the Trust has recorded a savings requirement of £9.5m and £15.7m respectively under the generic heading of 'Productivity Gains' pending the development of specific productivity proposals. During 2009/10, Directorates will be required to develop (and subsequently implement) Directorate specific cash releasing productivity measures to achieve these savings on a recurrent basis on the back of new ways of working, process reform, and improved IT. A process of engaging staff in the drawing up of such plans is ongoing under the "Best Care – Best Value" banner.

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Summary of the Reform and Efficiency Plan

A financial summary of the Reform and Efficiency plan proposals to achieve the savings targets across the three years is shown in Table four below. The savings envisaged from each discrete activity are shown in FP3 (T) (part of the performance attached to this TDP).

Table 4 – Summary of Reform and Efficiency savings plan

Area	£'000's 2008/09	£'000's 2009/10	£'000's 2010/11
RPA Savings	2,700	5,500	6,100 *
Regional Workstreams	682	1,798	3,061
Specific Proposals	1,825	5,096	11,186
Productivity Gain	4,489	9,466 #	15,706 #
Total	9,695	21,860	36,053

* Includes an expected further saving of £600k whenever Regional Shared Services has been introduced.

Before 'STEEEP' (or Project 34) with a potential yield of up to £3.6m and the OPPC 'Brokerage' Project with a potential yield of up to £1m are taken into account

A risk assessment has been carried on the Year Two specific savings proposals to gauge their deliverability. Threats to the achievement of the planned savings include, *inter alia*, the potential non availability of capital funding, the potential unavailability of supporting People funding and the possibility that some may not be approved.

The risk assessment indicates that, on a 'worst case scenario', the best that can be achieved is £2.5m out of the original planned savings. This indicates the need for additional contingency measures to bridge the shortfall of some £2.6m if this scenario proves to be realistic.

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RPA Plans

With regard to the RPA savings target, it is possible, because of the fact that some plans are phased that not all of the savings can be achieved in a recurrent basis in 2009/10. Again, any shortfall between target and the expected yield current savings plans will have to be bridged via in-year contingency measures.

Productivity Gain

The 'productivity gains' targets for 2009/10 and 2010/11 are £9.5m and £15.7m respectively (before expected yields from STEEEP and the OPPC Brokerage Project are factored into account). Directorates continue to work, under the Best Care – Best Value process, to identify further measures to unlock efficiency/productivity gains to offset this target. However, it would appear that a very substantial proportion of these planned £9.5m savings in 2009/10 will have to be delivered via stringent workforce control measures (including freezing vacancies, deleting vacant posts from structures, and bearing down strongly on overtime, agency and locum posts).

Financial Planning 2009/10 – 2010/11

Table five overleaf sets out the scale of the overall financial challenge facing the Trust over the two years 2009/10 – 2010/11. The succeeding paragraphs set out the Trust's plans (largely derived from the Trust's Phase Two Reform and Efficiency Plan Submission) to meet this challenge.

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Table 5 – Total Financial Challenge 2009/10 – 2010/11

	2009/10 £'000's	**2010/11 £'000's**
Assessment of baseline gaps CSR – 2007 Cash Release Savings	6,193 # 21,860	6,193 # 36,053 *
Total	**28,053**	**42,246**

See para 3.1.11

* Cumulative total

Potential Gap and 'Contingency' Plan

The overall potential funding gap for 2009/10 is shown below:

Table 6 – Potential Funding Gap 2009/10

	Potential Shortfall Vs Plan £'000's
Specific Year 2 RPE Proposals	2,596
Productivity Line (net of recurring savings achieved coming into 2009/10)	9,466
Baseline Pressures (from 3.1.11)	6,193
Total	**18,255**

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Contingency

All of the above shortfalls will have to be bridged using a range of 'contingency' and permanent measures as set out below:

- Strong Financial Management/Budgetary Control to correct overspends
- Stringent Workforce Controls (scrutiny by Directorates of all vacancies to ascertain if the post should be replaced, partially replaced, downgraded, or deleted)
- Substantially reducing the cost of covering for sick and absence
- Substantially reducing overtime, agency and locum posts where appropriate to do so
- Non-recurrent bridging finance/slippage
- Cost containment measures, (including the continuation of spending moratoria across a number of categories of spend e.g. furniture and equipment)

The Trust wishes to highlight to the Department, through this TDP, that the scale of the challenge is such that there is a very real risk to the maintenance of financial stability in 2009/10. While the Trust fully recognises the requirement to deliver on its CSR Cash Release Savings targets, it wishes to highlight that it is also carrying significant unfunded baseline pressures of some £6.1m. Whilst the Trust has described a range of contingency measures to be implemented in 2009/10 to bridge or close shortfalls, it is probable, such is the scale of the challenge, that the measures described above in themselves will not be sufficient to fully address the potential gap and that non recurring financial assistance will be required. It is not possible, at this time, to assess how much 'slippage' from Capitation Funding, Service Development Funding, (and from internally generated slippage) might be available to the Trust.

In light of this and all the current available information, the Trust is forecasting, in its high level Financial Plan a deficit of some £9m for 2009/10. Dialogue with Commissioners and the Department will continue given this forecast.

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A statement of the key assumptions used in arriving at this forecast plan are set out in the notes at the end of this section. These assumptions will require to be reviewed regularly to ensure that they remain valid.

High Level I & E Account

A high level forecast I&E Account reflecting foregoing is shown in the table below:

Table 7 – High Level I&E Account

	2009/10	2010/11
	This Year effect £000's	**Full year effect £000's**
Total Operating Income	**447,684**	**445,021**
Trust Expenditure		
Pay	287,730	290,892
Non-pay	169,154	170,508
Depreciation	11,306	11,306
Total Operating Expenditure	**468,190**	**472,706**
Operating Surplus Before Interest	(20,506)	(27,685)
Operational Surplus/(Deficit)	**(20,506)**	**(27,685)**
Adjustment for Non Cash Costs	11,306	11,306
Break Even Position	**(9,200)**	**(16,379)**

The total operating income figure in the financial plan above reflects the summation of Service and Budget Agreements (SBAs) reached with Commissioners together with a robust assessment of the income that the Trust will collect directly from patients and clients and from other funding sources. In the case of the Southern Trust, 99% of its Commissioner income comes from the SHSSB. Given that the bulk of

income comes from Commissioners, the above income figures represent, in relatively fixed terms, the total income likely to be available in 2008/09. It will only grow materially if additional non recurring income is allocated. The above figure therefore represents broadly speaking the level within which costs must be constrained in 2009/10.

Patient Access Targets 2009/10

The Trust, in conjunction with the SHSSB, is currently finalising a costed delivery plan to achieve, the 2009/10 patient/client access targets (Acute and Community). These plans will include an agreed position on efficiency improvements to be made within defined specialties and identify any remaining shortfall in capacity and associated costs. For the purposes of this TDP, it has been assumed that funding to cover the projected costs set out in the delivery plans, referred to above, will be made available primarily from funds held centrally by the Department of Health for this purpose and from funds reserved by the SHSSB.

Overall Conclusion

The requirement to make efficiency savings on an unprecedented scale added to the need to close baseline funding gaps, means that the next two years will present the Trust with a huge challenge in containing costs within reduced baseline income levels. Critical to maintaining financial stability is the need to ensure that baseline gaps are fully closed and the full delivery of the efficiency savings.

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Notes and Key Assumptions:

Savings Area	£'000's	Key Assumptions	Actions taken/to be taken	Residual Risk Rating
RPA	5,500	That the £5.5m saving required will be delivered in 2009/10 (rising to a cumulative £6.1m in 2009/10 (Dependant on Regional Shared Services)	Each Directorate, in response to its target, has formulated RPA Savings Plans. Some plans require further phases to be implemented and some bridging measures will be required in 2009/10	Medium (some Directorates still have to implement phases of their plans)
Regional Workstreams	1,799	That the measures will yield the cost savings in Pharmacy and Goods and Services in Trusts	Regional Project Groups and Sub-streams have been established to oversee delivery of the savings. A recent risk assessment has concluded that many of the G&S service measures may not deliver or fully deliver in year two This risk assessment has been communicated to the Department	High
Specific Reform and Efficiency				Medium to High

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Proposals Productivity Gain	5,096 9,446	That each of these proposals will be fully implemented and will deliver the predicted savings net of any bridging finance allocated That pending the development of specific proposals that this will be bridged in 2009/20 via recurring measures c/fwd from 2008/09, new recurring measures implemented in 2009/10 and 'one-off' measures	As previously mentioned, risk assessment suggests a potential under delivery of £2.6m. Monitoring will be carried out under the R&M Project Management arrangements Shared out to Directorates for each Directorate to formulate proposals Robust monitoring in place. Scale of savings to be achieved is unprecedented.	High
	21,860			

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4.2 Capital Investment Plan

Capital Allocations

The Trust has been notified that the agreed Capital Resource Limit for 2009-10 is £22,802,095. A breakdown by project of this total is included in the table below.

PROJECT	NEW REFERENCE	CRL
Portadown HCC	A102/600863/01	£3,500,000
T&O Craigavon	A105/600847/01	£7,702,000
Daisy Hill Interim Renal Unit	A105/600852/03	£38,095
Banbridge HCC - Design	A102/600856/01	£500,000
Newry Childrens Home	A102/600856/08	£1,660,000
Newry SEC	A102/600856/07	£2,188,000
Craigavon Theatre 5	A105/600852/01	£60,000
Neonatal/Maternity Extension	A105/600852/06	£3,500,000
MES- Prioritised small works	A105/600852/11	£520,000
General Capital	A105/600855/04	£3,134,000
TOTAL		**£22,802,095**

General Capital

The Trust has received a general capital allocation of £3,134,000 for 2009-10. Capital will be allocated to the following areas:

1. Carry forward schemes (ie schemes started in 08/09 which will be completed in 09/10),

2. Schemes which were approved in 08/09 to support the implementation of CSR, other efficiency proposals and system redesign.

3. Estate led schemes – this includes DDA, Health and Safety, Firecode and backlog maintenance.

4. Service led schemes – this includes the development of new services which may require capital estate works to be undertaken.

5. Transport – this allocation supports the fleet replacement programme.

6. Information technology – this includes systems management, infrastructure replacement and development, PACS etc

7. Medical equipment – this is to fund new and replacement equipment for both hospital and community.

The table below sets out the allocations for 2009/10:

TABLE 1

Project	**Proposed Capital Allocation 09/10 (£000)**
Review of Acute services	£750
Review of Paediatric Services	£200
CSR Proposals	£715
Environmental Strategy	£75
Boilers	£150
Data Centre	£135
Carry Forward Schemes 08/09	£424
Estate/service led schemes	£327
Medical Equipment	£154
IT	£120

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Transport	£84
TOTAL	**£3134**

Maintaining Existing Services (MES)

The Trust also received an allocation of £520,000 under the heading Maintaining Existing Services (MES). This was to cover the carry forward on the 08/09 MES schemes. Works are to be completed on Crozier House, Cloughreagh and Firecode.

In 2008/09, £2.8m was allocated to the Trust, under MES, however early indications are that this will be significantly less this year.

A sum of £3m has been set aside Regionally for 09/10 of which the Trust can expect a capitation share of approximately £600,000.

