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

Mr. Barry Conway
Assistant Director – Cancer and Clinical Services
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.

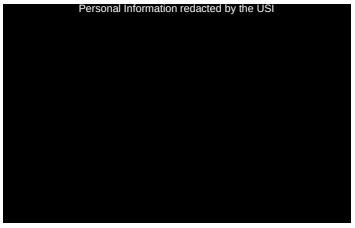
Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

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



Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 16 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:

Barry Conway
Assistant Director – Cancer and Clinical Services
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.**

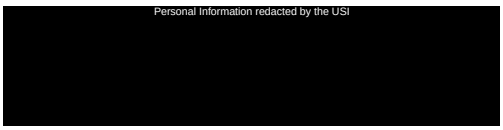
APPLICATION TO VARY OR REVOKE THE NOTICE

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 16 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 16 of 2022

Date of Notice: 29th April 2022

Witness Statement of: Barry Conway

I, Barry Conway, 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 The SHSCT was formed in April 2007. From April 2007 to February 2010, I worked in a Head of Service role for Emergency and Unscheduled Care in Acute Services. The job description for this post is referenced at:

1. ***20070906 Q5 JD Head of Service Emergency and Unscheduled Care located in S21 16 of 2022 Attachments***

1.2 I became an Assistant Director in Acute Services in March 2010. From March 2010 up to March 2016, I was Assistant Director for Medicine and Unscheduled Care and a member of the Acute Services Senior Management Team. The job description for this post is referenced at:

2. ***20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments***

1.3 The Director of Acute Services (Mrs Esther Gishkori) changed the Acute Directorate structure from April 2016. From April 2016 to January 2018, I became the Assistant Director for Strategy and Service Improvement. The job description for this post is referenced at:

3. ***20160401 Q5 JD Assistant Director for Strategy and Service Improvement***
   located in S21 16 of 2022 Attachments

Urology Services Inquiry

1.4 From 1 May 2016 to 3 October 2016, I covered [redacted] for the Assistant Director of Functional Support Services (Mrs Anita Carroll). Functional Support Services includes a range of services including Consultant Secretaries. I covered this role in addition to my own Assistant Director for Strategy and Service Improvement role during this period. The job description for Assistant Director for Functional Support Services is referenced at:

4. 20070301 Q5 JD Assistant Director for Function and Support Services located in S21 16 of 2022 Attachments

1.5 I was asked by the Director of Acute Services (Mrs Esther Gishkori) to add the Integrated Maternity and Women's Health Division into my existing Assistant Director portfolio from 1 February 2018. By that stage, the Strategy and Service Improvement work was reducing as the work plan had been delivered and transferred to the operational Assistant Directors in Acute Services. I therefore had capacity to take on this additional role. The job descriptions for these posts are referenced at:

3. 20160401 Q5 JD Assistant Director for Strategy and Service Improvement located in S21 16 of 2022 Attachments

5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022 Attachments

1.6 On 1 June 2018, I became the Assistant Director for Cancer and Clinical Services / Integrated Maternity and Women's Health, fully relinquishing responsibility for Strategy and Service Improvement. I remained in this role up to 31 May 2021. The job description for this post is referenced at:

5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022 Attachments

1.7 On 1 June 2021, the Director of Acute Services (Mrs Melanie McClements) sub divided the Cancer and Clinical Services / Integrated Maternity and Women's Health Division as it was too large. I therefore became the Assistant Director for Cancer and Clinical Services from 1 June 2021 and I remain in this post to date. Integrated Maternity and Women's Health is now a standalone Division with a dedicated Assistant Director. Mrs Caroline Keown commenced this role in October 2021 and remains in this post.

1.8 During my tenure in SHSCT, I have held a number of posts as noted above. From April 2007 to May 2016, the posts held had no links to Urology Services as these posts focussed on Medical Specialties or broader strategic work. I have been an Assistant Director from March 2010 and a member of the Acute Senior Management Team (SMT). From 1 June 2018 to date, I have been the Assistant Director for Cancer and Clinical Services. In this role, I have had links with the Urology service in terms of monitoring performance against the 31 and 62 day cancer access targets.

1.9 In my role as Assistant Director for Cancer and Clinical Services, I am responsible for:

a. Delivering against the access standards for cancer patients on 14 day, 31 day and 62 day pathways
b. Providing the Cancer Tracking function to eight Cancer Multidisciplinary Teams (MDTs) - i.e. Urology, Lung, Breast, ENT, Dermatology, Lower GI, Upper GI and Gynaecology
c. Supporting the Peer Review process for eight cancer tumour sites
d. Delivering a Systemic Anti-Cancer Treatment (SACT) Service through the Mandeville Unit in Craigavon Area Hospital
e. Delivery of local Oncology Outpatient Services in the Mandeville unit supported by Oncologists outreaching from Belfast HSC Trust
f. Laboratory Services
g. Radiology, Audiology and Neurophysiology Services
h. Acute Allied Health Professional Services (Physiotherapy, Occupational Therapy, Speech and Language Therapy, Dietetics and Orthoptics)

1.10 The Cancer and Clinical Services Division monitors performance against the cancer access targets. The cancer services are delivered through three other Acute Divisions as follows:

a. Surgery and Elective Care for Urology, Breast, ENT, Upper GI and Lower GI
b. Medicine and Unscheduled Care for Lung, Dermatology and Upper GI
c. Integrated Maternity and Women's Health for Gynaecology

1.11 In my role as Assistant Director for Cancer and Clinical services, I chair monthly Cancer Performance meetings. The Heads of Service and Assistant Directors from the three Divisions noted above attend these meetings along with representatives from the Trust Performance Team. At these meetings, we review cancer performance and consider pressures across the red flag patient pathways. Actions agreed will be noted and progressed by the Heads of Service with their clinical teams, including Urology. More detail on this process is included in my response to question 29.

1.12 During my tenure as Assistant Director for Cancer and Clinical Services, the Trust has not been able to meet the 31 and 62 day cancer access targets for all tumour sites, including Urology. Details on performance against the 31 and 62 day cancer access targets from 2018/19 to 2021/22 is included in my response to question 41.

1.13 In my role as Assistant Director for Cancer and Clinical Services, I monitor cancer performance as detailed in response to question 41. Where corrective action is needed to address cancer performance, the Head of Service for the specialty and the Assistant Director take these actions. The impact of corrective actions is reviewed at the next monthly Cancer Performance meeting.

1.14 The Urology Service has been unable to meet the 31 day or 62 day target during my tenure. It is my understanding from discussions at the Cancer Performance meetings that this is primarily due to workforce challenges at consultant level and the fact that demand for the service consistently exceeds the commissioned level of capacity in the service. The responsibility for addressing

consultant workforce pressures, sits with Head of Service for Urology (Mrs Martina Corrigan 2010 -September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care ((Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

1.15 In monitoring the cancer access targets for Urology, my main point of contact has been the Head of Services for Urology (Mrs Martina Corrigan 2010 - September 2020 and Ms Wendy Clayton from October 2020 to date). I have had limited contact with the Urology Consultants during my tenure, with the exception of Mr Tony Glackin (Chair of the Urology Cancer MDT) who attended some of the Cancer Checkpoint meetings which were held instead of the monthly Cancer Performance meetings during the COVID 19 Pandemic (April 2020 to April 2022).

1.16 During my tenure in SHSCT, I have never met with Mr O'Brien or been involved in any meetings where concerns were raised in relation to Mr O'Brien.

1.17 During my tenure in SHSCT, I have never had any cause to raise concerns in relation to Mr O'Brien, as noted in my response to question 63.

1.18 During 2016 (I cannot recall the exact date for this), I was aware that a Serious Adverse Incident review process was underway looking at a number of Urology cases, involving Mr O'Brien. I cannot recall exactly how and when I became aware of this, I presume this must have been stated at one of the Acute Directorate Senior Management Team governance meetings by the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). I was not aware of the details in relation to the Serious Adverse Incident review at this time. Also at this time, I was aware that there were some issues regarding Mr O'Brien and his patients' charts. Again, I cannot state exactly when I became aware of this, but I believe it was raised by Mrs Anita Carroll at one of the Acute Senior Management Team meetings during 2016.

1.19 I am now aware through the Urology Public Inquiry evidence gathering process, that an investigation was undertaken into Mr O'Brien through the Maintaining High Professional Standards process. I can confirm that I was not part of this process nor did I attend any meetings in relation to this process.

1.20 In the autumn of 2020, I became aware that a further review was being undertaken into Mr O'Brien and this was focussing on how he managed some of his cancer patients. Mr Dermot Hughes, who was the independent external chair of this review panel, was undertaking this review. Mrs Fiona Reddick (Head of Cancer Services) made me aware of this review as she was a member of the review group. Fiona reported to me as Assistant Director for Cancer and Clinical Services in her role as Head of Cancer Services.

1.21 I received the Dermot Hughes report in February 2021. The report detailed a number of areas that needed to be addressed in relation to the Urology Cancer Multidisciplinary Meeting (MDT). As detailed in my response to question 40, I was

previously aware of issues in relation to gaps in attendance / quoracy at the Multidisciplinary Team meeting and the need for additional clinical audit support, however I was unaware of the following issues:

a. Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer MDT meeting
b. Not all patients with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)
c. Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

1.22 Before receiving the Dermot Hughes report in February 2021, I was aware of a number of issues in relation to cancer services as follows:

a. SHSCT were unable to meet the 31 and 62 day cancer access targets across all tumour sites, including Urology
b. Gaps in attendance at Cancer MDTs, including Urology. Main concerns were in relation Oncology, Radiology and Pathology
c. Lack of clinical audit support to the Cancer MDTs

1.23 My actions to address the issues which I was aware of before receiving the Dermot Hughes report, are detailed in my response to question 40.

1.24 The Trust's inability to meet the 62 day cancer access target was added to the Acute Directorate risk register by the Head of Cancer Services (Mrs Fiona Reddick) on 3 September 2012 and this continues to be on the risk register. Performance against the 31 day target was not included, however as this target has been met on occasions and when not met, the shortfall was considered to be marginal through the various performance meetings.

1.25 During my tenure as Assistant Director for Cancer and Clinical Services, I have been concerned about the Oncology Cover for the Cancer MDTs, including Urology. SHSCT do not employ Oncology Consultants. This resource is provided from Belfast HSC Trust to cover the MDTs and also to provide Oncology Clinics in the Mandeville Unit. It is my understanding that there is a regional shortage of Consultant Oncologists in Northern Ireland and for this reason, Belfast HSC Trust have not been able to provide full cover to SHSCT. Mrs Fiona Reddick (Head of Cancer Services) added this risk to the Head of Service Risk register. I am unable to confirm the date on which this was added, as it was done before I became Assistant Director for Cancer and Clinical Services in June 2018. I cannot confirm this detail with Mrs Fiona Reddick [redacted] Personal Information redacted by the USI

1.26 The issues raised in relation to Cancer Services and the functioning of the Urology Cancer MDT are detailed in my response to question 54.

1.27 The Cancer and Clinical Services Division support the running of eight Cancer Multidisciplinary Teams (MDT), including Urology, as outlined in my response to question 7. The arrangements in place to support the Cancer MDTs have been consistent since the MDTs were established in April 2007. I believe the arrangements in place to support the Cancer MDTs are consistent with those in place in other HSC Trusts in Northern Ireland as they were commissioned by the Health and Social Care Board (HSCB) and established through the Northern Ireland Cancer Network (NICAN).

1.28 In the context of the concerns that have now been identified in the Urology Service, I believe the measures previously in place to assess the effectiveness of each Cancer MDT were not sufficiently robust for the following reasons.

a. There was no commissioned post to oversee the effectiveness of each of the MDTs (Cancer MDT Administrator)
b. There were no monthly reports in place to show how each MDT was working – including information on attendance / quoracy
c. There was no clinical audit support in place to check that actions agreed at MDT were implemented
d. There was no way of recording that the key worker had been allocated for each patient at MDT
e. There was no way of checking if a Cancer Nurse Specialist was involved with each patient and that information was shared with each patient in terms of their cancer diagnosis, their treatment plan and support available
f. Information from the pathology department, including cancers confirmed through laboratory tests, was not being cross referenced back to cases presented to each cancer MDT

1.29 It is my understanding that the arrangements previously in place in the SHSCT for the Cancer MDTs, including Urology, were the same as those in place in all HSC Trusts in Northern Ireland.

1.30 A Task and Finish Group was established in August 2021 to implement the recommendations outlined in the Dermot Hughes report. The Terms of Reference for this group, including the membership are attached for reference.

64. 20211011 Q55 TOR Trust Task and Finish Group into Urology SAI Recommendations located in S21 16 of 2022 Attachments

1.31 I am a member of the Task and Finish Group.

1.32 During my tenure as Assistant Director for Cancer Services, my primary focus was on performance against the 14, 31 and 62 Day targets. I have a clear line of sight to performance information through monthly reports and the monthly Cancer Performance meetings. With regards to the Cancer MDTs however, I did not have a clear line of sight, as I did not receive the Annual Reports from the Cancer MDTs and there was no monthly reports to show me how the Cancer MDTs were working. The monthly reports from the Cancer MDTs was the process that was in place since

the establishment of the Cancer MDTs in 2007. These processes are being improved as detailed in my response to question 50.

1.33 In my opinion, the changes being made to the Cancer MDTs processes will make the arrangements more robust for patients in future. All HSC Trusts in Northern Ireland are currently completing the National Cancer Team (NCAT) baseline assessment of their Cancer MDT processes. SHSCT are keeping all Trusts updated in terms of the learning linked to the Dermot Hughes report and the improvements being implemented.

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 All documents that I am aware of and that are relevant have been referenced in my responses to questions 4-72 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.

4.1 I qualified from the Queen's University of Belfast in June 1991 with a BA Hons Degree in Business Administration and Computer Science.

4.2 Following my graduation, I commenced a Post Graduate programme with the Chartered Institute of Marketing. This programme ran for one year and involved a number of work placements in Derry City, with the main placement being with Derry Youth and Community workshop. I completed and passed the Chartered Institute of Marketing programme in April 1992.

4.3 I joined Craigavon Area Hospital Group Trust as a temporary clerical officer in the Finance Department based in Lurgan Hospital on 1 June 1992.

4.4 I commenced a permanent clerical officer post in Craigavon and Banbridge Community Trust in the Finance Department based in Lurgan Hospital on 1 April 1994.

4.5 I commenced a Higher Clerical Officer post in Craigavon and Banbridge Community Trust in the Finance Department based in Lurgan Hospital on 1 April 1996.

4.6 I commenced a General Administrative Assistant role in the GP Fundholding section in the Eastern Health and Social Care Board on 1 April 1998.

4.7 I commenced a Project Officer role in the Unique Patient Client Identified Project in the Department of Health on 1 July 1999.

4.8 I commenced a Project Manager role in Armagh and Dungannon Local Health and Social Care Group on 1 July 2004.

4.9 I commenced a Service Planner role in Craigavon Area Hospital Group Trust on 25 July 2005.

4.10 At the request of the then Chief Executive, Mr John Templeton, I moved to a temporary role in an Operations Teams in Craigavon Area Hospital Group Trust in September 2005.

4.11 I commenced a regional Unscheduled Care Service improvement role on 1 December 2006. In this role, Craigavon Area Hospital Group Trust employed me; however, I worked between the Trust and the Service Delivery Unit of the Department of Health. I remained in this post up to 5 September 2007, with my role moving across to the SHSCT from 1 April 2007.