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5.0 Health Promotion

5.1 Investing for Health

The Trust will continue to build on the successes it has achieved in 2008–2009 in reshaping the focus, priority and resource given to the Promotion of Wellbeing across the Southern area and in seeking to ensure health improvement across the whole population and a reduction of health inequalities where these exist. As a member of the Southern Investing for Health (IfH) Partnership the Trust will continue to develop partnership working with other community, statutory and voluntary organisations at both strategic and operational levels. In 2009-2010 these will focus on:

- Developing locality based Health Improvement Plans that reflect both the current regional health improvement priorities and local community needs. These plans will focus on developing a partnership based response to local need, issues and priorities;

- Developing its response to the Hidden Harm Strategy, Sexual Health Strategy, Cardiovascular Services Framework and Stroke Strategy;

- Providing a Workplace Health Improvement Programme for staff;

- Developing Directorate/Programme of Care Health Improvement Plans that target the needs of specific population groups across the Southern area;

- Facilitating the development and implementation of CAWT funded initiatives to address the social inclusion of specific

marginalised communities and the wellbeing of older people in the community;

- Maintaining support for the development of the Regional Suicide Helpline and the implementation of a partnership based response to the provision of suicide prevention services across the Southern area;

- Participating in a range of local partnership based initiatives that address specific elements of the IfH Strategy in relation to: Neighbourhood Renewal, Community Safety, Community groups, networks and fora, CAWT, Traveller's Health Projects, SAAT, and Special Interest groups etc.

The Trust will continue to implement the Southern Board Community Development Strategy and provide ongoing facilitation, development and support to local communities to:

- identify their specific needs, issues and priorities;

- support their engagement with the Trust and other organisations to address these;

- provide specific training to build capacity, skill and resource;

- identify specific service provision issues and work together to address these;

- facilitate their involvement in service planning, decision making and development;

- strengthen networks, relationships and linkage both with the Trust, other partners and across communities themselves.

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6.0 User Involvement

6.1 Measures to Engage Users

In line with the Regional Strategy for Health & Social Services in Northern Ireland the Southern Trust is fully committed to ensuring the active and meaningful involvement of individuals, communities and stakeholders in all aspects of service planning, development and delivery. Building on the initiatives undertaken in 2008-2009 the Trust will continue to realise this commitment by ensuring:

- Directorates assess and evaluate the appropriateness and effectiveness of current Personal & Public Involvement (PPI) mechanisms and as a result identify areas for development and improvement;

- The development of a Trust PPI Action Plan that has been informed by an extensive consultation process with a wide range of local stakeholders;

- The provision of a dedicated resource team for PPI that will facilitate and support the work of Directorates and staff teams and provide expertise, leadership, coordination and training for PPI;

- The development of annual targets for PPI within Directorates that will form part of the ongoing monitoring and accountability processes;

- The establishment of a management infrastructure that will oversee the development of PPI across the organisation;

- The implementation of mechanisms to monitor, map and evaluate the ongoing development and impact of user involvement in shaping the work of the organisation;

- Ongoing support and investment in mechanisms that focus on and compliment particular aspects of the PPI agenda such as:
  - Community development;
  - Person centred planning;
  - Carers support;
  - Volunteer development;
  - Action to address diversity and equality.

- The completion of a training needs analysis of staff and as a result, the development and delivery of a training programme on PPI;

- The development of a communications strategy that will seek to better inform stakeholders about the work of the organisation and facilitate their involvement and communication with it as a result;

- Mobilising staff trained in community development approaches across the Trust to encourage and support the involvement of individuals and communities in the shaping and development of services;

- The establishment of a consultation database of individuals who are willing to engage in specific consultation on issues, themes and special interests.

6.2 Measures to Assess User Experience

The activities outlined in Section 6.2 above will contribute to the assessment of the user experience within the Trust. In addition the Trust will:

- Establish mechanisms within its Directorates to assess the views of users and use these to shape the ongoing provision and development of services;

- Maintain support for the range of service user groups within the organisation such as the Mental Health Service User groups, Maternity Liaison Group, Carers Support groups and other service specific user groups;

- Work closely with the new Regional Patient Client Council;

- Continue to work directly with individual communities, population groups and ethnic minority groups to:
  - identify their specific needs, issues and priorities;
  - support their engagement with the organisation;
  - provide specific training to build capacity and resource;
  - identify and address specific service provision issues;
  - facilitate their involvement in service planning and development and;
  - ensure effective communication, consultation and involvement with the organisation.

6.3 Complaints and User Views

The Trust continues to engage users as part of its overall corporate objectives in ensuring accessible and responsive care; and ensuring effective user and community engagement and promotion of partnership working. As part of this process the Trust has formal mechanisms in place for the management of user complaints.

The Trust will be implementing the new complaints procedure from the 1st April 2009. There will be an onus on the Trust to provide a first stage of the complaints process. This will prove to be extremely challenging for the organisation and it will be establishing its procedures for managing this change within the complaints procedure. The Trust has secured additional monies from the Department for the implementation of the new

complaints procedure and is currently recruiting a project manager. Regular report and updates will be provided to the Trust's Governance Committee and Senior Management Team on progress with implementing the new complaints procedure in 2009/2010. And the Trust will have developed its new procedures for enhanced local resolution by August 2009.

In addition to the changes in the new complaints procedure, the introduction of new regional standards for improving the patient and client experience namely, respect, attitude, behaviour, communication, privacy and dignity will require the further development of robust systems for capturing information on the patient and client experience.

New standards are to be introduced by September 2009 with a plan of monitoring thereafter. The Trust will realise this objective through the work of Trust Directorates and their staff teams.

It is essential that the Trust puts in place a number of mechanisms to support the active assessment of the patient and client experience in the key areas identified above. This should include the completion of a baseline assessment of patient and client experience, a review of the mechanisms within each of the Directorates to capture this information, development of the Trusts patient and client experience strategy, clear identification of the mechanisms to be used within each Directorate.

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7.0 Governance

7.1 Strategy

The Governance Strategy of the Southern Health and Social Care Trust is to develop and maintain systems and processes to achieve the organisational objectives, safety and quality of services and in which they relate to patients/clients, the community and partner organisations. The Trust continues to work within the parameters of the HPSSS Controls Assurance standards and the HPSS Quality Standards for Health and Social Care.

The Board Assurance Framework is an integral part of the governance arrangements for the Trust.

The specific areas relating to Governance include Clinical and Social Care Governance, Corporate Governance, Research Governance, Financial and Information Governance. The Trust's integrated Governance Strategy provides the direction for each of the above components seeking to move forward with, and incorporate key governance arrangements within the SHSCT.

The Trust focus for 2009/2010 will be to ensure further implementation and integration of the governance strategy and associated procedures with the provision of regular reports to the Trust's Senior Management Team, Board of Directors and the Governance and Audit Committees.

7.2 Governance

The Board Assurance Framework for 2009/2010 will define the organisations objectives, identifying risks to their achievement and highlight the key controls through which these risks will be

managed. The framework will provide the Board the necessary information to enable them to:

- Assess the assurances given
- Identify where there are gaps in control and/or assurances
- Take corrective action where gaps have been identified; and
- Maintain dynamic governance arrangements.

This overarching aspect of the Trust's Governance agenda is led by the Chief Executive as Accountable Officer. He continues to be assisted by the Board Secretary and Chief Executive office staff in co-ordinating the necessary information for the Trust's Governance Committee and Audit Committee.

7.3 Risk Management

The key components of Risk Management within the SHSCT are underpinned by the HPSS Controls Assurance Standard for Risk Management and the procedures for the identification and management of risk within the organisation. Leadership for this Controls Assurance Standard rests with the Medical Director, as the nominated Executive Director with responsibility for Risk Management.

There is a nominated senior Manager with the responsibility for Risk Management within each of the Directorates within the Trust. In addition to this there are a number of professional leads who also provide information on key risk areas. The process of risk identification and management closely follows the HPSS Guidance on the identification and management of risk (Australia/New Zealand Model Copy write since August 2003).

The key objectives for 2009/2010 are to promote further the risk identification and management process within all Directorates across all divisions and within each team of staff working within the Trust. The Trust has agreed that its policies and procedures for the identification and management of risk. The Trust now

needs to take a focus to ensure that all key risks are identified, managed and monitored. This will include financial risk, clinical risk, social care risk, health & safety risks and estate management risks as the key risk areas. Additional information will be sought from all Directorates within the Trust in order to collate a meaningful series of risk registers.

7.4 Clinical and Social Care Governance

The Medical Director is the nominated Executive Director with responsibility for Clinical and Social Care Governance within the Trust. He is assisted by all other Directors who have a Clinical or Social Care responsibility. The Clinical and Social Care Governance structures are embedded within the organisation and cut across all professions and Directorates.

Key aspects of Clinical and Social Care Governance will continue to shape the agenda for 2009/2010. This will include the further integration of professional standards and learning lessons from key internal and external reports. This process includes the reporting of incidents, scrutiny of risk associated with the provision of clinical and Social Care, safe systems of care delivery, the reporting of serious adverse incidents and the lessons learned from the same.

The development of the new Strategic Health Authority and the new Strategic Health Board will consolidate a number of external bodies such as RQIA, Mental Health Commission and confidential enquiries. The Trust will continue to work with the existing bodies and new regulatory bodies to ensure that patient safety is promoted and that the Trust is in a strong position to maintain and improve its Clinical and Social Care Governance Agenda.

The Trust will continue to foster a culture which promotes patient safety and care improvement. Critical to the success of this agenda would be ensuring that resources are targeted appropriately to the development of robust systems within the

each of its Directorates and Clinical and Social Care Teams. The Trust's Patient Safety Agenda incorporates a number of performance indicators which have been introduced in 2008/2009 and which will remain key areas for monitoring in 2009/2010. This includes the following patient safety projects:

- ♦ Prevention of infection following caesarean section
- ♦ Prevention of infection following orthopaedic surgery
- ♦ Prevention of a ventilator associated pneumonia
- ♦ Management of acute myocardial infargtion
- ♦ Medicines reconciliation
- ♦ Monitoring of crash calls
- ♦ Development of perinatal care standards

In addition to the above there are a number of on-going projects both on a regional and local basis which form the effectiveness and evaluation agenda for the Trust. These projects are led by the effectiveness and evaluation unit with the results from a wide variety of audits being fed into the overall quality improvement agenda. In addition to the above the Trust will be seeking to work with the Chief Medical Officer and the Chief Nursing Officer in developing assessment and monitoring tools for the prevention of venous thrombo embolism. Work is in the early stages at present and will be a significant quality improvement area for the Trust in 2009/2010.

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Appendix 1

Public Service Agenda and Ministerial Targets

Priority Area 1: Improving Health and Wellbeing	
Target	**Baseline, Actions & Timescales**
Bowel cancer screening (PSA 1.11): by December 2009, commissioners and Trusts should establish a comprehensive bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).	**This target is achievable and affordable assuming business case approval** The Trust's Business Case to provide a Bowel Cancer Screening Colonoscopy Service has been submitted to Dr Owen PHA via NiCON and also to the SCG. The resources identified in the business case were based on guidance issued to all Trusts in correspondence dated 20 May 09 from the Director of Performance Management & Service Improvement. The Joint Advisory Group (JAG) visited the endoscopy service at CAH on 28 May 09 their report highlighted a number of issues which are being addressed to ensure accreditation. A further JAG visit is expected in December 09 when the Trust will provide action plans to address any further issues raised.

Priority Area 2: Ensuring Safer, Better Quality Services	
Target	**Baseline, Actions & Timescales**
Healthcare Associated Infections: in the year to by March 2010, secure an overall reduction of 35% in MRSA, MSSA and Clostridium Difficile infections compared to 2007/08. **Associated PSA Target 2.1**: By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA), and a 20% reduction in cases of clostridium difficile infections	**This target is achievable and affordable** The Trust has established an infection control steering group which is chaired by the Chief Executive. In addition, the Trust has established a clinical forum chaired by the Medical Director and an operational forum chaired by Board Secretary. Senior clinical staff from the non-acute hospitals are members of this forum. The Trust via the Infection Control Team and associated infrastructure will endeavour to meet the HCAI reduction target. The targets will form the basis of the work plan for the infection control team and will be endorsed by the Infection Control Committee. A new infrastructure has been established within the SHSCT to ensure infection prevention and controls are addressed at all levels. The Trust is focusing its efforts at addressing infection control in a number of areas, key amongst these are: -Hand Hygiene -Isolation -Anti-biotic policy -Completion of Root Cause Analysis for each positive

	patient, multidisciplinary review and lessons learned communicated to all relevant staff -Environmental cleanliness -Safe patient transfer -Capital investment A stringent audit programme is in place within the SHSCT in relation to all the areas identified above. The Trust is aiming for 100% compliance in all areas and will continue to closely monitor outcomes to inform its training and education programme for all staff involved in patient care in the acute and non-acute sector, clinical and non-clinical. The Trust continues to ensure that all staff attend mandatory infection prevention and control training on an annual basis. The Trust has identified a link nurse for infection prevention and control within each ward. In addition, each Ward Manager has an action plan in place. The Trust will continue to take the advice of the “Cleaner Hospital Team” and consult best practice guidance in relation to HCAI’s. The Trust continues to complete a Route Cause Analysis (RCA) for each patient presenting with C. Difficile alongside ensuring an action plan is in place for each patient to facilitate future learning and can be shared with infection prevention and control fora.

	The OPPC Directorate are implementing the 'Dash Board' in all non acute hospitals which will assist in monitoring of the number of patients diagnosed with C-Difficile/ MRSA. Environmental audit results, hand hygiene compliance and compliance with antibiotic policy.
Trust quality initiatives: from April 2009, Trusts should ensure that satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash calls rate and mental health inpatient care. By 30 June 2009, Trusts should submit to the Department for approval and monitoring, quality improvement plans to prevent venous thromboembolism (VTE)	**This target is achievable and affordable** Baseline assessments have been completed and further implementation work is underway in the following intervention areas: -surgical site infection, -central line infection, -crash calls -ventilator associated pneumonia -acute mental health -acute myocardial infection A quality improvement plan has been approved by the Department. Work will continue in these areas in 2009/2010. Progress in each of the above interventions is variable, but within the parameters of the Quality Improvement Plan. Monthly reports measuring compliance are provided to the Trusts Senior Management Team. A quarterly report on patient safety is currently provided to the Governance Committee and Trust Board. Both groups currently receive

through risk assessment and adherence to local policies on VTE prophylaxis.	monthly reports on HCAI (see PSA 2.1) which is be modified to supplement the patient and client safety information currently considered by Trust Board to reflect these targets. Baseline work has been undertaken regarding the prevention of thromboembolism. The Trust will be seeking to develop assessment criteria or monitoring compliance with national guidelines.
Patient Experience: by September 2009, Trusts should adopt Patient and Client Experience Standards in relation to Respect, Attitude, Behaviour, Communication, and Privacy and Dignity, and have put in place arrangements to monitor and report performance against these standards on quarterly basis.	**This target is achievable and affordable** The Trust proposes to undertake the following actions to ensure compliance with this target: • Circulate standards widely to all staff within the OPPC directorate. **End January 2009** • Review current practice against the standards identified. **End of June 2009** • Develop an action plan for the implementation which will involve the development of robust monitoring to ensure standards are being met, this could be carried out via undertaking observation of care, audits of complaints handling, patient satisfaction and routine review of patient care plans. **July – August 2009**

	• Implementation of action plan and quarterly monitoring on performance. **September 2009 onwards**
Service Frameworks: by March 2010, ensure the implementation of agreed standards from (i) the Cardiovascular Service Framework and (ii) the Respiratory Service Framework, in accordance with guidance to be issued by the Department in April 2009 and June 2009 respectively.	**This target is achievable and affordable** The Trust will work with Commissioners to ensure standards within the Frameworks are implemented. Steering Groups have been established for both the Cardiovascular Framework and the Respiratory Service Framework. Both Steering Groups cover acute and community areas. In addition smaller working groups have been established e.g. COPD / Airways Diseases Working Group to take forward implementation of the agreed standards within specific service areas. Regular meetings of the Cardiovascular Disease (CVD) Framework group monitor progress against the 44 Framework Standards. The DHSSPSNI issued a draft framework for the Respiratory Service in January 2009. The Trust intends to hold a workshop in February 2009 to plan the implementation of the Framework and to develop investment proposals. The Trust has commenced the development of a comprehensive chronic disease failure service with the appointment of 2 Chronic Heart Failure Specialist Nurses. This is part of a planned service development which includes further Chronic Heart Failure Nurse posts and ICATS services. Other developments include the extension of the COPD teams through

	the introduction of skill mix, the use of a case management approach for patients with complex long term conditions and the introduction of tele-health monitoring. The Trust is currently undergoing a benchmarking exercise against the draft documentation. **June 2009** An action plan will be developed following the outcome of the benchmarking. **September 2009** Implementation of the action plan to ensure accordance with guidance. **March 2010**

Priority Area 3: Improving Acute Services	
Target	**Baseline, Actions & Timescales**
Specialist drug therapies for arthritis (PSA 3.1): by March 2010, no patient should wait longer than nine months to commence specialist drug therapies for the treatment of severe arthritis, reducing to 21 weeks by March 2011.	**This target is achievable and affordable** The Southern Board approved a Business Case to expand the rheumatology infrastructure for services within Southern Trust. The investment made by the Board in Medical, Nursing, Pharmacy and Clerical support has enabled expansion of the specialist drug therapy service at Craigavon Area Hospital for patients with severe inflammatory arthritis. A Consultant Rheumatologist has been appointed. This will enable the Trust to expand the current capacity of patients who receive drug therapy treatment at the Southern Trust. Additional funding for drug therapy will be required to allow all patients to be seen within the 21 week target. Funding packages will be negotiated with the commissioner. A process is underway to offer SHSSB patients on the waiting list for drug therapy at Musgrave Park Hospital the opportunity to transfer to the enhanced service at Craigavon Area Hospital.

PSA 3.2: from April 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment, working towards a total journey time of 25 weeks by 2011. **Related Targets:** **Elective care (consultant-led) (PSA 3.2):** from April 2009, no patient should wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 13 weeks for inpatient or day case treatment; and	**This target is achievable and affordable assuming agreement is reached on SDP bid** **The Trust has been engaged in extensive discussions on the in year and recurring capacity gaps requiring to be funded to ensure delivery of these targets.** **Proposals awaiting confirmation of funding by the commissioner are:** • **ENT** • **Neurology** • **Ophthalmology** • **Pain Management** • **Gynaecology** • **General Surgery including Scopes** • **Neurophysiology** • **Oral Surgery** • **AHPs** • **Colposcopy** • **General Medicine/Gastro** • **Respiratory/Thoracic** • **USS, CT and Dexa scanning** **On the basis that these proposals are accepted and the commitment to ongoing discussion on capacity gaps for 2010/11,**

	the Trust can confirm that the elective access targets are achievable. **In addition to the SDP proposals, the following areas have been agreed for development:** **Cardiology -** The appointment of a new Consultant Cardiologist at Daisy Hill Hospital in early 2009 will permit further expansion of the sessions at the cardiac catherisation laboratory at Craigavon Area Hospital, which will result in local provision of diagnostic angiography and PCI services for the Newry & Mourne population. There will also be a new service to implant permanent pacemakers at Craigavon Area Hospital. The Business Case to identify necessary resources to extend the working day for MRI to meet capacity shortfall has been submitted and has been approved in principle, subject to some small points of clarification. Ongoing monitoring of referrals and additional consultant reporting sessions in place to ensure full use of current daytime capacity. <u>Ultrasound Screening</u> Antenatal scanning is to be relocated to the maternity department. This will release capacity within the main Radiology Department. A

	business case for the required equipment and revenue is to be completed. <u>CT Reporting</u> With the appointment of new replacement consultant posts the number of reporting sessions has increased (additional four reporting sessions on average each week) in South Tyrone Hospital to ensure that full use is made of current daytime scanning time. <u>Nerve Conduction Studies (NCS) and ECG</u>: Business Case is in the process of being written, The SHSSB have been made aware of the demand –capacity gap for this service, which is currently being managed through the use of Information Systems. <u>Audiology</u> Ongoing action is being taken to avail of cross-site cover. Craigavon Hospital based audiologists are undertaking additional sessions to ensure waiting time targets can be met for Daisy Hill patients. There is a streamline referral and scheduling process to ensure optimum use of trained staff time. In addition there is ongoing Process Mapping and ongoing monitoring

	and management of waiting lists.
Diagnostic reporting: from April 2009, all urgent diagnostic tests should be reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.	**This target is achievable and affordable** The Trust is able to achieve this target for pure tone audiometry and neurophysiology. With regards to imaging tests the Trust is confident in being able to achieve this target with the introduction of PACs in Summer 09. In the interim the Trust has employed a manual system to capture the information, but this system is not robust and data verification is difficult. Following a demand and analysis exercise the Trust has prepared an Action Plan to ensure compliance with the target.
Elective care (AHP): from April 2009, no patient should wait longer than 13 weeks from referral to commencement of AHP treatment, reducing to 9 weeks by March 2010.	**This target is achievable and affordable assuming agreement of SDP proposals** The Trust is currently meeting the 13 week target. A project structure has been developed to facilitate the progress of work, along with quarterly reviews to ensure the 9 week target will be met by March 2010. **The Trust has agreed with Southern LCG the level of investment required to address capacity gaps (£524,174 recurring with in year non recurring investment) to achieve this access target and has included same in the SDP proposals to the commissioner. End March 2010**

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	The Trust will establish interim targets to ensure the overall achievement of the 9 week target which will be achieved through embedding Reform & Modernisation approaches into each service. **April 2009**
Fractures (PSA 3.3): from April 2009, 95% of patients should, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.	**This target is assumed achievable and affordable pending regional agreement on investment in T&O services** The Trust is currently preparing a business case for a 6th Trauma and Orthopaedic Consultant Surgeon. This will support a move to a 'unit job plan', incorporating 'trauma surgeon of the week' model. Trauma operating sessions will increase from the current 8 to 10 per week (covering 52 weeks of the year). In addition to the Saturday morning session which is currently being held, one of the new sessions will be a Sunday morning list. The additional consultant will considerably strengthen the Trust's ability to meet the fracture access target. In addition it will enable the Trust to increase the number of fracture patients treated from the Newry and Mourne area who are currently transferred to BHSCT. **A business case is currently being finalised for this development and will be submitted to the commissioner for consideration against regional investment funding for T&O.**
Cancer (PSA 3.4): from April 2009, all urgent breast cancer referrals should be seen within 14 days, 98% of cancer	**This target is achievable and affordable** Proactive monitoring mechanisms for predictions and target achievement projections have been established.

patients should commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	The Cancer tracking database (CAPPS) has been implemented. Funding has been approved for the appointment of a Cancer information officer. A Business case is being finalised which sets out proposals to modernise and redesign patient pathway. Additional resources will be required to improve performance of the cancer pathway and enhance quality of patient care. It is planned to provide training sessions to GPs to reinforce the procedure to follow in the use of the 'red flag' referral system for patients with suspected cancer. **Ongoing** A Project Team has been established to modernise Endoscopy services in the Trust in preparation for the bowel cancer screening programme Dec 09. This Team has been charged with insuring that the Trust is able to be accredited by the Joint Endoscopy Group (JAG) in Sept 09. This is an extensive piece of work involving clinicians, nurses, admin, managers and support services. The Trust has established its base position against the JAG standards and is working to achieving the required levels of performance. **Ongoing**