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 Since the SHSCT was formed on 1 April 2007, I have held the following posts:

5.2 Craigavon Area Hospital Group Trust was combined with Craigavon and Banbridge Community Trust and Newry and Mourne Trust to form SHSCT from 1 April 2007. From 1 April 2007 until 5 September 2007, I was employed as a Regional Unscheduled Care Improvement Manager. I have been unable to source a copy of this Job Description therefore I am unable to confirm if the duties in the job description are an accurate reflection of the post, however my recollection is that the key duties and responsibilities of this role were as follows:

5.3 Key duties and responsibilities:

a. I reported to Mrs Deborah Burns (Interim Director of Operations) in this role
b. Supporting unscheduled care improvement work in SHSCT
c. Working with the Emergency Department teams in Craigavon Hospital and Daisy Hill Hospital to improve patient flows within the Emergency Departments
d. Working with clinical teams across inpatient pathways to reduce waiting times in the Emergency Departments and to reduce delayed discharges
e. Working with community teams to reduce delayed discharges
f. Working as a network of Unscheduled Care Improvement Managers in each Trust to coordinate unscheduled care improvement work across Northern Ireland and to support shared learning
g. I had no staff management responsibilities in this role

Head of Service for Emergency and Unscheduled Care

5.4 I commenced this post on 6 September 2007 and left this post on 28 March 2010. The key duties and responsibilities for this post are detailed in the referenced Job Description. In summary these duties and responsibilities were as follows:

5.4 Key duties and responsibilities:

a. Reports to the Assistant Director of Medicine and Unscheduled Care (Mr Lindsay Stead)
b. Day to day operational management of the service
c. Delivering the service within the available budget
d .Delivering the service to a high standard, focussing on quality and a positive patient experience
e. Providing leadership and direction to the staff working in this service area
f. Lead of service improvement work in the service area
g. Work with the Clinical Director and Lead Nurse as a senior team to deliver the service to a high standard

5.5 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.

1. 20070906 Q5 JD Head of Service Emergency and Unscheduled Care located in S21 16 of 2022 Attachments

Acting Assistant Director for Medicine and Unscheduled Care (MUSC)

5.6 I commenced this post on 29 March 2010 and left this post on 30 April 2011. The key duties and responsibilities for this post are detailed in the referenced Job Description.

5.7 In summary these duties and responsibilities were as follows:

5.8 Key duties and responsibilities:

a. Reporting to the Director of Acute Services (Dr Gillian Rankin)

b. Supporting the Heads of Service in the delivery across the Medicine and Unscheduled Care Division
c. Implementation of commissioning priorities as set by Department of Health and meeting access times for patients on unscheduled care and elective care pathways across the Medicine and Unscheduled Care Division
d. Working closely with senior clinicians and other senior managers in the Medicine and Unscheduled Care Division to secure an appropriate balance between hospital and community services to maintain effective flow of patients across unscheduled care pathways

5.9 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.
2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

Assistant Director for Medicine and Unscheduled Care (MUSC)
5.10 I commenced this post on 1 May 2011 and left this post on 30 November 2014. The key duties and responsibilities for this post are detailed in the referenced Job Description below.

5.11 In summary these duties and responsibilities were as follows:

5.12 Key duties and responsibilities:
a. Reporting to the Director of Acute Services (Dr Gillian Rankin)
b. Supporting the Heads of Service in the delivery across the Medicine and Unscheduled Care Division
c. Implementation of commissioning priorities as set by the Department of Health and meeting access times for patients on unscheduled care and elective care pathways across the Medicine and Unscheduled Care Division
d. Working closely with senior clinicians and other senior managers in the Medicine and Unscheduled Care Division to secure an appropriate balance between hospital and community services to maintain effective flow of patients across unscheduled care pathways

5.13 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.
2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

5.14 During my tenure as Assistant Director for Medicine and Unscheduled Care, I was released from my operational role in April 2012 for a six-month period to focus on the Transforming Your Care programme. This was a regional initiative to focus on patient pathway improvement. During this time, I focussed on pathway improvements for Medicine and Unscheduled Care pathways. My colleague Mrs Heather Trouton focussed on Surgery and Elective Care pathway in a similar role at this time. This post was within SHSCT. There was no job description for this post; however, a Transforming Your Care Update is attached with background information with regards to the work that was being undertaken at this time. The key duties and responsibilities were as follows:

5.15 Key duties and responsibilities:

a. In this role I reported to the Director of Acute Services (Dr Gillian Rankin)
b. I did not manage staff whilst in this role
c. I had no budgetary responsibility in this role
d. I developed and implemented a number of projects to improve a number of unscheduled care pathways – that is, developing services to support patients to be managed in the community thus avoiding the need for admission to hospital
e. I project managed the implementation of a range of projects
f. I engaged with General Practitioners, senior community staff and senior clinicians and senior managers in the Acute Directorate to bring about a number of unscheduled care change initiatives

6. 20120621 Q5 TYC Unscheduled Care Update Barry Conway located in S21 16 of 2022 Attachments

5.16 Whilst I was working on the Transforming Your Care programme, Mrs Mary Burke covered my substantive Assistant Director of Unscheduled Care role.

Assistant Director for Unscheduled Care

5.17 I commenced this post on 1 December 2014 and left this post on 31 March 2016. The key duties and responsibilities for this post are detailed in the referenced Job Description.

5.18 The responsibilities and duties for this post are the similar to those for the Assistant Director of Medicine and Unscheduled Care post above, however the post was sub divided with a separate post for Unscheduled Care and a further post for Medicine which was taken by my colleague Mr Simon Gibson.

5.19 Key duties and responsibilities:

a. Reporting to the Director of Acute Services (Mrs Deborah Burns)
b. Supporting the Heads of Service in the delivery of services across the Unscheduled Care Division
c. Implementation of commissioning priorities as set by the Department of Health and meeting access times for patients on unscheduled care pathways across the Medicine and Unscheduled Care Division
d. Working closely with senior clinicians and other senior managers in the Medicine and Unscheduled Care Division to secure an appropriate balance between hospital and community services to maintain effective flow of patients across unscheduled care pathways

5.20 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.

2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

Assistant Director for Strategy and Service Improvement

5.21 In April 2016, the Director of Acute Services (Mrs Esther Gishkori) implemented a number of changes to the management structure in Acute Services. As a result of these changes, the Assistant Directors moved to other Divisions and the service portfolios in some Divisions changed.

5.22 Before April 2016, the Divisions were as follows:

a. Medicine (Mr Simon Gibson)
b. Unscheduled Care (Mr Barry Conway)
c. Integrated Maternity and Women's Health (Mrs Anne McVey)
d. Surgery and Elective Care (Mrs Heather Trouton)
c. Cancer and Clinical services / Anaesthetics Theatres and Intensive Care (Mr Ronan Carroll)
e. Functional Support Services (Mrs Anita Carroll)

5.23 From April 2016 onwards, the Divisions were as follows:

a. Medicine and Unscheduled Care (Mrs Anne McVey)
b. Surgery and Elective Care / Anaesthetics Theatres and Intensive Care (Mr Ronan Carroll)
c. Cancer and Clinical Services / Integrated Maternity and Women's Health (Mrs Heather Trouton)
d. Functional Support Services (Mrs Anita Carroll)
e. Strategy and service Improvement (Mr Barry Conway)

5.24 Key points to note from these changes are:

a. There was one less Assistant Director in Acute Services
b. Integrated Maternity and Women's Health, which was previously a standalone Division, was now coupled with Cancer and Clinical Services
c. Medicine and Unscheduled Care were recombined having previously been subdivided by Mrs Deborah Burns the previous Director of Acute Services as the portfolio was too large
d. I was allocated the new Strategy and Service Improvement Division as my background was general management / project management and I was not from a clinical background
e. Before the changes in April 2016, the Divisions would have had four Operational Support Leads (Band 7) who directly supported the Assistant Director in the monitoring and delivery of key performance targets. After the changes in April 2016, there were only three Operational Support Leads

5.25 At the time, the Assistant Directors advised Mrs Gishkori that the changes implemented in April 2016 were significant and were likely to cause significant disruption in the short term, as most Assistant Directors would take time to settle into the new roles and become familiar with the detail of their portfolios.

5.26 I commenced this Assistant Director for Strategy and Service Improvement post on 1 April 2016 and left this post on 31 May 2018.

5.27 The key duties and responsibilities for this post are detailed in the referenced Job Description. I was initially in this post only for one month when I had to temporarily cover [redacted] for the Assistant Director for Functional Support Services (Mrs Anita Carroll) at the request of the Director of Acute Services (Mrs Esther Gishkori). During this period, I continued to hold both roles – that is, the Assistant Director for Strategy and Service Improvement as well as Assistant Director for Functional and Support Services. I returned fully to the Assistant Director for Strategy and Service Improvement on 3 October 2016 and remained in this post until 31 May 2018.

5.28 The key duties and responsibilities were as follows:

5.29 Key duties and responsibilities:

a. I reported to the Director of Acute Services in this role (Mrs Esther Gishkori)
b. I had no staff management in this role
I had no budgetary responsibility in this post, with the exception of capital equipment planning
c. I developed the Trust winter plans
d. I was the Acute Directorate link to the planning team for the development of capital equipment and estate investment plans
e. I project managed key service improvement plans as directed by the Director of Acute Services

5.30 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.

3. 20160401 Q5 JD Assistant Director for Strategy and Service Improvement located in S21 16 of 2022 Attachments

Acting Assistant Director for Functional and Support Services

5.31 I commenced this post on 1 May 2016 and left this post on 3 October 2016, covering a period [redacted] for Mrs Anita Carroll. During this time, I continued to hold the role of Assistant Director for Strategy and Service Improvement, therefore this cover provided to the Functional and Support Services role was in a caretaking capacity rather than a fulltime basis. The key duties and responsibilities for this post are detailed in the referenced Job Description.

5.32 The key duties and responsibilities were as follows:

5.33 Key duties and responsibilities:

a. In this role I reported to the Director of Acute Services (Mrs Esther Gishkori)
b. In this role I managed the budget for Functional and Support Services Division
c. I supported the Heads of Service in the delivery of all services in the Function and Support Service including – laundry services, catering and domestic services, facilities management including on site living accommodation for medical staff, central sterile services department,

switchboard services, portering and security services, hospital administration services including referral and booking centre and secretarial staff

5.34 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.

4. 20070301 Q5 JD Assistant Director for Function and Support Services located in S21 16 of 2022 Attachments

Assistant Director for Strategy and Service Improvement / Integrated Maternity and Women's Health

5.35 I was asked by the Director of Acute Services (Mrs Esther Gishkori) to add the Integrated Maternity and Women's Health Division into my existing Assistant Director portfolio from 1 February 2018. By that stage, the Strategy and Service Improvement work was reducing as the main workplan had been delivered and transferred to the operational Assistant Directors in Acute Services. I therefore had capacity to take on this additional role.

5.36 At this time, SHSCT were establishing a new Executive Director of Nursing and Allied Health Professionals role on a part time basis and Mrs Heather Trouton was appointed to this role on an interim basis. With this change, Mrs Heather Trouton continued to be Assistant Director for Cancer and Clinical Services up to 31 May 2018.

5.37 I commenced the dual role of Assistant Director for Strategy and Service Improvement and Integrated Maternity and Women's Health t on 1 February 2018 and this continued up until 31 May 2018.

5.38 The key duties and responsibilities for this post are detailed in the referenced Job Description.

5.39 The key duties and responsibilities were as follows:

5.40 Key duties and responsibilities for Strategy and Service Improvement:

a. I reported to the Director of Acute Services in this role (Mrs Esther Gishkori)
b. I had no staff management in this role
c. I had no budgetary responsibility in this post, with the exception of capital equipment planning
d. I developed the Trust winter plans
e. I was the Acute Directorate link to the planning team for the development of capital equipment and estate investment plans
f. I project managed key service improvement plans as directed by the Director of Acute Services

5.41 Key duties and responsibilities for Integrated Maternity and Women's Health included overseeing the delivery of the following services:

a. Maternity Services, Craigavon Area Hospital
b. Maternity Services, Daisy Hill Hospital

c. Gynaecological Services
d. Fertility Services
e. Genitourinary (GUM) Services

5.42 I can confirm that the referenced Job Descriptions are an accurate reflection of the duties and responsibilities of these posts.
3. 20160401 Q5 JD Assistant Director for Strategy and Service Improvement located in S21 16 of 2022 Attachments
4. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022 Attachments

Assistant Director for Integrated Maternity and Women's Health / Cancer and Clinical Services
5.43 From April 2016, Mrs Gishkori made structural changes to the Acute Directorate; this included the establishment of the Assistant Director for Strategy and Service Improvement role. I held this role from 1 April 2016 to 1 June 2018 at which time the post was dissolved for two reasons. Firstly the key work identified to be progressed had been completed and secondly my experience was having this role separate to the other operational Assistant Director roles in Acute Services was challenging in that the other Assistant Directors felt that they should have responsibility for Strategy and Service Improvement for their own areas. On that basis, the Director of Acute Services, Mrs Esther Gishkori, dissolved the Assistant Director for Strategy and Service Improvement post and devolved these functions to the operational Assistant Directors. At this time, it was clear that the Executive Director of Nursing and Allied Health Professional role needed to be a full time post, therefore it was agreed that Mrs Heather Trouton would take up this role on a full-time basis and fully relinquish her responsibilities within the Acute Services. I therefore became Assistant Director for Integrated Maternity and Women's Health and Cancer and Clinical Services from 1 June 2018 up to 31 May 2021.

5.44 The key duties for this post are detailed in the referenced Job Description.

5.45 Key duties and responsibilities for Integrated Maternity and Women's Health included overseeing the delivery of the following services:
a. Maternity Services, Craigavon Area Hospital
b. Maternity Services, Daisy Hill Hospital
c. Gynaecological Services
d. Fertility Services
e. Genitourinary (GUM) Services

5.46 Key duties and responsibilities for Cancer and Clinical Services included overseeing the delivery of the following services:
a. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
b. Providing the Cancer Tracking function to Cancer Multidisciplinary Teams
c. Supporting the Peer Review process
d. Delivering Systemic Anti-Cancer Treatment (SACT) Service through Mandeville Unit

e. Delivering local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
f. Laboratory Services
g. Radiology, Audiology and Neurophysiology Services
h. Acute Allied Health Professional Services

5.47 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post.

5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022

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Assistant Director of Cancer and Clinical Services

5.48 On 1 April 2016 the Director of Acute Services, Mrs Esther Gishkori, made significant changes to the Acute Directorate management structure. These changes included taking Integrated Maternity and Women's Health, which was previously a stand-alone Division, and coupling it with Cancer and Clinical Services, which was previously aligned to Anaesthetics, Theatres and Intensive Care. During my time in the Assistant Director of Integrated Maternity and Women's Health and Cancer and Clinical Services role from 1 June 2018 to 31 May 2021, it was clear that the service portfolio was too large and needed to be split. [redacted] it was agreed that the portfolio was too large and needed to be urgently split to support my return to work. The Director of Acute Services, Mrs Melanie McClements, took the decision to split these Divisions and create two stand-alone posts, which would be effective from 1 June 2021. Mrs Melanie McClements and Ms Wendy Clarke, Head of Midwifery Services, provided a care-taking role for Integrated Maternity and Women's health from 1 June 2021 up to 25 October 2021 when Mrs Caroline Keown took up post as Assistant Director for Integrated Maternity and Women's Health. I returned to work [redacted] on 13 July 2021 to the stand-alone post of Assistant Director for Cancer and Clinical Services and I continue to be in this post at present. The key duties and responsibilities for this post are detailed in the referenced Job Description.