<table>
<tr><td>Radiotherapy services: by March 2011, radiotherapy capacity for an additional 600 patients per annum should be available.</td><td>N/A</td></tr>
<tr><td>A&E: from April 2009, 95% of patients attending any A&E department should be either treated and discharged home, or admitted within four hours of their arrival in the department.</td><td>Baseline figures showing % < 4 hours as at March 2009

<table>
<tr><th>% < 4 Hours</th><th></th></tr>
<tr><td>CAH</td><td>92.0%</td></tr>
<tr><td>South Tyrone</td><td>100%</td></tr>
<tr><td>Daisy Hill</td><td>98.3%</td></tr>
<tr><td>Armagh Community</td><td>100%</td></tr>
<tr><td>Mullinure</td><td>100%</td></tr>
<tr><td>SHSCT Total</td><td>95.1%</td></tr>
</table>
This target is achievable and affordable assuming the funding of additional infrastructure with the commissioner

The Trust is currently achieving this access target through ‘at risk’ investment in additional staffing including:

• enhanced middle grade rota for CAH A&E Department to provide improved senior medical cover
• to provide increased clinical decision making capacity to 10.00 pm within the clinical decision short stay unit at CAH</td></tr>
</table>

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	• to deliver an enhanced emergency nurse practitioner service 7 days per week at CAH and DHH • **Nurse management and staffing levels** • to establish an expediter role in CAH A&E Dept • analysis of feedback from patients/relatives **While some of these funding risks have been addressed by the commissioner in the HWIP, the Trust would wish to continue to discuss the funding infrastructure required to guarantee ongoing delivery of this access standard.** The Trust continues to link across to **patient flow and** simple/complex discharge project teams to ensure effective flow across the acute/non-acute facilities in the area. Review of medical admissions process to be completed and outcomes implemented on Craigavon Area Hospital site by March 2009. In January 2009 the SHSSB and the A & E Department in partnership with the Children's & Young Person's Directorate undertook a comprehensive review of children's Accident & Emergency services within the Southern Trust and are in the progress of developing a strategy to address findings. **April 2009**
PSA 3.5: By March 2011, ensure a 10% reduction in	**This target is achievable and affordable**

mortality and disability from stroke **Related link -** **Stroke services:** by March 2011, ensure that 50% of patients attending hospital within one hour of the onset of stroke symptoms receive a CT scan and report within a maximum of a further 90 minutes to inform the appropriate use of thrombolysis.	A Steering Group was established during September 2008. This group is jointly chaired by the Director of Acute Services and the Director of Older People and Primary Care. Sub groups have also been established for both the acute and the community areas to take forward the implementation of the Stroke Strategy for Northern Ireland. The work of the sub groups involves close liaison with the voluntary and community organisations alongside service users and carers. The Trust will seek guidance from the DHSS&PS regarding baseline data for 2009/10. The Trust will participate in the regional process to ensure that these targets are achieved. A Trust Project Group has been established to take forward the project locally. GPs have been asked by letter to prescribe anti-platelet therapy. A Thrombolysis Service is in place on both CAH and DHH sites from 9 – 5pm (Monday – Friday). **January 2009** Discussions have commenced as part of the Acute Stroke Sub-Group with regards to the provision of out of hours services at both CAH and DHH. A review of middle grade medical rotas will be required.

	The Trust has secured recurrent funding for the establishment of Earlier Supported Discharge / Community Rehabilitation Stroke Teams for both the Craigavon and Banbridge area and the Armagh & Dungannon area. Alongside the team already established in the Newry and Mourne area, these teams will focus on delivering specialist multi-disciplinary team support for rehabilitation. **End March 2009** The trust continues to ensure that all stroke patients are on the Stroke Care Pathway. **Ongoing**
PSA 3.6: By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010) **Renal services (PSA 3.6):** all patients should continue to have timely access to dialysis services. From April 2009, at least 50% of patients should	**This target is achievable and affordable** As of 12th January 09 = 34% of the haemodialysis patients are receiving dialysis through AV Fistula. (101 patients currently on dialysis). In order to meet the ministerial targets, 60% of our patients to be dialysed access via AV Fistula. Two Consultants from the Southern Trust will undertake a vascular access clinic on the 3rd Tuesday of the month on the Daisy Hill Site. Training has commenced for these members of staff. Vascular Access clinic will commence early March 09. Theatre sessions have been provided. Funding is in place to covers sessional commitment. Difficulties in achieving this target could be attributed to patient choice,

receive dialysis via a fistula, increasing to 60% by March 2010. And by March 2010, following the identification of an appropriate donor, no patient should wait longer than six months for a live donor transplant.	suitability of referral and if AV fistula matures when created. The Trust will continue to meet with the Regional Transplant co-ordinator on a monthly basis to facilitate the agreed regional process for live donor transplant. It will be completed by May 2009. **Ongoing Monthly**
Critical care: by March 2011, increase critical care capacity by two beds, or by the outreach equivalent of two beds, compared to the position in March 2008.	N/A
Neonatal transport: from April 2009, ensure that a dedicated paediatric and neonatal intensive care transport service is in place on a 24/7 basis.	The Trust will continue to work in partnership with the Belfast Trust and the Northern Ireland Ambulance Service to address this target. **Ongoing in line with the Regional plan**
Ambulance services (PSA 3.7)	N/A

Priority Area 4: Ensuring Safer, Better Quality Services	
Target	**Baseline, Actions & Timescales**
Supporting people at home (PSA 4.1): 45% of people in care management should have their assessed care needs met in a domiciliary setting by March 2010.	**This target is achievable and affordable** The Trust met the previous year's target of 44%. Work is ongoing to ensure that the 45% target is met within the timescale set through development of a Care Management Reform, Productivity and Efficiency Project which will ensure that regular monitoring of progress is taking place. **Quarterly Monitoring**
Assessment and treatment of older people (PSA 4.2): from April 2009, older people with continuing care needs should wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.	**This target has been achieved** As at January 2009, no patient is waiting more than 8 weeks for an initial assessment. All patients with the exception of one have had their care needs met within a further 12 weeks (the one exception was delayed due to patient choice). The Trust are currently exploring options for reducing dependence on residential care provision through the implementation of new service models which will support maintaining people in their own home. **Ongoing**
PSA 4.3: By 2011, secure a 50% reduction in unplanned hospital	**This target is achievable and affordable** This work stream is being taken forward regionally with representation

admissions for case-managed patients with severe chronic diseases (e.g. heart disease and respiratory conditions).	from the Southern Trust. The Trust currently has in place a Chronic Heart Failure Team, Diabetes Team and COPD Team. A Specialist Fracture Liaison Nurse Service has commenced and specialist practitioners in the fields of epilepsy and Parkinson's disease are being recruited. **Ongoing**
Unplanned admissions (PSA 4.3): early intervention approaches should be further developed to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50% by March 2010.	The specialist COPD Team in the community is being enhanced with the introduction of skill mix. A 0.5wte band 6 Physiotherapist and nurse has been appointed to each of the locality areas. The Trust continues to further develop and expand Tele-health into areas including Stroke, diabetes, Heart Failure and COPD which will support reductions in unplanned admissions. **March 2010** A range of self management programmes are delivered for people with diabetes. Self management programmes will be introduced for a range of other long term conditions e.g. arthritis, stroke, epilepsy and Parkinson's disease. **Ongoing** The Trust will be monitoring the reduction in unplanned admissions vigorously in 2009/10. **Ongoing**

Hospital discharges (PSA 4.4): from April 2009, 90% of complex discharges should take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.	**This target is achievable and affordable** As at January 2009: 93% of complex discharges took place within 48 hours 96.6% of all other discharges took place within 6 hours The Trust aims to further develop the 'Rapid Response Project' to support hospital discharge through timely domiciliary services. **September 2009** The impact of Rapid Response Team will be reviewed. The Trust will continue with the review of domiciliary care to ensure the service continues to be modernised both in terms of continuing efficiency of in-house providers and the development of appropriate models of contracting with independent sector on the basis of the regional direction established through the Social Care Procurement Group. **Ongoing** Within the Trust's non acute hospital sites, patients continue to be given an expected date of discharge on admission along with a discharge plan to support early discharges, Nurse facilitated discharge and daily patient flow meetings. **Ongoing** The Trust Discharge Steering Group and Delayed Discharge sub group continues to meet on a regular basis. **Ongoing**

	The further development of early supported discharge Teams e.g. for Stroke, COPD and Chronic Heart Failure will facilitate the achievement of earlier supported discharge to community and domiciliary settings. **Ongoing** The Intermediate Care Services will be extended over weekends and bank holidays and into the evening.
Palliative care: by March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.	**This target is achievable and affordable** Baseline N/A The Trust is continuing to rollout the Liverpool Care Pathway for patients at the end of life. **Ongoing** The Trust have recruited two temporary posts funded by Macmillan, one practice development practitioner (3 years) and one service improvement lead for the development of palliative care services in the Trust. The Trust supports the establishment of a multi-disciplinary Palliative Team to support all patients with a palliative care need to include patients with chronic conditions e.g. Cancer, Stroke, Cardiac and Respiratory conditions. The Trust has appointed a Macmillan Specialist Dietician to the Macmillan Nursing Team. It is anticipated that the Trust will seek to secure further funding to increase the multi-disciplinary team to include speech and language therapy, occupation therapy, social work and physiotherapy. **March 2011**

Direct payments: by March 2010, the number of direct payment cases should increase to 1,250 (rising to 1,500 by March 2011).	**This target is achievable and affordable** SHSCT target: 238 As at M/E December 2008 = 329 The Directorate of Older People and Primary Care will continue to ensure training is offered to all appropriate staff to ensure greater equity of access to direct payments across all localities in the Trust area. **Ongoing Process**

Priority Area 5: Improving Children's Services	
Target	**Baseline, Actions & Timescales**
Children in care (PSA 5.1): by March 2010, 90% of all children admitted to residential care should, prior to their admission: (i) have been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be agreed within six months.	**This target is achievable and affordable** The Southern Trust is committed to working with the Health and Social Care Board to achieve this target. The Southern Trust Resource Panel is operational and a number of placements have been matched to residential care via this method. The Trust is committed to ensuring that all children coming into care are subject to a thorough assessment of need. The Trust will review current administration resources, in conjunction with further negotiations with the commissioner with the view to supporting the work of the Southern Trust Resource Panel in order to achieve this target.
Family support interventions (PSA 5.2): by March 2010, provide family support interventions to 2,000 children in vulnerable families each year	**This target is achievable and affordable** At present the Family Support teams are working with approximately 750 families accounting for over 2000 children. There is a family support package in place for each family and child ranging from a child protection plan to preventative services including day care, therapeutic services and social work support. With the continued development and

(increasing to 3,500 each year by March 2011).	investment in services this number will increase and it is anticipated the agreed number of packages will be provided by the Trust by March 2010/11. From October 2008 to date we have provided Family Support interventions to 83 children in vulnerable families. In collaboration with the Trust's Informatics Department, the Children and Young People's Directorate has established a reporting mechanism to capture this activity within each team. Additional investment will be provided through Gateway and Family Support services to assist with achievement of this target.
Care leavers in education, training or employment (PSA 5.3): by March 2010, ensure that at least 70% of all care leavers aged 19 are in education, training or employment.	**This target is achievable and affordable** Achievement of target as at 31/12/08 = 79% and the average for first 9 months = 65.4%. An Employability Worker will be appointed in April 2009 to assist care leavers with securing education, training and employment. The Trust will consider and endeavour to address any implementation issues arising from the draft Regional Guidance on Education, Training and Employment. In partnership with Human Resources opportunities to promote training

	and employment for care leavers within the Trust will be explored. **February 2009** The Trust has a SLA with the 'Give and Take' project for 12 placements in employment.
Care leavers living with former foster carers or supported families (PSA 5.4): by March 2010, increase to 175 the number of care leavers aged 18-20 living with their former foster carers or supported family.	**This target is achievable and affordable** Achievement at 31/12/08 = 27 with the cumulative figure 1/4/08 – 31/12/08 = 31 against a target of 26. Monthly monitoring of the number of care leavers remaining with foster carers is already in place and the former foster care scheme is actively promoted. A process whereby all LAC Reviews in respect of young people aged 16+ formally considers the potential for them to continue living with their foster carers post age 18 years will be established.
Children on the child protection register (PSA 5.5): by June 2009, Commissioners and Trusts should agree regional policies, procedures and thresholds for the management of cases onto	**This target is achievable and affordable** The Reform Implementation Team (RIT), Understanding the Needs of Children in Northern Ireland (UNOCINI) Guidance, Threshold of Need Model and the Threshold of Intervention Model will enable professionals to communicate their concerns about children using a common format, language and understanding of the threshold of needs and intervention. These products will be widely disseminated in locality based workshops

and off the Child Protection Register.	planned in January 2009 with implementation dates of 1st April 2009. The Trust will then be in a position to agree the regional policies, procedures and thresholds required to meet this target.
Family group conferencing: during 2009-10, ensure that at least 500 children participate in family group conferences.	**This target is achievable and affordable** SHSCT target: 95 The Trust has a contract with Barnardos to undertake Family Group Conferencing (FGC) and have also trained 3 Trust employees to carry out FGC. Whilst the Trust will not meet the target for 2008/2009, we have significantly improved from the previous year. 97 children have been referred to date, with a total of 47 by the 31 December 2009 who have completed FGC. Currently there are 38 referred children being processed and every endeavour will be made to achieve a completed FGC by 31 March 2009. This will however be dependent on the families' commitment to complete or to participate in FGC. The Trust hopes to build on this for 2009/2010. Bi-monthly Steering Group meetings involving the Trust and Barnardos will continue. At these meetings, progress is reviewed and action plans developed to ensure target is achieved. In partnership with Barnardos each Team from the Children and Young

	People's Directorate will make appropriate referrals. Three Trust Staff are participating in FGC training provided by University of Ulster.
Assessment of children at risk and in need: from April 2009, all Child Protection referrals should be allocated within 24 hours of receipt. All Child Protection and Looked After Children pathway assessments should be allocated immediately following completion of the initial assessment. By March 2010, 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment. On completion of this initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further	**This target is achievable and affordable** The ACPC Regional Child Protection Policy and procedures and the UNOCINI Guidance provide staff with clear instruction regarding timescales for Initial and pathway Assessments. It is current practice that all child protection referrals are allocated within 24 hours. Children that are registered are also allocated and a pathway assessment completed within 3 months. The target for family support will depend on staffing levels and the volume of work. Given the complexity of cases it is not always possible to complete initial and pathway assessments within timescale particularly given the multi-disciplinary nature of our work. The Children and Young People's Directorate have submitted a capitation bid to provide additional staffing into Gateway and the Family Support Teams. Essential to achievement of this target is maintaining a full workforce. The Trusty has developed a workforce strategy document and is in

20 working days. All initial assessments and pathway assessments should be completed within 10 and 20 working days respectively.	discussions with the Boartd regarding the regional implication. ~~Currently the Trust has a high level of unallocated cases which will directly impact on meeting this target. The Trust has been pro-active on a number of fronts to try and reduce the level of unallocated cases as follows:~~ ~~• Part time staff are being offered additional hours~~ ~~• Bringing in agency staff~~ ~~• Current staff working additional hours.~~ ~~It is anticipated that when reporting in March the Trust will be in a more staple position and will be on track to meet this target.~~ ~~Due to current staffing difficulties and the increase in referrals all initial/pathway assessments are not completed within the respective timescales. Steps are being taken to address this – The Trust has recently advertised (35 applicants) and interviewed to recruit new staff into Children's Directorate.~~ Additional investment will be made in year (2009/10) and during 2010/11 to assit the Trust in meeting this target. Additional funding will be made available for additional practitioner Social Work posts for the Trust.

Priority Area 6: Improving Mental Health Services	
Target	**Baseline, Actions & Timescales**
Unplanned admissions (PSA 6.1): by March 2010, the number of admissions to mental health hospitals should reduce by 5%, with a further reduction to 10% by March 2011.	**This target is achievable and affordable** From 1/4/08 to 31/12/08 (9 months) there have been 1176 admissions to CPU (all wards) & SLH (ADU, wards 3 & 6, villa 3) – the projected total for 08/09 is therefore 1568. The projected 08/09 figure of 1568 is a reduction of 7.3% on 07/08 figure of 1691. The proposal to develop the Home Treatment/Crisis Response service and the enhancement of the current service to extend to over 65 years is due for completion in March 2009. The implementation of this proposal will assist the Trust in achieving this target. A Patient Flow Manager will be appointed in March 2009, which will ensure timely and effective discharge from inpatient units. The Trust will also be able to offer increased access to acute treatment to individuals. The new Resource Centres in Dungannon and Craigavon, which are due to open in Spring 2009, will also assist the Trust in achieving this target. These Centres will offer day treatment and will also provide an alternative to hospital admission for some acutely ill Mental Health

	patients. The centralisation of acute beds by June 2009 will reduce the total admission beds from 94 to 74 beds, which ultimately will reduce the availability of acute mental health beds.
Resettlement (PSA 6.2): by March 2010, resettle 60 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).	**This target is achievable and affordable** The SHSCT proportion of the PSA Regional Target (12) is achievable within the timeframe. The Trust aims to achieve this by implementing the following CSR proposals: i) Closure of Villas 1 & 2 at St Luke's Hospital ii) Reducing by 50% the bed availability of wards 2 and 5 at St Luke's Hospital (60 beds in total). This however, is contingent on approval following the consultation period which ends on 6th March 2009. The Resettlement Project Board and Structure are established and meet on a monthly basis to take forward the proposal.
Assessment and treatment (PSA 6.3): from April 2009, implement a stepped care model and ensure no patient waits longer than 13 weeks from referral to assessment and commencement of treatment for mental heath	**This target is achievable and affordable** The "Change in Mind" Project, which is a review of mental health services aimed at the implementation of a stepped care model of service delivery, was initiated by the Trust in May 2008. Stage 1 of the "Change in Mind" Project, which took place over the period June 2008 to November 2008, has been completed. This has

issues including psychological therapies, reducing to nine weeks by March 2010, other than psychological therapies.	resulted in a comprehensive review of current adult mental health service provision in the Southern Trust and a mapping of this provision against a proposed stepped care model. As this is a whole systems review with the aim of developing a stepped care model of service delivery, New Ways of Working (NIMHE, NWW 2007) has been adopted as underpinning the Workforce Planning and Development Strategy associated with "Change in Mind". **System Reform** A Management Structure for Mental Health Services has been developed based on functionality, governance requirements and sustainability that will be able to deliver on the Corporate and Directorate service delivery objectives over the next 5 to 10 years. This will be going to consultation in February 2009, with the implementation of the new structure planned for 1st April 2009. Senior clinical staff are integrally involved in the "Change in Mind" Project – Consultant Psychiatrists, Consultant Clinical Psychologists, Senior Clinicians in Social Work, Nursing, Occupational Therapy and CBT. This will allow current staff to re-orientate themselves around the three functional pillars of Primary Care, Acute and Recovery & Support. Work is on-going to establish the Mental Health Referral and Booking Centre by 1st March 2009. This will result in the centralisation of

	registration and booking of all new adult mental health referrals to the Southern Trust Mental Health Services. This encompasses new referrals previously made to directly to Consultant Psychiatrist Out-Patient Clinics, Consultant Clinical Psychology Out-Patient Clinics, CBT Service, CMHT's, Addictions Services and the Eating Disorder Service. It will also continue to deliver on the Integrated Elective Access Protocol (IEAP) and the 13week access target. The establishment of a Referral and Booking Centre has resulted in: • The establishment of a Referral and Booking Centre Administration Team that will result in the centralisation and streamlining of this function, which is currently, dispersed as a role of many mental health admin staff throughout the Trust. • The reconfiguration of those services currently primary care facing into the new Primary Mental Health Care Service. • The development of clinic templates for practitioners who have not previously worked to a clinic format which enables greater accuracy in relation to determining service capacity. This work is still on-going. • The introduction of the use of PAS IT system for registration, booking and capturing on-going clinical activity, outcomes and waiting list information.

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	• Consultant Psychiatrists moving to work in a functional model i.e. 3 Consultant Psychiatrists have volunteered to work in the New Primary Mental Health Care Service. • A move from uni-disciplinary to multi-disciplinary triage of referrals. **<u>Working in Teams</u>** Work is progressing on the restructuring and development of integrated care teams comprising of Consultant Psychiatrists, Clinical Psychologists, Associate Psychologists Senior Clinicians in Social Work, Nursing, Occupational Therapy and CBT and Graduate Workers for both the Primary Mental Health Care Service and the Support and Recovery Service. **April 2009** The new Service Leads will have responsibility of taking forward the Creating Capable Teams Approach (NIMHE, NWW 2007), which will support the on going mental health workforce planning, learning and development strategy. **April 2009** **7.4.1 New and Extended Roles** Within the newly configured Rehab and Recovery Teams new roles such as Support, Time and Recovery workers are being explored.

	Later part of 2009/10 This will be contingent on additional funding from Commissioner. Trust has submitted a capitation bid and an investment plan has been agreed for additional Primary Mental Health Care Workers. Within the newly configured Primary Mental Health Care Service new roles such as Associate Psychologists and Graduate Primary Mental Health Care Workers, who provide brief psychological interventions. Extended roles for Mental Health Practitioners who have a professional qualification such as RMN, SW or OT, in providing brief psychological interventions, brief psychosocial interventions, signposting and mental health clinical governance in the primary care team for people with common mental health disorders.
Discharge: from April 2009, ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All patients discharged from hospital who are to receive a	**This target is achievable and affordable** As at December 2008, 97% of all discharges were within 7 days and there are no delays existing over 90 days. Follow-up contact was confirmed within 7 days. The Trust aim to strengthen the discharge planning process and continue to sustain this high level of performance.

continuing care plan in the community should receive a follow-up visit within seven days of discharge.	
Respite – dementia: provide an additional 1,200 dementia respite places by March 2010 compared to the March 2008 total (and a further 800 by March 2011).	**This target is achievable and affordable** SHSCT target: 228 The Trust has a "Clear Path" Implementation Group in place, which includes membership from the SHSSB. Negotiations are ongoing with the SH&SSB in relation to the commissioning of additional respite places to ensure compliance with the 2008/09 target to provide an additional 60 respite places and the 2009/10 target to provide a further increase in respite provision. The Trust has submitted two proposals to the SHSSB including 1. Flexible domiciliary dementia respite proposal to support carers and 2. An additional proposal to further develop dementia respite services within the Southern Trust.
Domestic violence: a Local Domestic Violence Partnership should be established in each Trust area which should, by September 2009, have produced and begun the	**This target is achievable and affordable** There is currently a Domestic Violence Partnership established in the Southern Trust (June 2007) with an action plan in place. MARAC still has to be implemented. The PSNI and PBNI will take a lead. It is anticipated that the new 1wte Senior Social Worker

implementation of a local DV action plan based on the regional DV strategy and action plan. By March 2010 each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences held in their area during the year.	Practitioner, Band 7 to be appointed to work with the Public Protection Unit will help us achieve our attendance target at MARAC. It is anticipated that this post will be operational by May 2009.