5.49 Key duties and responsibilities for Cancer and Clinical Services include overseeing the delivery of the following services:

a. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
b. Providing the Cancer Tracking function to Cancer Multidisciplinary Teams
c. Supporting the Peer Review process
d. Delivering Systemic Anti-Cancer Treatment (SACT) Service through Mandeville Unit
e. Delivering local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
f. Laboratory Services
g. Radiology, Audiology and Neurophysiology Services
h. Acute Allied Health Professional Services

5.50 I can confirm that the referenced Job Description is an accurate reflection of the duties and responsibilities of this post. Please note that the job description has not yet been split to reflect the change which came into effect on 1 June 2021.
5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022
Attachments

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.

6.1 Within the Acute Services Directorate, there are four broad areas of responsibility that are pertinent to all Head of Service and Assistant Director senior management roles. These areas are:

1. Governance
2. Finance
3. Human Resources
4. Performance

6.2 This approach mirrors the structure followed by the Director of Acute Services for the Acute Senior Manager team meetings, that is, there is a weekly management meeting and 1 week in 4 will focus on one of these broad areas in turn. This approach is then adopted by the Assistant Director for their weekly meetings with their Heads of Service, and similarly for each Head of Service and their Departmental Leads.

6.3 By way of example, some of the key things which are considered within each of the four broad areas would include:

1. Governance
    a. Review of clinical incidents, including Serious Adverse Incidents and Significant Event Audits.
    b. Review of risk registers – corporate, acute and divisional
    c. Review of complaints and compliments
    d. Review of compliance against key quality standards – for example, Infection Prevention Control and Nursing Quality Indicators
    e. Review of compliance against standards and guidelines, e.g., guidelines issued by National Institute for Clinical Excellence (NICE) or other guidelines issued by Department of Health

2. Finance
    a. Review of monthly budgets, corporate, directorate, divisional and Head of Service level
    b. Capital Equipment Funding
    c. Prioritisation of capital and minor works
    d. Investment Proposal Templates and business cases

3. Human Resources
    a. Review of staffing levels – directorate, divisional and Head of Service level
    b. Sickness absence levels
    c. Updating on recruitment
    d. Review of mandatory training

4. Performance
    a. Performance against Department of Health access targets for out-patients, in-patients and day cases, cancer targets, diagnostic services
    b. Review of activity against commissioned service and budgetary activity (SBA)
    c. Performance challenges and opportunities for improvement
    d. Opportunities for non-recurrent funding to deliver additional activity and performance against same
    e. Service improvement initiatives

Head of Service for Emergency and Unscheduled Care (from 6 September 2007 to 28 March 2010)

6.4 In my role as Head of Service for Emergency and Unscheduled Care, I reported to Mr Lindsey Stead (Assistant Director of Medicine and Unscheduled Care).

6.5 As the Head of Service, I worked with all my departmental managers to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Head of Service, I would also have worked closely with the Clinical Director for Emergency Care, Mr Seamus O'Reilly during this tenure. Unfortunately, there was no Lead Nurse for Emergency Care at this time.

6.6 In my role as Head of Service for Emergency and Unscheduled Care, I had responsibility for supporting the Departmental Managers in the delivery of emergency and unscheduled care across the following areas:

a. Craigavon Area Hospital Emergency Department
b. Daisy Hill Hospital Emergency Department
c. South Tyrone Hospital Minor Injuries Unit
d. Emergency Out of Hours Dental Service.

6.7 In my role as Head of Service for Emergency and Unscheduled Care, the following Department Managers reported to me:

a. Sister Jeanette Thompson, Department manager (Craigavon Area Hospital Emergency Department)
b. Sister Nora Sheridan, Department Manager (Daisy Hill Hospital Emergency Department)
c. Sister Olive Sloan, Department Manager (South Tyrone Hospital Minor Injuries Unit)

d. Mrs Winnie Farrell, Lead Dental Nurse (Emergency Out of Hours Dental Service).

6.8 The role of this post is detailed in the attached Job Description
1. 20070906 Q5 JD Head of Service Emergency and Unscheduled Care located in S21 16 of 2022 Attachments

Acting Assistant Director for Medicine and Unscheduled Care (from 29 March 2010 to 30 April 2011)

6.9 In my role as Acting Assistant Director for Medicine and Unscheduled Care, I reported to Dr Gillian Rankin (Director of Acute Services)

6.10 As the Acting Assistant Director, I worked with all my Heads of Service to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Acting Assistant Director, I would also have worked closely with the Associate Medical Director, Dr Philip Murphy, the Clinical Director for Emergency Care, Mr Seamus O'Reilly and the Clinical Directors for Medicine, Dr Kate Ritchie (Clinical Director for Medicine in Craigavon Area Hospital) and Dr Charles O'Brien (Clinical Director for Medicine in Daisy Hill Hospital) and the Lead Nurse for Medicine, Mrs Kay Carroll during this tenure.

6.11 In my role as Acting Assistant Director for Medicine and Unscheduled Care, I had responsibility for supporting the Heads of Service in the delivery of medicine and unscheduled care services across the following areas:

a. Craigavon Area Hospital Emergency Department
b. Daisy Hill Hospital Emergency Department
c. South Tyrone Hospital Minor Injuries Unit
d. Emergency Out of Hours Dental Service
e. Patient Flow / Hospital At Night
f. Chaplains and Patient Support Services
g. General Medical wards in Craigavon Area Hospital
h. General Medical wards in Daisy Hill Hospital
i. Hospital Social Work services
j. Catherisation Lab, Craigavon Area Hospital
k. Cardiac Investigations
l. Lung function Lab
m. Neurophysiology
n. All medical specialties including – Acute Medicine, Cardiology, Care of the Elderly, Dermatology, Diabetes / Endocrine, Gastroenterology, Neurology, Respiratory, Rheumatology and Stroke Services

6.12 In my role as Acting Assistant Director for Medicine and Unscheduled Care, the following staff reported to me:

a. Mrs Mary Burke, Head of Service – Emergency and Unscheduled Care
b. Mrs Loraine Adair, Head of Cardiology
c. Mrs Eileen O Rourke, Head of General Medicine
d. Mrs Caitriona McGoldrick, Head of Patient Flow / Hospital At Night

e. Mrs Ruth Donaldson, Head of Hospital Social Work
f. Mrs Phyllis Richardson – Operational Support Lead

6.13 The role of this post is detailed in the attached Job Description
2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

Assistant Director for Medicine and Unscheduled Care (from 1 May 2011 to 30 November 2014)

6.14 In my role as Assistant Director for Medicine and Unscheduled Care, I reported to Dr Gillian Rankin (Director of Acute Services) between 01 May 2011 and 31 March 2013 and to Mrs Deborah Burns between 01 April 2013 and 30 November 2014. Dr Rankin left her post on 31 March 2013 and was replaced by Mrs Deborah Burns from 1 April 2013.

6.15 As the Assistant Director, I worked with all my Heads of Service to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Acting Assistant Director, I would also have worked closely with the Associate Medical Director, Dr Philip Murphy, the Clinical Director for Emergency Care, Mr Seamus O'Reilly and the Clinical Directors for Medicine, Dr Kate Ritchie (Clinical Director for Medicine in Craigavon Area Hospital) and Dr Charles O'Brien (Clinical Director for Medicine in Daisy Hill Hospital) and the Lead Nurse for Medicine, Mrs Kay Carroll during this tenure

6.16 In my role as Assistant Director for Medicine and Unscheduled Care, I had responsibility for supporting the Heads of Service in the delivery of medicine and unscheduled care services across the following areas:

a. Craigavon Area Hospital Emergency Department
b. Daisy Hill Hospital Emergency Department
c. South Tyrone Hospital Minor Injuries Unit
d. Emergency Out of Hours Dental Service
e. Patient Flow / Hospital At Night
f. Chaplains and Patient Support Services
g. General Medical wards in Craigavon Area Hospital
h. General Medical wards in Daisy Hill Hospital
i. Hospital Social Work services
j. Catherisation Lab, Craigavon Area Hospital
k. Cardiac Investigations
l. Lung function Lab
m. Neurophysiology
n. All medical specialties including – Acute Medicine, Cardiology, Care of the Elderly, Dermatology, Diabetes / Endocrine, Gastroenterology, Neurology, Respiratory, Rheumatology and Stroke Services

6.17 In my role as Assistant Director for Medicine and Unscheduled Care, the following staff reported to me:

a. Mrs Mary Burke, Head of Service – Emergency and Unscheduled Care

b. Mrs Loraine Adair - Head of Cardiology
c. Mrs Eileen O Rourke - Head of General Medicine
d. Mrs Caitriona McGoldrick - Head of Patient Flow / Hospital At Night
e. Mrs Ruth Donaldson - Head of Hospital Social Work
f. Mrs Phyllis Richardson – Operational Support Lead

6.18 The role of this post is detailed in the attached Job Description
2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

6.19 During my tenure as Assistant Director for Medicine and Unscheduled Care, I was released from my operational role in April 2012 for a six-month period to focus on the Transforming Your Care programme, whilst still reporting to the Director of Acute Services, Dr Gillian Rankin. This was a regional initiative to focus on patient pathway improvement and I had no staff management during that time. During this period, I had responsibility for pathway improvements for Medicine and Unscheduled Care pathways. My colleague Mrs Heather Trouton focussed on Surgery and Elective Care pathway in a similar role at this time**.**
6. 20120621 Q5 TYC Unscheduled Care Update Barry Conway located in S21 16 of 2022 Attachments

6.20 Whilst I was working on the Transforming Your Care programme, Mrs Mary Burke covered my substantive Assistant Director of Unscheduled Care role.

Assistant Director for Unscheduled Care (from 1 December 2014 to 31 March 2016)

6.21 In my role as Assistant Director for Unscheduled Care, I reported to Mrs Deborah Burns (Director of Acute Services)

6.22 As the Assistant Director, I worked with all my Heads of Service to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Assistant Director, I would also have worked closely with the Associate Medical Director, Dr Philip Murphy, the Clinical Director for Emergency Care, Mr Seamus O'Reilly and the Lead Nurse for Unscheduled Care, Mr Paul Smith during this tenure

6.23 In my role as Assistant Director for Unscheduled Care, I had responsibility for supporting the Heads of Service in the delivery of unscheduled care services across the following areas:
a. Craigavon Area Hospital Emergency Department
b. Daisy Hill Hospital Emergency Department
c. South Tyrone Hospital Minor Injuries Unit
d. Emergency Out of Hours Dental Service
e. Acute Medicine (Craigavon Area Hospital)
f. Patient Flow / Hospital At Night

6.24 In my role as Assistant Director for Unscheduled Care, the following staff reported to me:

a. Mrs Mary Burke, Head of Service – Emergency Medicine, Acute Medicine and Unscheduled Care
b. Mrs Caitriona McGoldrick, Head of Patient Flow / Hospital At Night
c. Mrs Ruth Donaldson – Head of Hospital Social Work

6.25 The role of this post is detailed in the attached Job Description
2. 20110201 Q5 JD Assistant Director for MUSC located in S21 16 of 2022 Attachments

Assistant Director for Strategy and Service Improvement (from 1 April 2016 to 30 April 2016)

6.26 In my role as Assistant Director for Strategy and Service Improvement, I reported to the Director of Acute Services (Mrs Esther Gishkori).

6.27 In this Assistant Director role, I worked alongside the operational Assistant Directors and led on key strategic and service improvement changes across the Acute Directorate. At this time I continued to be a member of the Acute Senior Management Team, however, I did not have any direct responsibility for any services nor did I manage any staff. The operational Assistant Directors continued to have responsibility for the four broad areas listed above, i.e., governance, finance, human resources and performance.

6.28 In my role as Assistant Director for Strategy and Service Improvement, I led on the following for the Acute Directorate:

a. Acute Capital equipment planning
b. Unscheduled Care Service Improvement
c. Winter planning
d. General Acute Service Improvement projects

6.29 The role of this post is detailed in the attached Job Description
3. 20160401 Q5 JD Assistant Director for Strategy and Service Improvement located in S21 16 of 2022 Attachments

Assistant Director for Strategy and Service Improvement / Integrated Maternity and Women's Heath (from 1 February 2018 to 31 May 2018).

6.30 In my role as Assistant Director for Strategy and Service Improvement / Integrated Maternity and Women's Health, I reported to Mrs E Gishkori (Director of Acute Services)

6.31 As the Assistant Director for Integrated Maternity and Women's Health, I worked with the Head of Midwifery to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Assistant Director, I would also have worked closely with the Associate Medical Director, Dr Martina Hogan and the Clinical Directors for Integrated Maternity and Women's Health, Dr Geoff McCracken (Clinical Director for

Craigavon Area Hospital) and Mr David Sim (Clinical Director for Daisy Hill Hospital) and the three Lead Midwives.

6.32 In my role as Assistant Director for Strategy and Service Improvement / Integrated Maternity and Women's Health, I led on and had responsibility for supporting the Head of Midwifery Service in the delivery of integrated maternity and women's health services across the following areas:

a. Acute Capital equipment planning
b. Unscheduled Care Service Improvement
c. Winter planning
d. General Acute Service Improvement projects
e. Maternity Services, Craigavon Area Hospital
f. Maternity Services, Daisy Hill Hospital
g. Gynaecological Services
h. Fertility Services
i. Genitourinary (GUM) Services

6.33 In my role as Assistant Director for Strategy and Service Improvement / Integrated Maternity and Women's Heath the following staff reported to me:

a. Mrs Patricia McStay – Head of Midwifery and Gynaecology Services
b. Mrs Sharon Glenny – Operational Support Lead

6.34 The role of this post is detailed in the attached Job Description
3. 20160401 Q5 JD Assistant Director for Strategy and Service Improvement located in S21 16 of 2022 Attachments
5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022 Attachments

Assistant Director for Integrated Maternity and Women's Health / Cancer and Clinical Services (from 01 June 2018 to 31 May 2021)

6.35 In my role as Assistant Director Integrated Maternity and Women's Health and Cancer and Clinical Services, I initially reported to Mrs Esther Gishkori (Director of Acute Services) from 01 June 2018 and then to Mrs Melanie McClements (Interim / Director of Acute Services) between 07 June 2019 and 31 May 2021. [redacted] Personal Information redacted by the USI [redacted], Mrs Gishkori left her post on 30 April 2020 and was replaced by Mrs McClements initially on an interim basis from 7 June 2019 and then subsequently she became permanent in post.

6.36 As the Assistant Director for Integrated Maternity and Women's Health and Cancer and Clinical Services, I worked with the Heads of Service to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Assistant Director, I would also have worked closely with the Associate Medical Director for Integrated Women's and Maternity Health, Dr Martina Hogan and the Associate Medical Director for Cancer and Clinical Services, Dr Shahid Tariq. I also worked closely with the Clinical Directors for Integrated Maternity and Women's Health, Dr Geoff McCracken

(Clinical Director for Craigavon Area Hospital) and Mr David Sim (Clinical Director for Daisy Hill Hospital) and the Clinical Director for Cancer (Dr David McCaul).