Priority Area 7: Improving Services for People with a Disability	
Target	**Baseline, Actions & Timescales**
Resettlement (PSA 7.1): by March 2010, resettle 90 patients from hospital to appropriate places in the community compared to the March 2006 total (and a further 30 by March 2011).	**This target is achievable and affordable** SHSCT target: 17 The Trust has already made considerable progress against this target with 28 clients resettled between 1 April 2006 and 31 March 2008. A further 8 clients will be resettled by 31 March 2009. The Trust target for 2009-2010 is 5 patients to be resettled. The Trust will invest £270,000 to secure the resettlements required and is currently taking forward plans to develop further resettlement in subsequent years.
Respite – Physical/ Sensory Disability (PSA 7.2): by March 2010, improve access to physical/sensory disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).	**This target is achievable and affordable** The Trust already provides a range of traditional respite care services and is actively promoting the use of more flexible "non traditional" and "alternative" approaches to respite care, both through the use of Direct Payments and through enhancement of the Community Access Officer role. Additional Community Access Officers have being recruited. These workers will source flexible daytime opportunities for people with physical/sensory disabilities. This will deliver a range of flexible and innovative respite opportunities for service users and their families. The Trust is currently working with the Headway Brain Injury

	Organisation in Newry on a project regarding the provision of approximately 30 “flexible respite” packages for carers, funded by a direct payment. The Trust envisages that the above developments will guarantee delivery of this target.
Specialised wheelchairs (PSA 7.3): by March 2010, ensure an 18-week maximum waiting time for 90% of all wheelchairs.	**This target is achievable and affordable** The SHSCT has progressed initiatives for Level 1 Ben 9 wheelchairs and Custom seating. These two initiatives have substantially reduced the waiting times for Level 1 wheelchairs and Custom seating. Building on this work the Trust will be able to work towards the 18 week target by 2010.
Housing adaptations: by March 2010, all lifts and ceiling track hoists are to be installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations are to be completed within 10 working days.	**This target is achievable and affordable** The Target for lifts and ceiling track hoists relates to all POCs. Physical Disability represents a small percentage. In order to meet this Target the Trust will further develop the existing IT system to enable the capture of information at all stages from request to Estates to installation and commissioning. The Trust is working on an electronic system which will be operational in June 2009. This will assist the Trust in streamlining the process of response times and will therefore reduce the timescales.

	The Trust proposes to develop a new Trust minor adaptations contract. This will be progressed through the early part of 2009 and it is envisaged that the contract will be in place by the end of 2009. A non-recurrent bid has been submitted to SHSSB for through floor lifts and stairs lifts to assist with clearing the current waiting lists. The Trust is currently developing a bid for recurrent funding for minor adaptations, through floor lifts and stair lifts to ensure that it can meet this target. Across the 3 legacy areas, this service was supported by end of year slippage with limited recurring funding. This target will be achievable on receipt of capitation monies is this funding identified in HWIP/agreed with commissioner?. The development of bid will be complete by June 2009 with an approximate cost of £150,000.
Respite – Learning Disability (PSA 7.4): by March 2010, improve access to learning disability care by providing an additional 100 respite packages a year compared to the March 2008 total (and a further 100 by March 2011).	**This target is achievable and affordable** The Trust has developed a range of flexible respite services and will continue to develop the range of respite available through investment of £65,000 to secure an additional respite places by March 2010, through extension of existing flexible respite schemes and the purchase of one additional bed respite place in the independent sector.
Discharge: from April 2009, ensure that, 75% of patients	**This target is achievable and affordable??** The Trust is currently meeting a cumulative figure of 83% (31/04/08 –

admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days.	31/12/08)of patients discharged within 7 days of a decision to discharge, although the Trust predicts that as in previous years a small number of patients will not be discharged within a maximum of 90 days. This will include a small number of patients returning to hospital who previously were resettled but for whom the placement cannot be maintained, requiring completely new placements to be developed. The Trust will continue to complete and submit the relevant proforma to the SDU for those clients delayed beyond 90 days and plan for their discharge.
Autism: by March 2010, ensure that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised treatment.	**This target is achievable if additional resources are agreed** The Southern Health & Social Care Trust lodged proposals with the Commissioners in December 2008 to further enhance current Autism Services and to create a specialist ASD Team. This will enable the Trust to enhance and expand the multi-disciplinary assessment services. This will involve the introduction of additional specialist staff and an Early Treatment Team. Teams redesign will ensure that the Trust will meet the 13 week assessment and the 13 week commencement of specialised treatment within the designated timeframe.
Acquired Brain Injury: by March 2010, ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.	**This target is achievable and affordable** The Area Brain Injury Team (ABIT) comprehensively revised its model of service delivery and aligned its activity with a 'best practice' model of focused community rehabilitation during 2007/2008. This revised model was agreed by Trust Board (June 2008).

	The ABIT changed its referral parameters in November 2007 and now endeavours to provide a service to those aged over 65 with a Traumatic Brain Injury. The revised Team model is more clearly rehabilitation and goal – directed and as such focuses the Team's involvement on a smaller number of people with Brain Injury who have identified rehabilitation goals. This approach supports access to the service by enabling people to move through the rehabilitation process more effectively. It supports good care and discharge planning processes. The use of a range of professional screening tools and targeted, time limited interventions will ensure that all clients are seen and will commence treatment within the 13 week maximum waiting time.

Priority Area 8: Ensuring Effective Financial Control and Improved Efficiency	
Target	**Baseline, Actions & Timescales**
Finance: the Department and all HSC organisations should live within the resources allocated and achieve financial balance.	The Trust has detailed the challenge it faces in delivering financial balance in 2009/10 given the scale of efficiency savings required which when added to baseline pressures equates to an overall savings target of some £44m in 2009/10. Notwithstanding the contingency measures that will be invoked given that CSR plans are not yet fully formulated, that there is, as yet, no indication of the level of non recurrent help that might be available, the Trust is forecasting, at this time, a projected deficit of at least £10m for 2009/10.
Timely implementation of service developments: Commissioners and Trusts should ensure that not less than 90% of the monies – but ideally, of course, 100% – allocated for service developments in 2009-10 are expended during the course of the year in accordance with agreed plans, and assuming full resources are required to deliver the targets	Achievement requires the Department, Commissioners and the Trusts to work together. A major risk is the recruitment lead times for new staff.

and commitments. This aim will be kept under review between the Department, Commissioners and Trusts to secure the best available balance between the overriding aim of actually improving services and the need to secure economy, efficiency and effectiveness in the full and proper use of the money available.	
Efficiency targets: Commissioners and Trusts should, during 2009-10, achieve the efficiency targets specified by the Department. As part of this, throughout the year, Commissioners and Trusts should ensure that all initiatives within the Regional Pharmaceutical Clinical Effectiveness Programme, including the specially dedicated investments, are implemented in accordance	This is covered under the Finance heading above.

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with Departmental targets.	

Priority Area 9: Improving Productivity	
Target	**Baseline, Actions & Timescales**
PSA 9.1: Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as: **Hospital productivity (PSA 9.1):** each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.	**This target is achievable and affordable** The Trust will work with DHSSPS in reaching an agreed definition/measure of hospital productivity. The following action will be taken forward by the Trust in 2009/10 in support of this: • To inform targeted improvement work, the Trust will provide regular benchmarked information against a range of key productivity indicators to frontline teams. A contract with CHKS has been agreed to support this process. • The Acute Care Quality Project will consider the following initiatives with a view to improve quality of care at the same time as improving hospital productivity. - MAU Pilot Project approved by SMT to commence March/April 2009 for 9 months duration. This is based on an Acute Physician model and a number of productivity outcome measures having been agreed as part of the project evaluation. - Other initiatives aimed at reducing the need for in-patient beds by

	providing alternative treatment pathways (e.g. blood transfusions, Continuous Positive Airway Pressure (CPAP) etc.) Implementation of the above initiatives will take place in 2009/10 in line with the CSR proposals for the Acute Services Directorate. The Older People and Primary Care (OPPC) Directorate continue to work to reduce the number of bank/agency staff used, ensure staff sickness and absenteeism issues are addressed and that productivity efficiency plans are in place and monitored.
Day case rate (PSA 9.1): each Trust should secure improvements in day case rates for a defined range of procedures in accordance with Departmental targets for March 2010 and 2011.	**This target is achievable and affordable** The Surgical Division has identified a number of initial procedures and is working with the respective surgical teams to improve day case rates: • Varicose Veins • Vasectomies • Tonsillectomies • Laparoscopic Cholecystectomy Maternity and Women's Health Division have identified a number of procedures that will secure improvements in day case rates: • Tension free vaginal tape TVT • laparoscopic hysterectomy • laparoscopic management of benign ovarian conditions

Pre-operative length of stay (PSA 9.1): each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2010 and 2011.	**This target is achievable and affordable** The Acute Directorate is implementing a pre-op assessment service which will provide 100% of patients requiring an elective procedure with an appropriate pre-op assessment. The Trust is planning to combine pre-operative assessment with pre admission work for each patient to maximize the volumes of patients admitted on the morning of surgery.
Absenteeism (PSA 9.1): each Trust should reduce its level of absenteeism to 5.5% in the year to March 2010, reducing to 5.2% in the year to March 2011.	**Target is achievable and affordable** The Trust continues to promote Health and Wellbeing amongst its staff and seeks to support its Managers in actively managing sickness absence through robust attendance management arrangements. Sickness absence managers have been appointed within the HR function to assist managers in dealing with specific problems consistently and fairly and in line with good practice. Each Directorate is finalizing action plans to reduce sickness absence as required. It should be noted however that the 2008/9 PFA targets included a requirement to reduce levels of absenteeism to 10% below the 2007/8 levels (working towards a regional target of 5.2% in 2010/11). The SHSCT's 2007/8 baseline sick leave rate was 5.58%, and a 10% reduction left the 08/9 target at 5.02%. The Trust is currently below target - the sick leave rate for the month of October 2008 was 4.79%, at which stage the cumulative rate for 2008/9 (i.e. April – Oct 08) was

	4.91%.
Greater use of generic drugs (PSA 9.1): the level of dispensing of generic drugs should increase to at least 59% by March 2010, and to 64% by March 2011.	**This target is achievable and affordable** All hospitals sites in the Southern HSCT area implemented the generic prescribing campaign on 1st August 2006. The Trust has a zero tolerance policy in operation so that all prescriptions are written generically. Audits carried out in 2008-09 show an 80% compliance rate within the Trust. Audits will continue in 2009-10 to maintain and improve upon this.
Cancelled operations: from April 2009, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.	**This target is achievable and affordable** All surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons. Information re non –clinical cancellation is being collected and presented monthly to SDU. TMS is installed on all hospital sites.
Related PSA Target 9.1: Improve productivity , efficiency and effectiveness in the HSC as measured by such indicators as: • Proportion of people with community care needs supported at home	**This target is achievable and affordable** **<u>Community Care Needs</u>** The Trust will review the eligibility criteria for access to care management services to ensure it is being uniformly applied and to ensure that people whose needs can be met by being maintained in the community are. Review complete

	September 2009 Development of an action plan following the outcome of the review **April – September 2009** Review of action plan and development of further recommendations if appropriate **October 2009** Implementation of action plan to ensure target is met**.** **October 2009 onwards**

Priority Area 10: Modernising the Infrastructure	
Target	**Baseline, Actions & Timescales**
Investment Programme – during 2009-10, Trusts must ensure that, for all key strategic projects, agreed timescales are met for the completion of business cases, project procurement, and project delivery.	**This target is achievable and affordable** The Trust will ensure that for all key strategic projects, agreed timescales are met. The Trust is in discussion with IID in relation to the funding profile for such projects. **Picture Archiving & Communications System (PACS)** The introduction of PACS (Picture Archiving and Communications System) into Craigavon Area Hospital will enable x-rays and scans to be stored electronically and accessed easily on screen by medical/clinical staff. A regional system has been procured and a regional implementation programme is underway. Additional non recurring investment of £625,000 is required for roll out to Craigavon Area Hospital. <u>Actions</u> Recruit PACS Manager by February 2009. Procurement and installation of equipment by March 2009. Staff training to be completed by April/May 2009. Implementation per regional roll out. Full implementation estimated for Summer 2009.

Appendix 2

Financial Proformas

Please see attached spreadsheet

1.1 Urology Fixed Sessions

AM/PM	Monday			Tuesday			Wednesday			Thursday			Friday			Total
Week 1 AM	Main Theatre	DHH	Week 1 [New Consultant]	Day Surgery	CAH	Week 1 [Mr O'Brien]	Main Theatre	CAH	Week 1 [A.O'Brien]				Cysto	CAH	Week 1 Mr Young	
Week 1 AM				Main Theatre	CAH	Week 1 [M.Young]	Outpatients	CAH [Thorndale]	Week 1 [M.Akhtar]				Main Theatre	CAH	Week 1 [Mr Akhtar]	
Week 1 AM				Outpatients	DHH	Week 1 [New Consultant]										
Week 1 AM				Cystoscopy	STH	Week 1[M Akhtar]										
Week 2 AM	Main Theatre	DHH	Week 2 [A O'Brien]	Day Surgery	CAH	Week 2 [New Consultant]	Main Theatre	CAH	Week 2 [New Consultant]				Cysto	CAH	Week 2 Staff Grade	
Week 2 AM				Main Theatre	CAH	Week 2 [M.Young]	Outpatients	CAH [Thorndale]	Week 2[M.Akhtar]				Main Theatre	CAH	Week 2 [Mr Akhtar]	
Week 2 AM				Outpatients	DHH	Week 2 [A O'Brien]										
Week 2 AM				Day Surgery	STH	Week 2 [M Akhtar]										
Week 3 AM				Day Surgery	CAH	Week 3 [Mr O'Brien]	Outpatients	CAH [Thorndale]	Week 3 [M.Akhtar]				Main Theatre	CAH	Week 3 [Mr Akhtar]	
Week 3 AM	Main Theatre	DHH	Week 3 [Mr Young]	Main Theatre	CAH	Week 3 New Consultant	Main Theatre	CAH	Week 3 [Mr O'Brien]				Day Surgery	CAH	Week 3 [Mr Young]	
Week 3 AM				Cystoscopy	STH	Week 3 [Mr Akhtar[										
Week 3 AM				Outpatients	DHH	Week 3 [Mr Young]										

AM/PM	Monday			Tuesday			Wednesday			Thursday			Friday			Total
Week 4 AM				Day Surgery CAH	CAH	Week 4 [Mr O'Brien]	Outpatients	CAH [Thorndale]	Week 4 [M.Akhtar]				Main Theatre	CAH	Week 4 [New Consultant]	
Week 4 AM				Day Surgery	STH	Week 4 [New Consultant]										
Week 4 AM	Main Theatre	DHH	Week 4 [Mr Akhtar]	Main Theatre	CAH	Week 4 [M Young]	Main Theatre	CAH	Week 4 [A. O'Brien]				Day Surgery	CAH	Week 4 [Mr Young]	
Week 4 AM				Outpatients	DHH	Week 4 [Mr Akhtar]										
Week 5 AM	Main Theatre	DHH	Week 5 [New Consultant]	Main Theatre	CAH	Week 5 [M Young]	Main Theatre	CAH	Week 5 [A. O'Brien]				Day Surgery	CAH	Week 5 Mr Young	
Week 5 AM				Outpatients	DHH	Week 5 [New Consultant]	Outpatients	CAH [Thorndale]	Week 5 [Mr Akhtar]				Main Theatre	CAH	Week 5 [M Akhtar]	
Week 5 AM				Cystoscopy	STH	Week 5 Mr Akhtar]										
Week 5 AM				Day Surgery	CAH	Week 5 [Mr O'Brien]										
Week 1 PM	Main Theatre	DHH	Week 1 [New Consultant]]	Outpatients	CAH	Week 1 [A O'Brien]	Main Theatre	CAH	Week 1[A O'Brien]	Outpatients	BBPC	Week 1 [A O'Brien]	Main Theatre	CAH	Week 1 [M.AKhtar][	
Week 1 PM				Main Theatre	CAH	Week 1 [M Young]							Outpatient	CAH	Week 1[Michael Young]	
Week 1 PM													Outpatients	DHH	Week 1 [New Consultant]	
Week 1 PM				Outpatients	STH	Week 1 [M Akhtar]							Cysto	CAH	Week 1 [Staff Grade]	
Week 2	Main	DHH	Week 2 [A	Outpatients	CAH	Week 2	Main	CAH	Week 2				Outpatient	CAH	Week 2 [M	

AM/PM	Monday			Tuesday			Wednesday			Thursday			Friday			Total
PM	Theatre		O'Brien]			[New Consultant]	Theatre		[New Consultant]						Young]	
Week 2 PM				Main Theatre	CAH	Week 2 [M Young]							Main Theatre	CAH	Week 2 [M Akhtar]	
Week 2 PM				Outpatients	STH	Week 2 [M Akhtar]							Cysto	CAH	Week 2 Staff Grade	
Week 2 PM													Outpatient	DHH	Week 2 [New Consultant]	
Week 3 PM	Main Theatre	DHH	Week 3 [Mr Young]	Outpatients	CAH	Week 3 [A OBrien]	Main Theatre	CAH	Week 3 [Mr O'Brien]]	Outpatients	ACH	Week 3 [A OBrien]	Cysto	CAH	Week 3	
Week 3 PM				Main Theatre	CAH	Week 3 [New Consultant]				Outpatients	BBPC	Week 3 [New Consultant]	Main Theatre	CAH	Week 3 [M Akhtar]	
Week 3 PM				Outpatients	STH	Week 3 Mr Akhtar							Outpatients	CAH	Week 3 [M Young]	
Week 3 PM													Outpatient	DHH	Week 2 [New Consultant]	
Week 4 PM	Main Theatre	DHH	Week 4 [Mr Akhtar]	Outpatients	CAH	Week 4 [A OBrien]	Main Theatre	CAH	Week 4 [Mr O'Brien]	Outpatients	DHH	Week 4 [New Consultant]	Outpatient	CAH	Week 4 [M Young]	
Week 4 PM				Main Theatre	CAH	Week 4 [M Young]				Outpatients	ACH	Week 4 [M Young]	Main Theatre	CAH	Week 4 [New Consultant]	
Week 4 PM				Outpatients	STH	Week 4 [New Consultant]							Cysto	CAH	Week 4	
Week 5 PM	Main Theatre	DHH	Week 5 [New Consultant]	Outpatients	CAH	Week 5 [A OBrien]	Main Theatre	CAH	Week 5[Mr O'Brien]	Outpatients	ACH	Week 5 [[A OBrien]	Outpatient	CAH	Week 5 [M Young]	
Week 5 PM				Outpatients	STH	Week 5 [Mr Akhtar]							Cysto	CAH	Week 5 {Staff	

AM/PM	Monday			Tuesday			Wednesday			Thursday			Friday			Total
															Grade]	
Week 5 PM				Main Theatre	CAH	Week 5 [M Young]							Main Theatre	CAH	Week 5 [M Akhtar]	
Week 5 PM													Outpatient	DHH	Week 5 [New consultant]	

Southern Health & Social Care Trust

Medical Directors Office

Screening report on Dr Aidan O'Brien

Context

The Medical Director sought detailed information on a range of issues relating to the conduct and performance of Dr O'Brien. This report provides background detail and current status of these issues, and provides a recommendation for consideration of the Oversight Committee.

Issue one – Un-triaged outpatient referral letters

When a GP refers a patient into secondary care, the referral is triaged to consider the urgency of the referral. If triage does not take place within an agreed timescale as per the Integrated Elective Access Protocol (IEAP), then health records staff schedule the referral according to the priority given by the GP. This carries with it the risk that a patient may not have their referral "upgraded" by the consultant to urgent or red flag if needed, if triage is not completed. This may impact upon the outcome for a patient.

In March 2016, Dr O'Brien had 253 untriaged letters, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 174 untriaged letters, dating back 18 weeks; the rest of the urology team triage delay is 3-5 working days.

Issue two – Outpatient review backlog

Concerns have been raised that there may be patients scheduled to be seen who are considerably overdue their review appointment and could have an adverse clinical outcome due to this delay.

In March 2016, Mr O'Brien had 679 patients in his outpatient review backlog, which was raised in writing with him and a plan to address this was requested. No plan was received and at August 2016, there were 667 patients in his outpatient review backlog, dating back to 2014: whilst outpatient review backlogs exist with his urological colleagues, the extent and depth of these is not as concerning.

Issue three – Patients notes at home

Mr O'Brien has had a working practice of taking charts home with him following outpatient clinics. These charts may stay at his home for some time, and may not be available for the patient attending an appointment with a different specialty, making the subsequent consultation difficult in the absence of the patients full medical history.

For a period in 2013/14, instances when charts were not available were recorded on the Southern Trusts Adverse Incident Reporting (IR) system: there were 61 consultations where charts were not available. In speaking to the Health Records Manager, Mr O'Brien is currently continuing this practice although this is not now recorded on the IR system.

Mr O'Brien was spoken to about this issue in 2012 by Dr Rankin, and twice in 2014 by Mrs Burns, the Directors of Acute Services at the time, seeking a change in behaviour, although none of these meetings were formally recorded.

Issue four – Recording outcomes of consultations and inpatient discharges

Whilst there has been no formal audit of this issue, concern has been raised by his urological colleagues that Mr O'Brien may not always record his actions or decisions regarding a patient following a period of inpatient care or outpatient consultation. This may cause subsequent investigations or follow up not to take place or be delayed.

Summary of concerns

This screening report has identified a range of concerns which may be counter to the ***General Medical Councils Good Medical Practice*** guidance of 2013, specifically paragraphs 15 (b), 19 and 20:

15. ***You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:***
    a. *Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient*
    b. ***Promptly provide or arrange suitable advice, investigations or treatment where necessary***
    c. *Refer a patient to another practitioner when this serves the patient's needs.*
19. *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible.* ***You should make records at the same time as the events you are recording or as soon as possible afterwards.***
20. ***You must keep records*** *that contain personal information about patients, colleagues or others* ***securely, and in line with any data protection requirements.***

Conclusion

This report recognises that previous informal attempts to alter Dr O'Brien's behaviour have been unsuccessful. Therefore, this report recommends consideration of an NCAS supported external assessment of Dr O'Brien's organisational practice, with terms of reference centred on whether his current organisational practice may lead to patients coming to harm. **The options available for this external assessment are provided in Appendix A.**

Date of report 7/9/2016

Appendix A – Extract from NCAS Assessment Services www.ncas.nhs.uk

1. **Record-based assessment**

This assessment, currently focused on primary medical and dental care, enables the referring body to decide whether there is a problem that needs further investigation or assessment. An in depth, structured review of clinical records is useful for identifying concerns at an early stage but does not, on its own, give enough information to support a decision on a practitioner's fitness for purpose. The process may include an interview with the practitioner to explore issues arising from the review.