6.37 In my role as Assistant Director for Integrated Maternity and Women's Health and Cancer and Clinical Services, I had responsibility for supporting the Heads of Service in the delivery of integrated maternity and women's health services and cancer and clinical services across the following areas:

a. Maternity Services, Craigavon Area Hospital
b. Maternity Services, Daisy Hill Hospital
c. Gynaecological Services
d. Fertility Services
e. Genitourinary (GUM) Services
f. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
g. Providing the Cancer Tracking function to Cancer Multidisciplinary Teams
h. Supporting the Peer Review process
i. Delivering Systemic Anti-Cancer Treatment (SACT) Service through Mandeville Unit
j. Delivery local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
k. Laboratory Services
l. Radiology, Audiology and Neurophysiology Services
m. Acute Allied Health Professional Services

6.38 In my role as Assistant Director Integrated Maternity and Women's Health and Cancer and Clinical Services, the following staff reported to me:

a. Mrs Patricia McStay - Head of Midwifery and Gynaecology Services (replaced by Wendy Clarke on 1 July 2018)
b. Ms Cathie McIlroy – Head of Acute Allied Health Professional Services (replaced by Mrs Charlotte Wells on 1 July 2019)
c. Mrs Jeanette Robinson – Head of Radiology, Neurophysiology and Audiology (replaced by Mrs Denise Newell on 1 December 2020)
d. Mr Geoff Kennedy – Head of Laboratory Services
e. Mrs Fiona Reddick – Head of Cancer Services ([Personal Information redacted by the USI] leave covered by Mrs Clair Quin from 4 May 2021 to date)
f. Mrs Sharon Glenny – Operational Support Lead

6.39 The role of this post is detailed in the attached Job Description
5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 of 2022
Attachments

Assistant Director of Cancer and Clinical Services (from 01 June 2021 to date)

6.40 In my role as Assistant Director for Cancer and Clinical Services, I have reported to Mrs Melanie McClements (Director of Acute Services) from June 2021 to date.

6.41 As the Assistant Director for Cancer and Clinical Services, I worked with the Heads of Service to manage the services focussing on the four broad areas of governance, finance, human resources and performance as described above. In my role as Assistant Director, I would also work closely with the Associate Medical Director for Cancer and Clinical Services, Dr Shahid Tariq and the Clinical Director for Cancer (Dr David McCaul).

6.42 In my role as Assistant Director for Cancer and Clinical Services, supporting the Heads of Service in the delivery of cancer and clinical services across the following areas:

a. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
b. Providing the Cancer Tracking function to Cancer Multidisciplinary Teams
c. Supporting the Peer Review process
d. Delivering Systemic Anti-Cancer Treatment (SACT) Service through Mandeville Unit
e. Delivery local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
f. Laboratory Services
g. Radiology, Audiology and Neurophysiology Services
h. Acute Allied Health Professional Services

6.43 In my role as Assistant Director for Cancer and Clinical Services, the following staff reported to me:

a. Mrs Charlotte Wells – Head of Acute Allied Health Professional Services
b. Mr Geoff Kennedy – Head of Laboratory Services
c. Mrs Fiona Reddick – Head of Cancer Services ([Personal Information redacted by the USI] leave covered by Mrs Clair Quin from 4 May 2021 to date)
d. Mrs Sharon Glenny – Operational Support Lead

6.44 The role of this post is detailed in the attached Job Description
5. 20070301 Q5 JD Assistant Director for IMWH & CCS located in S21 16 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 I have been an Assistant Director in Acute Services from 29 March 2010. Between 29 March 2010 and 31 May 2018, I held a range of Assistant Director roles, none of which had interaction with the urology services as they were mainly medicine and unscheduled care in nature, strategic/service improvement or integrated maternity and women's health.

7.2 From 1 June 2018, I have been the Assistant Director with the responsibility for Cancer Services. As Assistant Director for Cancer and Clinical Services, I am responsible for the following:

a. Delivering against the access standards for cancer patients on 14 day, 31 day and 62 day pathways
b. Providing the Cancer Tracking function to Cancer Multidisciplinary Teams
c. Supporting the Peer Review process
d. Delivering Systemic Anti-Cancer Treatment (SACT) Service through Mandeville Unit
e. Delivery local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
f. Laboratory Services
g. Radiology, Audiology and Neurophysiology Services
h. Acute Allied Health Professional Services

7.3 With specific reference to the operation and governance of urology services, the key points from a cancer perspective in my role are as follows:

1. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
    a. My role is primarily a monitoring of performance against the 14 day, 31 day and 62 day cancer targets. This would be applicable to all tumour sites, including urology.
    b. The monitoring function of my role included the production of monthly cancer performance reports, which provided details of performance against the access targets for each tumour site, including urology. The performance reports were discussed at monthly cancer performance meetings, which I chaired. These meetings were attended by the operational Head of Service, Operational Assistant Directors and Operational Support Leads from across the tumour sites, as well as the corporate performance team. During this meeting, we would have looked at trends for red flag referrals into each service, focusing particularly on growth and what actions the operational service could take to meet this demand if it was outside of current clinical capacity. At these meetings, we also discussed any significant service pressures, which could have an effect on the performance against the cancer access targets including consultant vacancies or gaps in capacity relating to the commissioning of services. During the COVID-19 pandemic, the monthly cancer performance meeting was stood down for a time, before being replaced with a cancer checkpoint meeting, which was held initially fortnightly and then moved to monthly. The checkpoint meeting was put in place to assess the impact of COVID-19 on the delivery of cancer services and to minimise the impact where possible. These meetings were not only attended by those listed above, but also by the cancer tumour site leads or their deputy.
    c. In addition to the monitoring, there was also a look back at the patients who had breached the access targets in month and a case by case review on why patients had breached their target so that the operational service could consider any action that needed to be put in place to improve the cancer performance going forward.

   d. This is an ongoing monthly review process whereby performance information is reviewed for each tumour site, actions agreed if this were possible within the capacity restrictions of the tumour site, that is, at times there was little or no capacity for the operational service to improve cancer performance without additional investment or within the confines of what staffing levels they had in their service, e.g., in the urology service there is an ongoing consultant staffing shortage which has impacted on the services ability to meet demand.

2. Providing the Cancer Tracking function and multi-disciplinary team (MDT) meeting co-ordinator support to Cancer Multidisciplinary Teams Meetings.
   a. In my role as Assistant Director for Cancer and Clinical Services I provide Cancer Tracker and MDT Co-Ordinator support to eight cancer tumour sites. The cancer tracker will record information on the Regional Cancer Patient Pathway System (CAPPS) logging the patient's journey from referral to first definitive treatment. The cancer tracker will co-ordinate the information required for discussion at and attend each cancer MDT meeting to support the logging of outcomes onto CAPPS. They also record Cancer MDT Meeting attendance.
   b. Following the Cancer MDT meeting, the cancer tracker will record the outcome of discussion and record progress against the agreed plan for each patient. Where there are delays, against the active 14 day, 31 day and 62 day pathways, the tracker will escalate these to the operational teams on an ongoing basis for resolution.
3. Supporting the Peer Review process
   a. Within Cancer Services, we have a Service Improvement Lead, Mrs Mary Haughey, who supports the Chairs of each Cancer MDT in the production of an annual report and workplan. The annual report outlines the achievements and challenges for each tumour site during the past year. The annual report is shared with all members of the MDT, the Senior Management Team for cancer including the Associated Medical Director, Dr Shahid Tariq, the Clinical Director, currently vacant but previously Dr David McCaul, the Assistant Director, Mr Barry Conway and the Head of Service for Cancer, Mrs Clair Quin (interim).
   b. The Service Improvement Lead will also support cancer tumour sites in preparation for any peer review, which are scheduled. Please note that the peer review process has been stood down during the COVID-19 pandemic and there is currently a question over when these will be re-established.
4. Delivery of local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust
   a. Within Cancer Services, we provide a number of oncology out-patient clinics in the Mandeville Unit, Craigavon Area Hospital, which are attended by Belfast Oncology Consultants and supported by Mandeville Unit nursing and support staff. The oncology clinics will be attended by patients from a range of tumour sites, including urology.

7.4 The points above describe how cancer services interact with urology services. My main links with the service were with the Head of Urology Service, formerly Mrs

Martina Corrigan and currently Ms Wendy Clayton and the operational Assistant Director for Surgery and Elective Care, Mr Ronan Carroll. I would have had no interaction with the consultant urologists until the Cancer Checkpoint Meetings were initiated at which time Mr Anthony Glackin was invited to attend as Chair of the Urology MDT; unfortunately, he was unable to attend at times due to his clinical commitments.

7.5 With specific reference to the operation and governance of urology services, my role as Assistant Director for Cancer and Clinical Services is primarily a monitoring and support role. Where corrective action is needed to address cancer performance issues as raised through the meetings described above, or through the escalation process, these actions can only be taken by the operational Head of Service for Urology, formerly Mrs Martina Corrigan and currently Ms Wendy Clayton and the operational Assistant Director for Surgery and Elective Care, Mr Ronan Carroll in discussion with the clinical team in urology. Any corrective actions will be implemented by the operational team and not the cancer and clinical services team. The impact of any corrective action taken will be reviewed through the monthly cancer performance meetings; however, it is important to note that the cancer and clinical services team are not always made aware of actions taken from escalations to the operational services, including urology.

7.6 During my tenure as Assistant Director for Cancer and Clinical Services since 1 June 2018, the urology service has been unable to meet the 31 day or 62 day target for their service. It would be my understanding from discussions at the cancer meetings that this is primarily due to workforce challenges at consultant level and the fact that demand for the service consistently exceeds the commissioned level of capacity.

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 My roles and responsibilities with regard to the operation and governance of Urology Services are detailed in my response to question 7 above. Although my role as Assistant Director for Cancer and Clinical Service is primarily a monitoring and support role, it is important to note that any corrective action to address issues raised through monitoring can only be taken by the operational Head of Service and Assistant Director in discussion with the clinical team in urology.

8.2 Since taking up my Assistant Director role in Cancer and Clinical services on 1 June 2018, through my monitoring and support role I am aware of the capacity challenges in the Urology Service, particularly in relation to the delivery of the 31 and 62 day Cancer access targets. These challenges have led to delays for patients on cancer pathways. The challenges in meeting the 31 and 62-day cancer access targets including Urology have been logged as a high risk on the Acute Risk register

from 3 September 2012 by Mrs Heather Trouton who was the Assistant Director for Surgery and Elective Care at that time.

7. 20220401 Q8 Acute Directorate Risk Register located in S21 16 of 2022 Attachments

8.3 As Assistant Director of Cancer and Clinical Services, I do not have any operational governance responsibility for the Urology Service or for dealing with any challenges that the service is facing – for example, consultant work challenges that would affect the delivery of cancer access targets. This responsibility sits with the operational Head of service for Urology (Formerly Mrs Martina Corrigan and currently Ms Wendy Clayton) and the Assistant Director for Surgery and Elective Care (formerly Mrs Heather Trouton and currently Mr Ronan Carroll).

8.4 More generally, the role of the Assistant Director is to operationally manage all services, which fall into their area of responsibility. This includes the day to day running of the service with each Head of Service leading for their area. In summary, the broad areas of operational management fall into four groups – Governance, Finance, Human Resources and Performance that are described in more detail at the beginning of my response to Question 5 above.

8.5 In operationally managing their services, the Assistant Director will work closely with their Heads of Service, Clinical Directors and the Divisional Medical Director. The Divisional Medical Director and Clinical Directors lead on clinically managing the service – this includes the line management of the consultants, leading on job planning, appraisal / revalidation and medical education.

8.6 The Assistant Director, Head of Service, Divisional Medical Director, and Clinical Directors collectively manage all aspects of the service as a senior team working in partnership. Given the complexity of Acute Services, there will inevitably be areas where the operational and clinical management roles overlap. Examples of these areas are – Consultant job planning, reviewing clinical incidents, workforce planning, implementing learning from Serious Adverse Incidents and service improvement. With reference to such areas in Urology specifically, it would be my understanding that these issues would have been addressed by the operational Head of service for Urology (Formerly Mrs Martina Corrigan and currently Ms Wendy Clayton) and the Assistant Director for Surgery and Elective Care (formerly Mrs Heather Trouton and currently Mr Ronan Carroll) working in partnership with the Clinical Director and Divisional Medical Director for Urology.

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 Between 6 September 2007 and 28 March 2010, I was the Head of Service for Emergency and Unscheduled Care.
1. 20070906 Q5 JD Head of Service Emergency and Unscheduled Care located in S21 16 of 2022 Attachments

9.2 Whilst working in this role I was not involved in the regional review of Urology Services or in the establishment of the Urology Unit in SHSCT. This work was led by Mrs Heather Trouton in her role as Assistant Director for Surgery and Elective Care and Mrs Martina Corrigan in her role as Head of Service for Urology.

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

10.1 Between 6 September 2007 and 28 March 2010, I was the Head of Service for Emergency and Unscheduled Care.
1. 20070906 Q5 JD Head of Service Emergency and Unscheduled Care located in S21 16 of 2022 Attachments

10.2 Whilst working in this role I had no knowledge of performance indicators that were used in the Urology Unit at its inception. I believe Mrs Heather Trouton and Mrs Martina Corrigan would be best placed to provide this information.

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 As outlined in my response to question 5 above, I did not commence my tenure in any Assistant Director role until March 2010. At the time the Integrated Elective Access Protocol (IEAP) was published in April 2008, I was in a Head of Service role focussing on Emergency and Unscheduled Care. In this role I was focussed on unscheduled care pathways and I was not involved in elective work, therefore the IEAP had no relevance to my role and was not shared with me for that reason.

11.2 I can confirm that I did not receive or disseminate the IEAP to the urology consultants or any other consultants. I believe Mrs Heather Trouton or Mrs Martina Corrigan would have circulated IEAP as they managed Urology Services in April 2008.

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 The primary responsibility for the implementation and monitoring of the Integrated Elective Access Protocol (IEAP) sits with the Head of Service for Urology and the Assistant Director for Surgery and Elective Care. It would be my understanding that the protocol was implemented in April 2008, therefore at this time; the Head of Service for Urology was formerly Mrs Martina Corrigan and is currently Ms Wendy Clayton. The Assistant Director for Surgery and Elective Care was formerly Mrs Heather Trouton and is currently Mr Ronan Carroll.

12.2 Since 1 June 2018, I have been the Assistant Director for Cancer and Clinical services. In this role, I monitor performance against the 31 and 62 day cancer access targets including for Urology. IEAP applies to elective referrals including red flag referrals and there is a requirement on me to monitor performance against the cancer targets, including time to first outpatient appointment. There is also a requirement to track progress for each red flag referral up to the time for first definitive treatment.

12.3 The cancer access targets are set by the Department of Health and apply to all tumour sites including Urology. The cancer access targets are as follows:

a. 14 day target (Breast) – 100% for the 2 week wait for first breast symptomatic appointment
b. 31 day target – 98% from date decision to treat until first definitive treatment
c. 62 day target – 95% from date of receipt of GP referral until first definitive treatment.

12.4 An overview of 31 and 62 day cancer access targets for Urology from April 2016 to March 2022 is provided in the attached document. This shows that the Urology service have performed reasonably well against the 31 day target during this period, however performance against the 62 day cancer access target has been consistently well below the 95% target.