2. **Assessment of health**

Sometimes concerns about a practitioner focus on health and how this may be influencing performance. In these cases we can offer an occupational health assessment or provide advice to organisations who may wish to commission their own health assessment. We have significant experience in occupational health services specifically tailored for clinicians in performance difficulties. We are also able to offer timely access to specialist health services where onward referral is necessary. For example, health or behavioural assessment might suggest that a problem has its origins in cognitive impairment, requiring advice from a neuropsychiatrist or neuropsychologist.

3. **Assessment of behavioural concerns**

Where the concerns about an individual practitioner have their primary focus on the practitioner's behaviour and relationships with colleagues, and where there is not misconduct requiring use of disciplinary or fitness to practise procedures, we may suggest an assessment of behavioural concerns. This assessment involves completion of psychometric questionnaires followed by a full-day structured interview with an NCAS behavioural assessor, drawn together with an occupational health assessment and multi-source feedback. The aim is to:

- provide an independent view on any behavioural factors about the practitioner which are causing concern
- identify other factors that may be contributing to these concerns
- make recommendations for addressing any difficulties identified.

4. **Full performance assessment**

This is our most detailed intervention, taking a broad view of performance and making detailed practical recommendations. It is particularly valuable where there are complex, longstanding and/or multiple concerns. It includes an assessment of the practitioner's health, a behavioural assessment and assessment of clinical practice based on workplace observation. The process looks not just at the practitioner but at the practitioner's working environment - referred to as 'the context of practice'. The result is a comprehensive report with clear findings and conclusions in. respect of the individual's practice, which provides

the referring body with a clear way forward to bring the case towards a resolution. Where indicated, a full performance assessment may also include a review of the practitioner's communicative competence, i.e. a review of the practitioner's ability to communicate effectively with patients and colleagues in a clinical context.

The validity and reliability of the NCAS assessment depends on wide sampling across a practitioner's work, using a range of assessment instruments; this ensures its defensibility and fitness for purpose.

5. Multi-source feedback (MSF)

Whilst not in itself a detailed assessment of practice, multi-source feedback can be a useful tool for understanding the views of colleagues and patients on a practitioner's work. The referring organisation works with NCAS to collect peer and patient feedback which NCAS then analyses and reports on.

Gibson, Simon

From: Gibson, Simon
Sent: 05 May 2022 09:46
To: Powell, Brendan
Subject: RE: Email archive - 2007 to 2009

Thanks Brendan

Much appreciated

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Personal Information redacted by USI

07841101952

From: Powell, Brendan <Personal Information redacted by USI>
Sent: 05 May 2022 09:45
To: Gibson, Simon <Personal Information redacted by USI>
Subject: RE: Email archive - 2007 to 2009

Simon
The Archive defo didn't kick in until 2009. Not exactly sure what date in 2009 though.

Regards
Brendan Powell
IT Server Infrastructure Team
Southern Health & Social Care Trust
Trust Headquarters
Craigavon Area Hospital
Tel: Personal Information redacted by USI
Mobile: Personal Information redacted by USI

From: Gibson, Simon <Personal Information redacted by USI>
Sent: 05 May 2022 09:41
To: Powell, Brendan <Personal Information redacted by USI>
Subject: Email archive - 2007 to 2009

Dear Brendan

I'm looking to access the above, but am getting inconsistent results – can you confirm whether the archive system goes back this far?

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Personal Information redacted by USI

Personal Information redacted by USI

Gibson, Simon

From: Gibson, Simon
Sent: 10 May 2022 11:25
To: Gibson, Simon
Subject: FW: Preparing Urology referrals for triage

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office [redacted]

[redacted]

-----Original Message-----
From: Gibson, Simon <[redacted]
Sent: 03 October 2008 09:43
To: Glenny, Sharon <[redacted]
Cc: OBrien, Aidan <[redacted]>; [redacted]; Clayton, Wendy [redacted]
Subject: Preparing Urology referrals for triage

Dear Sharon

What would be the practical issues required to prepare referrals with lab results for Aidan, in a deal with Aidan to triage within 48 hours.

Kind regards

Simon

Simon Gibson

Assistant Director of Acute Services - Surgery & Elective Care

Southern Health & Social Care Trust

[redacted]

[redacted]t <mailto:[redacted]>

P Please consider the environment before printing this e-mail.

Gibson, Simon

From: Gibson, Simon
Sent: 10 May 2022 11:40
To: Gibson, Simon
Subject: FW: URGENT - Urology ICATS referrals

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office [redacted]

[redacted]

-----Original Message-----
From: Young, Michael Mr <[redacted]>
Sent: 04 December 2008 12:31
To: 'Mackle, Eamon' <[redacted]>; 'Gibson, Simon' <[redacted]>; 'Young, Michael' <[redacted]>
Cc: McCorry, Monica <M[redacted]>; Akhtar, Mehmood <[redacted]>
Subject: RE: URGENT - Urology ICATS referrals

AOB was on leave and I note that some were mine - I have triage all letters in my box till tues 4pm - if mine are outstanding someone else has them. I do note that my 'triaged box' letters has not been taken from last weeks session of triage. Therefore several factors involved - will speak in person.
MY

-----Original Message-----
From: Mackle, Eamon [mailto:[redacted]
Sent: 03 December 2008 15:44
To: Gibson, Simon; Young, Michael
Subject: Re: URGENT - Urology ICATS referrals

Michael

We talked about this before. If you don't think Urology can cope I think we have no choice but to ask Philip Rogers.

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust

----- Original Message -----
From: Gibson, Simon <[redacted]>

To: Young, Michael [redacted]
Cc: Mackle, Eamon [redacted] Gibson, Simon
[redacted]
Sent: Wed Dec 03 09:51:37 2008
Subject: FW: URGENT - Urology ICATS referrals

Dear Michael

What solutions could you propose to this continuing problem?

Kind regards

Simon

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
[redacted]

P Please consider the environment before printing this e-mail.

-----Original Message-----
From: Cunningham, Teresa
[mailto:[redacted]
Sent: 02 December 2008 17:22
To: Gibson, Simon; Mackle, Eamon
Subject: URGENT - Urology ICATS referrals
Importance: High

Dear Simon/Eamon

Please see attached a spreadsheet showing the numbers of referrals which have not as yet been triaged.

As you know this problem has been raised on a number of occasions and for a short while, the situation had improved. Mr O'Brien was triaging the referrals last week and I appreciate that he only returned from a week's leave last Monday. Unfortunately however, as we are working to a
6 week target, the current situation is intolerable.
When I ran the PTL's yesterday, there were only 12 patients on the PTL to be appointed for January, because the referrals have not been triaged. This will undoubtedly lead to a panick situation later on this month in the run up to the Christmas holidays, trying to get patients booked. I think it is unfair that undue pressure is being exerted on me to ensure patients are treated within target dates, and subsequenty on the appointments staff, because I put pressure on them to ring patients to get them appointed.

The service is not manageable under these circumstances and I feel I can not continue to manage it unless this issue is properly addressed. If Mr O'Brien is constantly facing difficulties triaging his referrals within the timeframes specified within the IEAP, then we need to put something else in place to faciitate the smooth operation of the service and to ensure that we can offer patients reasonable notice.

I would appreciate if you could let me know what action will now be taken to resolve this problem once and for all.

Regards

Teresa

_____

From: Cox, Sara [mailto:[redacted]]
Sent: Tue 02/12/2008 15:16
To: Cunningham, Teresa; Manly, Ann-Marie
Subject: Urology referrals

Gibson, Simon

From: Gibson, Simon
Sent: 10 May 2022 11:20
To: Gibson, Simon
Subject: FW: Communication Sub-Group - Referral & Booking Centre
Attachments: Communication Strategy v1_5.02.02.09update.doc

Kind regards

Simon

Simon Gibson
Assistant Director – Medical Directors Office
Personal Information redacted by the USI

Personal Information redacted by USI

From: Gibson, Simon <Personal Information redacted by USI
Sent: 03 February 2009 14:02
To: Mackle, Eamon <Personal Information redacted by USI >; Epanimeritakis, Manos <Personal Information redacted by USI >; Hewitt, Gareth <Personal Information redacted by USI >; Sloan, Samantha <Personal Information redacted by USI ; Weir, Colin <Personal Information redacted by USI >; Lewis, Alastair <A Personal Information redacted by USI >; Hall, Sam <Personal Information redacted by USI >; McNaboe, Ted Personal Information redacted by USI ; Leyden, Peter <Personal Information redacted by USI >; Basha, Irfan <Personal Information redacted by USI >; Young, Michael <Personal Information redacted by USI >; Personal Information redacted by USI Akhtar, Mehmood <Personal Information redacted by USI >; Brown, Robin <Personal Information redacted by USI >; Mockford, Brian <Personal Information redacted by USI t>; McKeown, Ronan <R Personal Information redacted by USI >; Personal Information redacted by USI ; Bailie, Graham <Personal Information redacted by USI >; Bunn, Jonathon <J Personal Information redacted by USI >
Cc: Stead, Lindsay <L Personal Information redacted by USI >; McVey, Anne <Personal Information redacted by the USI >; Carroll, Ronan <Personal Information redacted by the USI >; Carroll, Anita <Personal Information redacted by the USI >; Glenny, Sharon <Personal Information redacted by the USI >
Subject: FW: Communication Sub-Group - Referral & Booking Centre

Dear all

I am writing to check your awareness of the imminent changes in the way in which referrals are going to be processed through the centralized Referral and Booking Centre. I have attached the most recent update provided to me by the team managing this process for information.

Can you please let me know whether you are familiar with the new electronic method by which the Referral and Booking Centre are going to send you referrals - which have been scanned - for triage by yourselves and then returned to be processed for appointments. I am informed that there is to be a staged process of transferring onto this new method of triage and would need to know where there are issues unresolved.

I look forward to hearing from you at your earliest convenience.

Kind regards

Simon

Lindsay, Anne, Ronan - you may wish to make similar enquiries within your respective divisions.

Simon Gibson

Assistant Director of Acute Services - Surgery & Elective Care

Southern Health & Social Care Trust

Personal Information redacted by USI

Personal Information redacted by USI

-----Original Message-----
From: Hanna, Siobhan [mailto:Personal Information redacted by USI]
Sent: 03 February 2009 11:15
To: Murchan, Cara; Weaver, Catherine; Bennett, Edel; Hamilton, George; Matier, Pauline; Glenny, Sharon; Cully, Susan
Cc: Carroll, Anita; Gibson, Simon
Subject: Communication Sub-Group - Referral & Booking Centre

Dear All,

See updated version from our meeting yesterday. The next meeting has been confirmed for:

Monday 23rd February at 3.30pm, Ferndale Meeting Room, Bannvale Site, Gilford

Anita & Simon - I have copied to you as the membership from your Directorate has broken down with Sharon and Pauline both on sickleave.

Mrs Siobhan Hanna

Assistant Director of Informatics

Ferndale

Bannvale Site

GILFORD

Co Armagh

BT63 5JX

Tel: Personal Information redacted by USI

email: Personal Information redacted by USI

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Southern Health & Social Care Trust IT Department ([redacted])

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