8. 20220516 Q12 31 and 62 Day Cancer Performance for Urology Tumour Site located in S21 16 of 2022 Attachments

12.5 In my role as Assistant Director for Cancer and Clinical Services, I chair a number of meetings to monitor performance against cancer access targets which will included monitoring compliance against IEAP. The details and purpose of these meetings are as follows:

a. Monthly Cancer Performance meeting

12.6 I chair the Monthly Cancer Performance meeting. These meetings are attended by the operational Head of Services, Operational Assistant Directors and Operational Support Leads from across the cancer tumour sites, as well as the corporate performance team. During this meeting we review trends for red flag referrals into each service, focusing particularly on growth and what actions the operational service could take to meet this demand if it was outside of current clinical capacity. At these meetings we discuss any significant service pressures which could impact

on the performance against the cancer access targets including consultant vacancies or gaps in capacity relating to the commissioning of services. During the COVID-19 pandemic, the monthly cancer performance meeting was stood down for a time, before being replaced with a Cancer Checkpoint meeting which was held initially fortnightly and then moved to monthly. Minutes and cancer performance dashboards are included for reference.

Relevant to Acute, Document 14, Monthly Cancer Performance, 20180920 Cancer Performance Minutes
Relevant to Acute, Document 14, Monthly Cancer Performance, 201809 Cancer Performance Dashboard
Relevant to Acute, Document 14, Monthly Cancer Performance, 20190321 Cancer Performance Minutes
Relevant to Acute, Document 14, Monthly Cancer Performance, 201903 Cancer Performance Dashboard

Cancer Checkpoint meetings (during COVID19 Pandemic)

12.7 I chaired the Cancer Checkpoint meetings during the COVID 19 pandemic. I established these meetings to replace the monthly cancer performance meetings in order to work more closely with the clinical leads for each of the cancer tumour sites. These meetings were also attended by the Acute Assistant Directors and Heads of Service who manage specialties that deliver cancer services. These meetings moved to monthly during the later stages of the pandemic and were stood down in May 2022. Minutes and papers for the Cancer Checkpoint meetings have been included for reference.

Relevant to Acute, Evidence after 4 November Acute, Document No 14, Cancer Checkpoint Notes, 20210730 Cancer Chkpoint Mtg Notes
9. 20210730 Q12 Cancer Rebuild Plan Update located in S21 16 of 2022 Attachments
10. 20210730 Q12 New GP Red Flag Referrals Report located in S21 16 of 2022 Attachments
11. 20210730 Q12 New GP Red Flag Longest Waiters Report located in S21 16 of 2022 Attachments
12. 20210730 Q12 Longest Waiters by Tumour Site Report located in S21 16 of 2022 Attachments

12.8 I also attend the following Trust or regional meetings to provide updates on cancer performance or to discuss pressures across cancer services linked to the COVID 19 pandemic.

Regional Trust Cancer Performance meeting with Health and Social Care Board

12.9 The Health and Social Care Board (HSCB) meet quarterly with all Trusts to review cancer performance in their role of regional commissioner of services. These meetings are chaired by the HSCB Director of Commissioning. The Director of Acute

Services and I attend these meetings along with all Assistant Directors and Heads of Service in Acute Services that manage specialties that deliver cancer services – i.e. Urology, Lung, Breast, ENT, Dermatology, Lower GI, Upper GI and Gynaecology. A senior manager from the Trust Performance Team will also attend these meetings. Unfortunately there were no formal minutes of these meetings, however, Mrs Lynn Lappin, Head of Performance, has shared her internal notes taken at the meeting. An example of the HSCB presentation discussed at the meeting is also referenced below:

13. 20190117 Q12 Lynn Lappin Internal Notes HSCG Cancer Performance Meeting 2019-2021 located in S21 16 of 2022 Attachments
14. 20201125 Q12 ST Cancer Performance Meeting Presentation located in S21 16 of 2022 Attachments

Trust Performance Committee

12.10 Trust Performance Committee is comprised of Non-Executive Directors and Trust Directors. The Performance Committee is a sub-committee of the Trust Board and is chaired by a Non-executive Director. The Performance Committee meets quarterly to review performance against all access targets, including cancer access targets. I am not a member of Performance Committee; however I have attended the committee on two occasions at their request – once to update on the provision of diagnostic imaging services and second to update on cancer performance. Minutes are referenced below with further detail.

15. 20210318 Q12 Approved Performance Committee Minutes
16. 20210318 Q12 Performance Committee Diagnostics Presentation
16a. 20210318 Q12 Performance Committee Agenda
17. 20210520 Q12 Approved Performance Committee Minutes
18. 20210520 Q12 Performance Committee Cancer Presentation
19. 20210520 Q12 Performance Committee Agenda
Documents located in S21 16 of 2022 Attachments

Acute Performance Senior Management Team

12.11 The Acute Senior Management Team (SMT) meetings take place weekly and are chaired by the Director of Acute Services. The focus for each Acute SMT follows the four broad areas for management in the Acute Directorate - performance, governance, human resources and finance. At the Acute SMT performance meeting, we review performance against all access targets including cancer access targets through a performance dashboard report. Copies of minutes and dashboard reports are included for reference.

20. 20181127 Q12 Acute SMT Performance Meeting Minutes
21. 20190326 Q12 Acute SMT Performance Meeting Minutes
22. 20190625 Q12 Acute SMT Performance Meeting Minutes
23. 20200128 Q12 Acute SMT Performance Meeting Minutes
24. 20210322 Q12 Acute SMT Performance Meeting Minutes

25. 20210920 Q12 Acute SMT Performance Meeting Minutes
26. 20211004 Q12 Acute SMT Performance Infographic Phase 6 August SDP
27. 20211018 Q12 Acute SMT Performance Infographic October 2021
Documents located in S21 16 of 2022 Attachments

Cancer Reset Cell (during COVID19 Pandemic – coordinated by Health and Social Care Board / Public Health Agency)

12.12 The Cancer Reset Cell was a regional meeting established by the Health and Social Care Board (HSCB) / Public Health Agency (PHA) during the COVID 19 pandemic to enable closer links with Trusts to assess and minimise the impact of the pandemic on the delivery of cancer services. These meetings initially happened fortnightly and reduced to monthly. I represented SHSCT at these meetings. Terms of Reference for the Cancer Reset Cell and sample minutes are attached for reference.

28. 20200626 Q12 Cancer Reset Cell Terms of Reference
29. 20210115 Q12 Cancer Reset Cell Record of Discussion Action Points
30. 20210226 Q12 Cancer Reset Cell Record of Discussion Action Points
Documents located in S21 16 of 2022 Attachments

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?

13.1 In June 2010, I was Acting Assistant Director for Medicine and Unscheduled Care and a member of the Acute Senior Management Team. I had no role in the development and the implementation of the Team South Plan, as this would have been the responsibility of the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton).

13.2 As a member of Acute Senior Management Team in 2010, I was aware that there was a regional review of Urology Services as this was referenced at Acute SMT performance meetings by the Assistant Director of Surgery and Elective Care (Mrs Heather Trouton) and Director of Acute Services (Dr Gillian Rankin). I was also aware that Mrs Trouton was working with the Head of Service for Urology (Mrs Martina Corrigan) to implement the Team South plan. I would however not have known any details about the plan as it was not relevant to me as the Acting Assistant Director for Medicine and Unscheduled Care.

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

13.3 In June 2010, I was Acting Assistant Director for Medicine and Unscheduled Care and a member of the Acute Senior Management Team. I had no role in the development and the implementation of the Team South Plan, as this would have been the responsibility of the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). Mrs Heather Trouton would therefore be best placed to comment on the implementation of the Team South plan.

III. What was your role in that process?

13.4 I had no role in this process as this was not relevant to me in my role as Acting Assistant Director for Medicine and Unscheduled Care.

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 June 2010, I was Acting Assistant Director for Medicine and Unscheduled Care. I had no role in the development and the implementation of the Team South Plan, as this would have been the responsibility of the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). I therefore would not have been aware of the detail of the plan including its aims, as this was not relevant to me in my role as Assistant Director for Medicine and Unscheduled Care.

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 first joined the Acute Senior Management Team (SMT) in March 2010 as the Acting Assistant Director for Medicine and Unscheduled Care. As this role focussed on medical specialties and unscheduled care, I had no involvement in the delivery or management of Urology Services. It is my understanding that the Regional Urology Review was completed and the implementation plan agreed before I joined the Acute SMT.

14.2 I believe the responsibility for progressing the implementation of the plan sat with the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton) as Urology Services are managed within the Surgery and Elective Care Division.

14.3 If there are concerns or risks in relation to any service, it is the responsibility of the Head of Service and the Assistant Director to complete a risk assessment and if necessary, to add the risk to a risk register. If there were any risks in Urology

Services, this would therefore have been the responsibility of Mr Martina Corrigan and Mrs Heather Trouton at this time. I am not aware if any risks were logged for Urology Services at this time and I believe Mrs Heather Trouton and Mrs Martina Corrigan are best placed to respond to this question.

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 The Regional Review of Urology Services was completed before I took up my Acting Assistant Director role in Medicine and Unscheduled Care. This role focussed on medical specialties and unscheduled care patient pathways, therefore I had no involvement with the Urology Service as this is a surgical specialty which was managed within the Surgery and Elective Care Division. As the Acting Assistant Director for Medicine and Unscheduled Care, I was not aware of the issues that were considered as part of the Regional Review of Urology Services and the actions outlined in the Team South Implementation plan as this was not relevant to me in my role as it applied to the Urology Service.

15.2 I have been the Assistant Director for Cancer and Clinical Services from June 2018. In this role I monitor performance against the 31 and 62 day cancer access targets for all tumour sites including Urology. During this time, the Urology Service have been unable to meet the cancer access targets as the service have been unable to deal with the volume of red flag referrals being received within the staffing and resources available to them.

15.3 The responsibility for reviewing the resources available to the Urology Service sat with the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

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 During my tenure in SHSCT, I have never managed Urology Services. I therefore would not know if the Urology Service was adequately staffed or not. I believe this question can be best answered by the Head of Service for Urology (formerly Mrs Martina Corrigan and currently Ms Wendy Clayton)

16.2 I have been the Assistant Director for Cancer and Clinical Services from June 2018. In this role I monitor performance against the 31 and 62 day cancer access targets for all tumour sites including Urology. During this time, the Urology Service has been unable to meet the cancer access targets as the service has been unable to deal with the volume of red flag referrals being received within the staffing and resources available to it. It is my understanding that the Urology Services has had difficulty in recruiting Consultant Urologists and this has affected the available capacity in the service to see and treat patients in a timely way.

16.3 The responsibility for consultant staffing within the Urology Service sits with the Head of Service for Urology (Mrs Martina Corrigan 2010 September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care ((Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

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 The responsibility for addressing staffing problems in the Urology Service sits with the Head of Service for Urology (Mrs Martina Corrigan 2010 September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care ((Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

17.2 Between March 2010 and May 2016 I held a number of senior management roles in the Acute Directorate as described in my response to question 5 above. During this period, none of these roles related to Urology Services.

17.3 I have been the Assistant Director for Cancer and Clinical Services from June 2018. In this role I monitor performance against the 31 and 62 day cancer access targets for all tumour sites including Urology. During this time, the Urology Service has been unable to meet the cancer access targets as the service has been unable to deal with the volume of red flag referrals being received within the staffing and resources available to it. It is my understanding that the Urology Services has had difficulty in recruiting Consultant Urologists and this has affected the available capacity in the service to see and treat patients in a timely way. The Urology consultant workforce pressures were referenced at the monthly Cancer Performance meetings and I was aware that the Urology Team were regularly trying to secure consultant staff.

17.4 The responsibility for consultant staffing within the Urology Service sits with the Head of Service for Urology (Mrs Martina Corrigan 2010 September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care ((Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

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 I would not have information on vacancies within the Urology Service. The responsibility for consultant staffing within the Urology Service sits with the Head of

Service for Urology (Mrs Martina Corrigan 2010 September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

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 I have been the Assistant Director for Cancer and Clinical Services from June 2018. During this time, I have held monthly Cancer Performance meetings to monitor performance against Cancer access targets.

19.2 It is my view that the Urology Service has been unable to meet the cancer access targets mainly due to consultant staffing shortages. This will also have had a negative impact on the provision, management and governance of Urology Services as patients will have waited longer to be seen and the staff in the Urology Service would be under pressure to deliver the service with less staff.

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

20.1 During my tenure in SHSCT I have never managed the Urology Service, therefore I do not know if posts, roles or responsibilities changed in the unit. The responsibility for consultant staffing within the Urology Service sits with the Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date). These staff are best placed to answer this question.

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 my tenure in SHSCT, I have held a number of senior manager posts and they are detailed in the response to question 5 above. From March 2010 to May 2016, these posts focussed mainly on Medical specialties and other strategic roles, none of which related to Urology Services. All senior manager roles will however have a governance focus relating to the services that they are responsible for. In general, this will include:

a. Review of incidents
b. Responding to complaints
c. Sharing compliments
d. Maintaining risk registers including logging new risks and mitigating existing risks

e. Monitoring trends – including performance against access targets, reviewing compliance against Infection prevention and Control (IPC)
f. Delivering service improvement

21.2 During the period March 2010 to May 2016, I can confirm that these governance responsibilities would have no relevance to Urology Services as they relate to medical specialties.

21.3 My governance role changed since taking up my Assistant Director role in Cancer and Clinical services on 1 June 2018. It is now my responsibility to monitor performance against Cancer access targets for all tumour sites including Urology. From 1 June 2018 to date, I have chaired monthly Cancer Performance meetings attended by senior managers from the Acute Directorate including the Head of Service for Urology. The purpose of these meetings was to monitor performance, identify trends and to consider what actions could be taken to improve performance. In leading on this monitoring role, I would be flagging pressures to services, including Urology. The responsibility for taking this information and considering corrective action sits with the Head of Service, the Assistant Director and the clinical team for the tumour site.

21.4 The governance responsibility for Urology Services sits with the Head of Service for Urology Services (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).The Head of Service for Urology and the Assistant Director for Surgery and Elective Care work in partnership with the Clinical Director for ENT and Urology (Dr Ted McNaboe until December 2021, currently vacant) and the Associated Medical Director for Surgery, Mr Mark Haynes until December 2021) in respect to the governance of the Urology Service. The Divisional Medical Director for Surgery and Elective Care is currently Mr Ted McNaboe.

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 During my tenure in SHSCT, I have never managed the Urology Service; therefore, I would have no detail in terms of non-medical support resource within the Urology Service. In my opinion the individuals best placed to answer this question would be the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date) and the Assistant Director for Functional and Support Services (Mrs Anita Carroll).

22.2 I covered [redacted] for the Assistant Director for Functional and Support Services (Mrs Anita Carroll) between 1 May 2016 and 3 October 2016. Functional and Support Services Division are responsible for providing a range of

support services including portering, switchboard, domestic services, booking and secretarial support to clinical teams including Urology. I have no recollection of any issues relating to administrative support for the Urology Service being raised with me during this period.

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 During my tenure in SHSCT, I have never managed the Urology Service therefore, I would not know how administration staff worked within the unit or how they were allocated to each consultant. I would not know how administrative workload was monitored. I believe the Assistant Director for Functional Support Services (Mrs Anita Carroll) would be best placed to provide this information.

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 During my tenure in SHSCT, I have never managed the Urology Service therefore any issues regarding administrative support staff would not have been raised with me. In my opinion, any issues regarding administrative support would have been raised with the Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date).

24.2. I covered [redacted] for the Assistant Director for Functional and Support Services (Mrs Anita Carroll) between 1 May 2016 and 3 October 2016. The Functional and Support Service Division would be responsible for providing administrative support to clinical teams including Urology. I have no recollection of any issues relating to administrative support for the Urology Service being raised with me during this period.

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 During my tenure in SHSCT, I have never managed the Urology Service.

25.2 The person in charge of the Urology Unit would be the Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date). The Head of Service for urology reports to the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

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

26.1 During my tenure in SHSCT, I have never managed the Urology Service. I would therefore have had no role in completing staff performance reviews for staff in the Urology Unit. Staff performance reviews in Urology would have been completed by Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date).

26.2 During my tenure in SHSCT, I would have held regular 1:1s with the Heads of Service that reported directly to me. The purpose of these meetings was to review how the service was being delivered in relation to the four broad areas of management – governance, performance, finance and human resources. I can confirm that this would not have included the Head of Service for Urology as they report to the Assistant Director for Surgery and Elective Care.

26.3 In addition to regular 1:1s, I would also complete an annual performance review with my Heads of Service. Sometimes the annual performance review may be delayed due to staff absence or time constraints due to service pressures. I chaired the annual performance review with each of my Heads of Services separately looking at the following key areas:

a. Review of objectives from the previous year which would be set based on how the service was performing in the previous year against the four broad areas of management – governance, performance, finance and human resources. Areas for improvement would be considered and objectives set.
c. Setting objectives as noted above for the incoming year based on how the service is performing, consideration of service pressures or areas for improvement.
d. Taking feedback from the staff member on their own performance for the year.
e. Providing feedback to the staff member in terms of their performance for the year, including how effective they have been in meeting their objectives from the previous year.
f. Update on mandatory training and other training needs for the incoming year.

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 As an Assistant Director in the SHSCT from March 2010 to date, I am expected to complete a performance review with my line manager each year. This review would be completed during a 1:1 meeting with my line manager (Director of Acute Services). A copy of the SHSCT Performance and Personal Development Review Policy is attached for reference:

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31. 20210722 Q27 Performance and Personal Development Review Policy located in S21 16 of 2022 Attachments

27.2 The table below shows the details of annual performance reviews that I completed with my line manager (Director of Acute Services) from March 2010 to date. During this period, I believe I completed seven annual performance reviews with my line manager. Unfortunately I have only been able to find copies of four of these performance review documents and these are attached for reference. There were five years when no performance reviews were completed as follows:

a. 2014 and 2015 – I believe Mrs Deborah Burns did not complete performance reviews with the Acute Assistant Directors during her tenure
b. 2016 and 2018 – no reason given by Mrs Gishkori for not completing the performance review, however I believe it was due to time constraints on her part
c. 2020 – not completed by Mrs McClements as this was during the COVID 19 pandemic and my 2019 review was completed in December

27.3 Details of performance reviews completed from 2010 to 2021 are as follows:

Post	**year**	**Director of Acute**	**Date of annual review**	**Document reference**
Acting Assistant Director for Medicine and Unscheduled Care	2010	Dr Gillian Rankin	Completed – but unable to locate a copy	
Assistant Director for Medicine and Unscheduled Care	2011	Dr Gillian Rankin	Completed – but unable to locate a copy	
Assistant Director for Medicine and Unscheduled Care	2012	Dr Gillian Rankin	5 September 2012	***32. 20120905 Q27 Barry Conway PDP 2012***
Assistant Director for Medicine and Unscheduled Care	2013	Dr Gillian Rankin	Completed – but unable to locate a copy	
Assistant Director for Medicine and Unscheduled Care	2014	Mrs Deborah Burns	Not completed	
Assistant Director for Medicine and Unscheduled Care	2015	Mrs Deborah Burns	Not completed	

Assistant Director of Strategy and Service Improvement	2016	Mrs Esther Gishkori	Not completed	
Assistant Director of Strategy and Service Improvement	2017	Mrs Esther Gishkori	1 February 2017	***33. 20170201 Q27 Barry Conway PDP 2017***
Assistant Director of Cancer and Clinical Services / Integrated Maternity and Women's Health	2018	Mrs Esther Gishkori	Not completed	
Assistant Director of Cancer and Clinical Services / Integrated Maternity and Women's Health	2019	Mrs Melanie McClements	4 December 2019	***34. 20191204 Q27 Barry Conway PDP 2019***
Assistant Director of Cancer and Clinical Services / Integrated Maternity and Women's Health	2020	Mrs Melanie McClements	Not completed due to COVID 19	
Assistant Director of Cancer and Clinical Services	2021	Mrs Melanie McClements	4 May 2021	***35. 20210504 Q27 Barry Conway PDP 2021***

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 From March 2010 up to May 2018, I held a number of Assistant Director roles as detailed in my response to question 5 above. These roles focussed on medical specialties and therefore there was no need to meet with the Urology Service, as Urology is a surgical specialty managed within the Surgery and Elective Care Division.

28.2 Since taking up my Assistant Director role in Cancer and Clinical Services on 1 June 2018, it is my responsibility to monitor performance against Cancer access targets.

28.3 In this role, I engage with the Head of Service for urology and the Assistant Director for Surgery and Elective Care to monitor performance against the 31 and 62 day cancer access targets. This happens through monthly Cancer performance meetings which I chair. At these meetings we would consider pressures across the patient pathway which would include for example, delays in triage of red flag referrals, delays in first outpatient appointments, delays with investigations and delays for surgery. When these issues were discussed at the monthly Cancer Performance meetings, the Head of Service for urology would provide an update on actions being taken or they would agree to take the issue back to the urology clinical team for further discussion and to consider corrective actions.

28.4 The Cancer Performance meetings were held monthly up to the start of the COVID19 pandemic. These meetings would have been attended by Heads of Service that delivered Cancer Services, Assistant Directors that delivered Cancer Services, Operational Support Leads and Trust Performance Team staff.

28.5 During the pandemic, the Cancer Performance meetings were replaced by fortnightly Cancer Checkpoint meetings (reduced to monthly from autumn 2021) which I chaired. The Cancer Checkpoint meetings were attended by the staff that previously attended the monthly Cancer Performance meeting but also by the Cancer Multidisciplinary Team leads for the eight Cancer tumour sites including Urology (attended by Mr Tony Glackin). The Cancer Checkpoint meetings were focussed on the impact of COVID 19 on the delivery of Cancer Services. At these meetings, the clinical leads gave an update on how things were going for their tumour site – focussing on key pressures and actions taken by the clinical team to address the pressures. At these meetings, the clinical leads could raise any issues with me or to seek my support in helping them progress actions that would help mitigate the impact of COVID 19 on the delivery of Cancer Services.

28.6 In addition to the monthly Cancer Performance meetings, the Cancer Trackers would also track Urology red flag referrals from receipt of referral to first definitive treatment. Where the trackers identified delays across the pathway, these delays would be escalated by the Service Administrator for Cancer Services to the Head of Service for Urology. These escalations would typically have been issued weekly, with a Cancer performance report issued monthly.

28.7 Examples of key cancer performance documents are attached for reference:

Regional cancer pathway escalation policy
Relevant to Acute, Document 18, CCS, Cancer Pathway Escalation Policy Final August 2019 updated located in S21 16 of 2022 Attachments

Urology escalation communications
36. 20181218 Q28 Email Urology Escalation
37. 20190919 Q28 Email Urology Escalation

38. 20220126 Q28 Email Urology Escalation
39. 20220704 Q28 Email Urology Escalation
Documents located in S21 16 of 2022 Attachments

Cancer performance dashboard / Cancer Performance meeting minutes
Relevant to Acute, Document 14, Monthly Cancer Performance, 201910 Cancer Performance Dashboard
Relevant to Acute, Document 14, Monthly Cancer Performance, 20191017 Cancer Performance Minutes
Relevant to Acute, Document 14, Monthly Cancer Performance, 201812 Cancer Performance Dashboard
Relevant to Acute, Document 14, Monthly Cancer Performance, 20181220 Cancer Performance Minutes

Cancer checkpoint meeting documents
Relevant to Acute, Evidence after 4 November Acute, Document No 14, Cancer Checkpoint Notes, 20210730 Cancer Chkpoint Mtg Notes
9. 20210730 Q12 Cancer Rebuild Plan Update
10. 20210730 Q12 New GP Red Flag Referrals Report
11. 20210730 Q12 New GP Red Flag Longest Waiters Report
12. 20210730 Q12 Longest Waiters by Tumour Site Report
40. 20220304 Q28 Minutes Cancer Checkpoint Meeting
41. 20220401 Q28 Agenda Cancer Checkpoint Meeting
42. 20220401 Q28 Cancer Rebuild Plan Update
43. 20220401 Q28 New GP Red Flag Referrals Report
44. 20220401 Q28 New GP Red Flag Longest Waiters Report
45. 20220401 Q28 Longest Waiters by Tumour Site Report
Documents located in S21 16 of 2022 Attachments

28.8 I commenced as Assistant Director for Cancer and Clinical Services / Integrated Maternity and Women's Health on 1 June 2018. I believe it is important to note that this Division was one of the largest Divisions in SHSCT with a budget of £62m and with approximately 1,030 staff. At any time, there were multiple competing priorities across all the services that I managed, including Cancer services, and I had to take decisions quickly and move on to the next issue. This Division was eventually split in two from June 2021. See attached document which I prepared for Mrs Melanie McClements in June 2019 which gives an overview of my Division and the key challenges in each service area including for Cancer Services.
46. 201906 Q28 Pen Portrait – CCS & IMWH Division located in S21 16 of 2022 Attachments

28.9 In terms of the allocation of my time in this Assistant Director role from June 2018 to June 2021, around 75% of my time was focussed on Cancer and Clinical Services and 25% on Integrated Maternity and Women's Health. For the 75% of my time that was focussed on Cancer and Clinical Services, around 25% of that time was focussed on Cancer Services – that equates to around seven hours per week. Any issues relating to urology would have been discussed at the monthly Cancer

performance meeting or at the Cancer Checkpoint meetings. These meetings would typically last one hour with time being equally spread across the eight tumour sites.

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 From March 2010 up to May 2018, I held a number of Assistant Director roles as detailed in my response to question 5 above. These roles focussed on medical specialties and therefore there was no need to meet with the Urology Service, as Urology is a surgical specialty managed within the Surgery and Elective Care Division.

29.2 I became Assistant Director for Cancer and Clinical Services on 1 June 2018. In this role, it is my responsibility to monitor performance against Cancer access targets.

29.3 In this role, I chair monthly Cancer Performance meetings. The Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date) and the Assistant Director for Surgery and Elective Care (Mr Ronan Carroll) attended these meetings along with other Heads of Service and Assistant Directors. At these meetings, we would consider pressures across the patient pathway, including Urology. Examples of issues raised in relation to Urology included - delays in triage of red flag referrals, delays in first outpatient appointments, delays with investigations and delays for surgery. When these issues were discussed at the monthly Cancer Performance meetings, the Head of Service for Urology would provide an update on actions being taken or they would agree to take the issue back to the Urology clinical team for further discussion and to consider corrective actions.

29.4 During the pandemic, the Cancer Performance meetings were replaced by fortnightly Cancer Checkpoint meetings (reduced to monthly from autumn 2021) which I chaired. The Cancer Checkpoint meetings were attended by the same staff that attended the monthly Cancer Performance meeting but also by the Cancer Multidisciplinary Team leads for the eight Cancer tumour sites including Urology (attended by Mr Tony Glackin). The Cancer Checkpoint meetings were focussed on the impact of COVID 19 on the delivery of Cancer Services.

29.5 The Cancer Performance meetings and the Cancer Checkpoint meetings would usually last for one hour.

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 in SHSCT, I had no meetings with the Urology Service up to 1 June 2018 when I commenced as Assistant Director for Cancer and Clinical

Services. From 1 June 2018 onwards I was responsible for monitoring performance against the cancer access targets for all tumour sites including Urology. In monitoring cancer performance, I met monthly with the Head of Service for Urology and the Assistant Director for Surgery and Elective Care. Dr Tony Glackin also attended some of the Cancer Checkpoint meetings. During all these meetings, I found the Urology Team professional and helpful. In my opinion, they were trying their best to deliver the Urology Service with the resources available to them.

Governance – generally

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

31.1 During my tenure in SHSCT I have never managed the Urology Service as this responsibility sits with the Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date). The Head of Service for urology reports to the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date).

31.2 I became the Assistant Director for Cancer and Clinical Services on 1 June 2018. In this role, it is my responsibility to monitor performance against Cancer access targets through monthly Cancer Performance meetings which I chair. The Head of Service for Urology and the Assistant Director for Surgery and Elective Care attend these meetings along with other Heads of Service and Assistant Directors from Acute Services. At these meetings, we would consider pressures across the patient pathway, including Urology. Examples of issues raised in relation to Urology included - delays in triage of red flag referrals, delays in first outpatient appointments, delays with investigations and delays for surgery. When these issues were discussed at the monthly Cancer Performance meetings, the Head of Service for Urology would provide an update on actions being taken or they would agree to take the issue back to the Urology clinical team for further discussion and to consider corrective actions. At this stage I had no direct contact with the Urology consultants or any other clinicians in the unit as this contact was made through the Head of urology Services or the Assistant Director for Surgery and Elective Care.

31.3 When the COVID 19 pandemic commenced in April 2019, the Cancer Performance meetings were replaced with fortnightly Cancer Checkpoint meetings. The Cancer Multidisciplinary Team (MDT) leads for the eight tumour sites, including Urology were invited to these meetings. The purpose of these meetings was to have closer links with the clinical teams to minimise the impact of the pandemic on the delivery of cancer services. These meetings continued up be held fortnightly up to Autumn 2021 when they were reduced to monthly and they ended in May 2022 when the COVID 19 pressures eased. The monthly Cancer Performance meetings have now been re-established.

31.4 Therefore, in summary, my role from a clinical governance perspective was to monitor performance against the cancer access targets from 1 June 2018. The Head of Service and Assistant Director for the Urology Service are responsible for working with the consultants and other clinical staff in the unit to deliver the service and work to meeting the cancer access targets.

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 In Acute Services, we operate a collective leadership model for management whereby the Head of service, the Assistant Director, the Clinical Director and the Divisional Medical Director (previously known as the Associate Medical Director) oversee the clinical governance arrangements for the services that they manage.

32.2 For Urology Services the following staff have held these roles:

Head of Service for Urology

b. Mrs Martina Corrigan – 2010 to September 2020
c. Ms Wendy Clayton – October 2020 to date

Assistant Director for Urology

d. Mrs Heather Trouton – 2010 to March 2016
e. Mr Ronan Carroll – April 2016 to date

Clinical Director for ENT and Urology

f. Mr Ted McNaboe until December 2021
g. Currently Vacant

Clinical Lead for Urology

h. Mr Michael Young until June 2022
i. Currently Vacant

Associated Medical Director

j. Mr Mark Haynes until December 2021

Divisional Medical Director (replaced the Associated Medical Director from April 2022)

k. Mr Ted McNaboe

32.3 From 1 June 2018, I have been the Assistant Director for Cancer and Clinical services. In this role I monitor performance against the cancer access targets for all eight tumour sites including Urology. In performing this monitoring role, I highlight trends or issues to each service and it is their responsibility to review this information and take corrective action where possible. The management team for the Urology

Service, as described above, are responsible for overseeing the clinical governance arrangements in the Urology Service.

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 From 1 June 2018, I have been the Assistant Director for Cancer and Clinical services. In this role, I monitor performance against the cancer access targets for all eight tumour sites including Urology. Timely access to services is a recognised indicator of quality. During my tenure as Assistant Director for Cancer and Clinical Services the Urology Service has been unable to meet the 31 and 62 cancer access targets. During my tenure, I chaired monthly Cancer Performance meetings with Heads of Service and Assistant Directors, including those who manage Urology Services. At these meetings, information is shared in terms of trends or issues. The Heads of Service provided updates at these meetings on actions being taken to improve performance or agreed to take issues back to their clinical teams for further discussion. This was a monthly monitoring cycle whereby information is shared, actions agreed and the impact of the actions taken reviewed at the next meeting. For Urology Services, it is my understanding that the clinical team have been unable to meet the 31 and 62 cancer access targets mainly due to consultant workforce pressures. The management team in Urology are responsible for the recruitment and retention of consultant Urologists, however I am aware that there is a regional shortage of these staff and the team are continuing to work to recruit and retain consultants.

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 The performance metrics that I oversee for Urology, are the 31 and 62 day cancer access targets.

34.2 The cancer access targets are set by the Department of Health and apply to all tumour sites including Urology. The cancer access targets are as follows:

a. 14 day target (Breast only) – 100% for the 2 week wait for first breast symptomatic appointment
b. 31 day target – 98% from date decision to treat until first definitive treatment
c. 62 day target – 95% from date of receipt of GP referral until first definitive treatment.

34.3 From 1 June 2018, I have been the Assistant Director for Cancer and Clinical services. In this role I monitor performance against these performance metrics (31 and 62 day cancer access targets) for all eight tumour sites including Urology. In performing this monitoring role, I highlight trends or issues to each service and it is their responsibility to review this information and take corrective action where

possible. The management team for the Urology Service, are responsible for taking corrective action where possible to meet these cancer access targets.

34.4 From 1 June 2018, the Urology Service have been unable to meet the 31 and 62 cancer access targets mainly due to consultant workforce pressures. The management team in Urology are responsible for the recruitment and retention of consultant Urologists; however, I am aware that there is a regional shortage of these staff and the team are continuing to work to recruit and retain consultants.

34.5 In terms of performance against the 31 day cancer access target, the table below demonstrates how urology is performing against the Trust overall 31 day cancer performance position across the last 4 fiscal years, as well as how it compares with two other tumour sites for reference.

31 Day Cancer Performance Target = 98% (Red denotes breach of target)				
Fiscal Year	**Trust**	**Urology**	**Lower GI**	**Gynae**
2018/2019	**99.50%**	99.41%	99.54%	100.00%
2019/2020	**98.17%**	98.93%	97.57%	91.07%
2020/2021	**92.42%**	94.65%	95.26%	89.29%
2021/2022	**85.67%**	97.81%	89.21%	73.20%

34.6 In terms of performance against the 62 day cancer access target, the table below demonstrates how urology is performing against the Trust overall 31 day cancer performance position across the last 4 fiscal years, as well as how it compares with two other tumour sites for reference.

62 Day Cancer Performance Target = 95% (Red denotes breach of target)				
Fiscal Year	**Trust**	**Urology**	**Lower GI**	**Gynae**
2018/2019	**74.33%**	54.41%	69.80%	74.78%
2019/2020	**65.92%**	41.59%	30.56%	50.18%
2020/2021	**60.75%**	32.10%	28.10%	44.21%
2021/2022	**49.75%**	27.13%	37.78%	23.71%

34.7 All tumour sites continue to be unable to meet the 62 day cancer access targets in SHSCT and I believe this is consistent with performance in other HSC Trusts in Northern Ireland.

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 From March 2010 up to May 2018, I held a number of Assistant Director roles as detailed in my response to question 5 above. These roles focussed on medical specialties and therefore there was no links to the Urology Service in terms of patient

risk and safety, as Urology is a surgical specialty managed within the Surgery and Elective Care Division.

35.2 I became Assistant Director for Cancer and Clinical Services on 1 June 2018. In this role, I monitor performance against Cancer access targets. This monitoring applies to the 31 and 62 day cancer access target for eight tumour sites, including Urology

35.3 With specific reference to performance against the 31 and 62 day cancer access targets for Urology, I did the following:

a. Provided a team of Cancer Trackers to track Urology patients on cancer pathways from referral to first definitive treatment

b. The Cancer Tracking Team escalated delays for Urology patients on cancer pathways to the Head of Service for Urology

c. Chaired monthly Cancer performance meetings with Heads of Service and Assistant Directors from Acute Services, including the Head of Service for Urology and the Assistant Director for Surgery and Elective Care – sample agenda and minutes are attached for reference
Relevant to Acute, Document 14, Monthly Cancer Performance, 20180920 Cancer Performance Minutes
47. 20181018 Q35 Cancer Performance Meeting Agenda
48. 20190117 Q35 Cancer Performance Meeting Agenda
Documents located in S21 16 of 2022 Attachments
Relevant to Acute, Document 14, Monthly Cancer Performance, 20190321
Cancer Performance Minutes

d. The Service Administrator prepared Cancer Performance reports for the monthly Cancer Performance meetings. This report includes an update on performance against the 31 and 62 day cancer access targets, the number of red flag referrals received per month and the number of red flag referrals that are confirmed as cancer. The report also highlights any challenges that each tumour site are experiencing in meeting the cancer access targets. A sample Cancer Performance report is attached for reference

Relevant to Acute, Document 14, Monthly Cancer Performance, 201809 Cancer Performance Dashboard
Relevant to Acute, Document 14, Monthly Cancer Performance, 201903 Cancer Performance Dashboard

e. During the COVID 19 pandemic, I chaired a Cancer Checkpoint meeting which replaced the Cancer Performance meeting. The Checkpoint meetings were held fortnightly from April 2019 up to Autumn 2021, and subsequently

monthly from Autumn 2021 up to May 2022 when the Cancer Performance meetings were re-established. A sample agenda and actions notes from a Cancer Checkpoint meeting are attached for reference

Relevant to Acute, Evidence after 4 November Acute, Document No 14, Cancer Checkpoint Notes, 20210730 Cancer Chkpoint Mtg Notes
9. 20210730 Q12 Cancer Rebuild Plan Update
10. 20210730 Q12 New GP Red Flag Referrals Report
11. 20210730 Q12 New GP Red Flag Longest Waiters Report
12. 20210730 Q12 Longest Waiters by Tumour Site Report
49. 20210924 Q35 Cancer Checkpoint Meeting Agenda
Documents located in S21 16 of 2022 Attachments

f. In addition to meetings that I chaired, I also attended Acute Senior Management Team performance meetings which were held monthly and were chaired by the Director of Acute Services. All performance was reviewed at these meetings including performance against the cancer access targets. A summary dashboard was produced by the Trust Performance team for these meetings and a representative for the performance team also attended

25. 20210920 Q12 Acute SMT Performance Meeting Minutes
26. 20211004 Q12 Acute SMT Performance Infographic Phase 6 August SDP
27. 20211018 Q12 Acute SMT Performance Infographic October 2021
Documents located in S21 16 of 2022 Attachments

g. Trust Senior Management Team (SMT) are updated monthly on performance in general including performance against cancer access targets. Trust SMT is chaired by the Chief Executive. Trust SMT are given a performance dashboard by the Director of Performance and Reform (currently Mrs Lesley Leeman, previously Mrs Aldrina Magwood and Mrs Paula Clarke). The Director of Acute Services attends Trust SMT for Acute Services.

50. 20220510 Q35 Corporate CPD Performance Scorecard
51. 20220519 Q35 Corporate CPD Performance Scorecard Narrative
Documents located in S21 16 of 2022 Attachments

h. I attend quarterly Cancer Performance meetings with Health and Social Care Board (HSCB) along with other senior managers from SHSCT. These meetings are chaired by the Director of Commissioning in HSCB. At these meetings, we review SHSCT performance against the 14, 31 and 62 cancer access targets, compare trends per month and the rolling performance from the year from April onwards. We also compare SHSCT performance to that in other Trusts in Northern Ireland. Unfortunately there were no formal minutes of these meetings, however, Mrs Lynn Lappin, Head of Performance, has shared her internal notes taken at the meeting. An example of the HSCB presentation discussed at the meeting is also referenced below:

13. 20190117 Q12 Lynn Lappin Internal Notes HSCG Cancer Performance Meeting 2019-2021
14. 20201125 Q12 ST Cancer Performance Meeting Presentation
Documents located in S12 16 of 2022 Attachments

i. Trust Performance Committee meets quarterly to review all performance including performance against the cancer access targets. Trust Performance Committee is chaired by a Trust non-Executive Director. The Director of Acute Services attends Trust Performance Committee to represent Acute Services. Assistant Directors may be asked to attend Performance Committee to update on areas if requested. I have attended on two occasions, one of which was to update on cancer performance.
15. 20210318 Q12 Approved Performance Committee Minutes
16. 20210318 Q12 Performance Committee Diagnostics Presentation
16a. 20210318 Q12 Performance Committee Agenda
17. 20210520 Q12 Approved Performance Committee Minutes
18. 20210520 Q12 Performance Committee Cancer Presentation
19. 20210520 Q12 Performance Committee Agenda
Documents located in S21 16 of 2022 Attachments

35.4 The arrangements noted above describe the systems that I have in place to monitor performance against cancer access targets for all eight tumour sites including Urology. The systems are in place to support performance against the cancer access targets and therefore support patient safety and minimise risk.

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 from within and outside the Urology Service would primarily be brought to the attention of the Head of service for Urology or the Assistant Director for Surgery and Elective Care as they manage Urology Services. Issues could also, however be raised with managers that are responsible for services that link to or support Urology – for example, Functional and Support Services (managed by Mrs Anita Carroll) and Cancer and Clinical Services (managed by me from June 2018).

36.2 In my experience from managing other services (but not Urology), concerns could be raised by staff or by patients or their relatives as outlined below. In my view, the same processes would apply to Urology.

36.3 Staff could raise issues of concern by:
a. Raising the issue at a team meeting
b. Confidentially by speaking to their line manager or another senior member of staff in the service on a 1:1 basis

c. Writing or emailing their line manager or another senior member of staff in the service to raise the concern
d. Raising the concern anonymously through the SHSCT Your right to raise a concern Policy (April 2021)

Relevant to HR, reference no 2i, 20180401 Ref 2i - Regional Your Right to Raise a Concern Policy and Procedure

36.4 Patients could raise issues of concern by:
a. Make a formal complaint. This can be done face to face, by telephone, by letter or by email
b. If a patients feels their concern was not addressed properly through the complaints process, they can link with the Patient Client Council or as a last resort, through the Northern Ireland Public Services Ombudsman

36.5 During my tenure in SHSCT I have held a number of Assistant Director posts. Between March 2010 and May 2018, these posts focussed on unscheduled care and medical specialties, therefore I was not responsible for Urology as it is a surgical specialty which is managed within the Surgery and Elective Care Division. As my posts focussed on medical specialties and they did not support Urology services, I would not have expected any issues of concern relating to Urology to have been raised with me in this role.

36.6 Between 1 May 2016 and 3 October 2016, I covered [Personal Information redacted by the USI] for the Assistant Director of Functional and Support Services (Mrs Anita Carroll). The Functional and Support Services Division manages secretarial staff and the Referral and Booking Centre in support of all specialties, including Urology. If there were issues with regard to secretarial support to the Urology consultants at this time, I would have expected these issues to be raised with me in this role, however I have no recollection of any issues being raised at that time.

36.7 From 1 June 2018, I have been the Assistant Director for Cancer and Clinical Services. In this role, I monitor performance against the cancer access targets for the eight tumour sites, including Urology. I also provide support to the cancer Multidisciplinary Teams as detailed in my response to question 7 above. In this role I chair monthly Cancer Performance meetings which are attended by the Head of Service for urology. Issues relating to performance against the 31 and 62 cancer access targets in respect of Urology have been raised through these meetings. These issues have been in relation to consultant workforce gaps which have reduced the capacity within the Urology Service to deal with red flag referrals in line with the 31 and 62 day cancer targets.

36.8 The Cancer and Clinical Services Division also support the running of eight Cancer Multidisciplinary Teams (MDT), including Urology, as outlined in my response to question 7 above. Up to January 2022, the effectiveness of each Cancer MDT meetings was assessed through the annual MDT Business meeting. This was done through discussion at each of the MDTs with the members reflecting on what is working well in the MDT and also the ongoing challenges. If there were significant issues of concern identified during the year which needed addressed

urgently, these issues would be escalated by the Cancer MDT Chair to the Divisional Medical Director for Clinical and Clinical Services (post previously known as the Associate Medical Director), Director for Cancer for Cancer Services or the Assistant Director for Cancer Services. For example, the Chair of the Urology Cancer MDT (Mr Tony Glackin) raised concerns with the Cancer and Clinical Services Division about quoracy and specifically gaps in consultant Radiologist cover at the MDT. Actions taken to address this issue are detailed in my response to question 40 below.

36.9 In the context of the concerns that have now been identified in the Urology Service, I believe the measures previously in place to assess the effectiveness of each Cancer MDT were not sufficiently robust for the following reasons.

a. There was no commissioned post to oversee the effectiveness of each of the MDTs (Cancer MDT Administrator)
b. There were no monthly reports in place to show how each MDTs was working – including information on quoracy
c. There was no audit support in place to check that actions agreed at MDT where implemented
d. There was no way of recording that the key worker have been allocated for each patient at MDT
e. There was no way of checking if a Cancer Nurse Specialist was involved with each patient and that information was shared with each patient in terms of their cancer diagnosis, their treatment plan and support available
f. Information from the pathology department, including cancers confirmed through laboratory tests, was not being cross referenced back to cases presented to each cancer MDT

36.10 Previously the Cancer and Clinical Services Division did not have the resources in place to monitor the effectiveness of each MDT and were dependant on the Cancer Chair MDT to raise issues by exception – for example, if there was an urgent issue that the MDT chair felt needed to be addressed immediately as it was having a negative impact on the running of the MDT. There was previously insufficient support in place to support the MDT Chairs and to provide ongoing assurances with regard to the effectiveness of each Cancer MDT as noted above. Additional measures have now been established to makes these processes more robust and these are detailed in response to question 68 below with regard to learning.

36.11 In terms of the efficacy of the systems and processes in place to deal with issues of concern in Urology, the findings outlined in the Dermot Hughes report show that these arrangements were not sufficiently robust to identify these issues at an early stage and to resolve them. Report attached for reference.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

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

37.1 As outlined in my response to question 36 above, during my tenure in the Trust my main interface with Urology Services would have been in relation to my time as Assistant Director for Cancer and Clinical Service from 1 June 2018 to the present time. This interface has been focussed on the monitoring of the 31 and 62 day Cancer access targets and providing support to the eight Cancer MDTs, including Urology.

37.2 The systems for monitoring performance against the 31 and 62 day Cancer access targets have remained the same since I became Assistant Director for Cancer and Clinical Services from 1 June 2018. Monthly Cancer Performance meetings are held and a monthly performance report issued. I chair the monthly Cancer Performance meetings that are attended by Heads of Service and Assistant Directors that manage services that deliver cancer services, including Urology. Since the beginning of 2022 however, the Cancer MDT Chairs, including Mr Tony Glackin who is the chair of the urology MDT, have requested more bespoke performance information for their own specific specialty rather than the overarching Cancer performance report and Cancer Checkpoint meeting report**.** In future, the MDT chairs (including Urology) would like the monthly Cancer Performance report changed with a section specific to each tumour site.
The report will contain the same information but will have it all in one section for ease of reference. The Cancer and Clinical Services Division are currently working to reformat the monthly Cancer Performance reports and they will be in place by July 2022. Given that the Cancer Checkpoint meetings ceased in May 2022, the team are focussing on re-establishing the monthly Cancer Performance meetings from July 2022 with the new format report. This will take until July as the team are currently working to establish the new monitoring for the Cancer MDTs.

37.3 The system for providing support to the Cancer MDTs is currently being changed to address the learning from the Dermot Hughes report. See attached for reference.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

37.4 The following changes are being implemented to evidence the effectiveness of the MDTs including Urology:

a. Cancer MDT Administrator (Mrs Angela Muldrew) appointed in January 2022 This is the first role of this kind in Northern Ireland. The post is not yet funded by the commissioner but the Trust has moved to bring this post in at financial risk.
52. 201205 Q37 MDT Administrator and Projects Officer JD located in S21
16 of 2022 Attachments
b. Established a monthly crosscheck mechanism for cancers confirmed in the cellular pathology laboratory against cases brought to the cancer MDT for discussion. This will ensure laboratory confirmed cancers are discussed at the Cancer MDT.
c. Agreed a Principles Document which outlines how each Cancer MDT will function. This includes the principle that the key worker role for each patient

will be the Cancer Nurse Specialist and this will be formally noted at each Cancer MDT by the Cancer Tracker and recorded on the Cancer Patient Pathway System (CAPPS)

53. 202201 Q37 MDT Principles Document located in S21 16 of 2022 Attachments

d. The Cancer Nurse Specialist (CNS) as the designated key worker will support cancer patients from the point of diagnosis until their treatment is complete. This will include the provision of key patient information in relation to each condition. This information is now recorded on the Cancer Information Recording Form.

54. 201502 Q37 Cancer Information Pathway Recording Form located in S21

16 of 2022 Attachments

e. A Holistic Needs Assessment (HNAs) is offered to all newly diagnosed Cancer patients and a care plan established. The key worker is responsible for the HNA. The HNAs is now recorded electronically on a new system, which has been developed by Macmillan Cancer Support. Monthly audits are now undertaken by randomly selecting a subset of patients across all Cancer MDTs to check completion of the Cancer Information Recording Form and the HNAs. This is currently a manual time consuming process, therefore the frequency is monthly currently however the system may be changed in future to support more regular audits.

f. Establishing a new Cancer Audit and Information Officer. This new role will focus on new system and process checks to provide assurance that plans agreed for patients at Cancer MDT are implemented. This will include for example, a review of actions agreed at the MDT and a process to check that each action has been implemented. If any action agreed at the MDT has not been implemented, this will be flagged to the Cancer MDT Lead, the responsible Consultant and the relevant Clinical Directors

55. 202205 Q37 Cancer Information and Audit Officer JD located in S21 16

of 2022 Attachments

g. Established monthly quoracy reports to track Cancer MDT attendance and identify any deficits at an early stage. Previously quoracy was reviewed annually in each Cancer MDT Annual Report.

56. 202205 Q37 MDM Attendances 2022 located in S21 16 of 2022 Attachments

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

38.1 During my tenure in SHSCT, I have never managed the Urology Service therefore; I would not expect to be appraised of any concerns generally with the unit.

38.2 As Assistant Director for Cancer and Clinical Services from 1 June 2018, I have monitored performance against the 31 and 62 day cancer access targets for the eight tumour sites including Urology. I am appraised of performance against these

cancer targets through a monthly Cancer Performance report and a monthly cancer performance meeting.

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 The Head of Service for Urology and the Assistant Director for Surgery and Elective Care should ensure that the governance systems, including clinical governance, within the unit are adequate working as a collective leadership team with their Clinical Director and Divisional Medical Director.

39.2 I have been the Assistant Director for Cancer and Clinical Services from 1 June 2018. In this role I monitor performance against the 31 and 62 cancer access targets for all eight tumour sites, including Urology. The Cancer and Clinical Services Division produce monthly reports that enable all specialties to see how they are performing against the cancer access targets. The reports also include information in relation to red flag referral numbers and trends. I also chair monthly Cancer Performance meetings as described in my response to earlier questions. The Head of Service for Urology takes this cancer performance information back to the Urology specialty meeting for further discussion and action as necessary. Specialty meetings will include a section on clinical governance including review of incidents, risk registers and learning from previous serious adverse incidents. I am aware that these meetings happen for all specialties, however I would not be involved at specialty meetings unless invited to attend. During my tenure as Assistant Director for Cancer and Clinical Services, I have never attended a Urology specialty meeting.

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 joined the Acute Senior Management Team (SMT) in March 2010 as the Acting Assistant Director for Medicine and Unscheduled Care. As this role focussed on medical specialties and unscheduled care, I had no involvement in the delivery or management of Urology Services. I continued to work in Medicine up to March 2016. From April 2016 to May 2018, I worked in a strategic and reform role in the Acute Directorate. During this time, there were no concerns raised with me in relation to Urology Services.

40.2 Since taking up my Assistant Director role in Cancer and Clinical services on 1 June 2018, it is my responsibility to monitor performance against 31 and 62 day Cancer access targets. Before I took up post, the challenges the Trust was facing in meeting the cancer access targets had been logged as a high graded risk on the Acute Risk register from 3 September 2012 by the Head of Cancer Services at that time, Mrs Fiona Reddick reference below. This risk related to all eight cancer tumour sites, including Urology. All eight tumour sites were performing reasonably well

against the 31 day target, however all tumour sites, including Urology, were unable to meet the 62 day target. The common challenge that all tumour sites were facing was that they were unable to deal with all the red flag referrals being received within the required timeframes, ensuring the patients were triaged, seen, investigations completed, surgery completed (if necessary) and treatment commenced within 62 days.

57. 202204 Q40 Acute Directorate Risk Register located in S21 16 of 2022 Attachments

40.3 Since 1 June 2018, I have also been concerned about the Oncology Cover for the eight Cancer MDTs. SHSCT do not employ any Oncology Consultants, therefore this resource is provided from Belfast HSC Trust to cover the MDTs and also to provide Oncology Clinics in the Mandeville Unit. It is my understanding that there is a regional shortage of Consultant Oncolgists in Northern Ireland and for this reason, Belfast HSC Trust have not been able to provide full cover to SHSCT during my tenure as Assistant Director for Cancer and Clinical Services. This risk was added to the Head of Service Risk register by Mrs Fiona Reddick (Head of Cancer Services. I am unable to confirm that date on which this was added, as it was done before I became Assistant Director for Cancer and Clinical Services in June 2018. I cannot confirm with Mrs Fiona Reddick [redacted]. Personal Information redacted by the USI

40.4 I received an email from Mrs Fiona Reddick (Head of Cancer Services) on 27 November 2018 – email attached for reference.

Relevant to Acute, Evidence after 10 December Acute, Barry Conway, 20181127 email re radiology presence

40.5 The email was from Mr Tony Glackin, Chair of the Urology Cancer MDT. The email was sent to Dr Imran Yousuf (Clinical Director for Radiology) and Dr David McCaul (Clinical Director for Cancer). In his email, Mr Glackin raised concerns in relation to consultant Radiology gaps in attendance at the Urology MDT. Mrs Reddick shared the email with me for discussion at our next 1:1 meeting with a view to me following this issue up with Dr Imran Yousuf as I am also the Assistant Director responsible for Radiology Services.

40.6 The concerns in relation quoracy (attendance at MDT) was also raised in the Urology MDT Annual Report in 2019 – see attached, section 3 of the Annual Report which refers to Oncology and Radiology gaps at MDT meetings.

Relevant to Acute, Document Number 28, 20201105 Urology MDT Annual Report 2019

40.7 In order to address these issues, I did the following:

> **a. Radiology** – There are major challenges regionally and nationally with the recruitment of Consultant Radiologists, especially those with expertise in Urology. Ideally there should be two consultant Radiologists with expertise in Urology in attendance at the Urology MDT, however with the number of Radiologists in SHSCT, we often struggle to have one Radiologist at each of the eight Cancer MDTs, including Urology. On receipt of the email from Mr

Tony Glackin, Chair of the Urology MDT, I discussed this issue with Dr Imran Yousuf in his role as Clinical Director for Radiology. Dr Yousuf manages the Consultant Radiologists and he is best placed to review the rotas and to improve Radiology cover at the Urology MDT.

40.8 Since my time in Cancer and Clinical Services (from 1 June 2018), 11 attempts have been made to recruit Radiologists (usually trawls per year) including three attempts more specifically for Radiologists with expertise in Urology – the radiology specific trawls were held in April 2019, February 2020 and January 2021. The timing of all of the trawls for these posts would be in line with trainees that were due to complete their training and be eligible for consultant posts. Radiology attendance at each MDT is important as it enables the MDT to discuss cases and for the Radiologist to comment on their report in person as necessary. In January 2021 the Trust was successful in appointing a Consultant Radiologist with expertise in Urology. Before taking up post, the successful candidate travelled to Australia with his wife to gain further experience as a Consultant Radiologist before commencing his job with SHSCT from April 2022. This will enable improved cover for the Urology MDT during 2022.

a. Pathology - There are major challenges regionally and nationally with the recruitment of Consultant Pathologists. There should be at least one Pathologist in attendance at each Cancer MDT to support further discussion on pathology reports if necessary. I approached the Director of Acute Services in April 2021 to seek approval to advertise for an additional Cellular Pathologist. Like most services, Cellular Pathology were struggling to meet the demands on their services and additional reporting sessions were being done each month to meet the demand. It was also proving difficult to have a Pathologist at every Cancer MDT given the competing demands on their services. Approval for one additional consultant post would help address these pressures and improve cover to the Cancer MDTs. This approval was given by Director of Acute services (Mrs Melanie McClements) on 5 May 2021. The timing of the trawl was deferred until early 2022 in order to target trainees that were due to quality and be eligible to apply for consultant posts in spring 2022.

40.9 The approach was made to the Director of Acute Services as I was seeking approval to commit resources in excess of my budget – essentially to put additional resource in place at financial risk which required Director approval. An interview for an additional Cellular Pathologist was held on 7 April 2022 but no appointment was made. The post was re-advertised in May 2022 and further interviews are scheduled for 28 June 2022. In the interim, a locum Consultant Cellular Pathologist has been appointed and has been in post from 6 April 2022 providing 30 hours additional cover per week. A fulltime consultant works 40 hours per week. The service would prefer a fulltime locum, however only 30 hours locum cover was available. This additional capacity will support improved pathology cover to Cancer MDTs during 2022.

58. 20210505 Q40 Email confirmation of additional cellular pathologist located in S21 16 of 2022 Attachments

a. Oncology - There are major challenges regionally and nationally with the recruitment of Consultant Oncologists. The SHSCT do not employ Consultant Oncologists. Consultant Oncology support to Cancer MDTs is provided by Belfast HSC Trust. There should be at least one Consultant Oncologist in attendance at all Cancer MDTs, including Urology. With this in mind, I worked alongside the Head of Cancer Services (Mrs Fiona Reddick) to liaise with Ms Joanne Cullen (Head of Service for Cancer Services in Belfast HSC Trust) to offer funding for 50% of a Consultant post. This was to support the appointment of an additional Consultant Oncologist to work between SHSCT and Belfast HSC Trust. A job plan was agreed between SHSCT and the Belfast Trust which led to the appointment of Dr Adam Uprichard week commencing 18th May 2022. Dr Adam Uprichard now works two days per week in SHSCT and this includes one hour per week to attend the Urology Cancer MDT and the provision of two Oncology Clinics in the Mandeville Unit.
Relevant to Acute, Evidence after 10 December Acute, Barry Conway, 20200513 email re Dr Uprichard Updated Job Plan
Relevant to Acute, Evidence after 10 December Acute, Barry Conway, 20200521 email re Urology MDT - Oncology

b. With the addition of Dr Uprichard two days per week, the Oncology support to the Urology MDT has improved from 5% in 2019 to 86% in 2022 (to date). I will continue to monitor Oncology attendance at the Urology MDT on a monthly basis.

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 Before I took up my role as Assistant Director for Cancer and Clinical Services on 1 June 2018, this post was held by Mrs Heather Trouton between 1 April 2014 and 31 May 2018 and by Mr Ronan Carroll between 1 April 2007 and 31 March 2014. Mrs Trouton and Mr Carroll would be best placed to comment on systems for collecting cancer performance during this period.

41.2 Since taking up my Assistant Director role in Cancer and Clinical services on 1 June 2018, I monitored performance against the 31 and 62 day Cancer access targets for eight tumour sites including Urology. When a red flag referral is received for Urology, the cancer tracker/MDT co-ordinator will record information on the Regional Cancer Patient Pathway System (CAPPS) logging the patient's journey from referral to first definitive treatment. The cancer tracker/MDT co-ordinator will co-ordinate the information required for discussion at and attend each cancer Multidisciplinary Team Meeting (MDT) to support the logging of outcomes onto CAPPS. They also record Cancer MDT Meeting attendance. Following the Cancer MDT meeting, the cancer tracker/MDT co-ordinator will record the outcome of discussion and record progress against the agreed plan for each patient. Where

there are delays, against the 31 day and 62 day pathways, the tracker (or Cancer MDT Administrator) will escalate these to the Head of Service for Urology for resolution, where possible. Once the issue has been escalated to the Head of Service, they are responsible for following this up with their clinical team. The Head of Service will then provide an update back to the tracker (or Cancer MDT Administrator).

41.3 Overall performance against the 31 and 62 cancer access targets is reviewed at a monthly cancer performance meeting, which I chair. I am responsible for monitoring performance against the cancer access targets; however the clinical teams are responsible for delivering cancer care to each patient. In terms of performance against the 31 day cancer access target, the table below demonstrates how urology is performing against the Trust's overall 31 day cancer performance position across the last 4 fiscal years, as well as how it compares with two other tumour sites for reference.

31 Day Cancer Performance Target = 98% (Red denotes breach of target)				
Fiscal Year	**Trust**	**Urology**	**Lower GI**	**Gynae**
2018/2019	**99.50%**	99.41%	99.54%	100.00%
2019/2020	**98.17%**	98.93%	97.57%	91.07%
2020/2021	**92.42%**	94.65%	95.26%	89.29%
2021/2022	**85.67%**	97.81%	89.21%	73.20%

41.4 In terms of performance against the 62 day cancer access target, the table below demonstrates how urology is performing against the Trust's overall 62day cancer performance position across the last 4 fiscal years, as well as how it compares with two other tumour sites for reference.

62 Day Cancer Performance Target = 95% (Red denotes breach of target)				
Fiscal Year	**Trust**	**Urology**	**Lower GI**	**Gynae**
2018/2019	**74.33%**	54.41%	69.80%	74.78%
2019/2020	**65.92%**	41.59%	30.56%	50.18%
2020/2021	**60.75%**	32.10%	28.10%	44.21%
2021/2022	**49.75%**	27.13%	37.78%	23.71%

41.5 All tumour sites continue to be unable to meet the 62 day cancer access targets in SHSCT and I believe this is consistent with performance in other HSC Trusts in Northern Ireland.

41.6 The Cancer and Clinical Services Division also support the running of eight Cancer Multidisciplinary Teams (MDT), including Urology, as outlined in my response to question 7 above. Up to January 2022, the effectiveness of each Cancer MDT meeting was assessed through the annual MDT Business meeting. This was done through discussion at each of the MDTs with the members reflecting on what was working well in the MDT and the ongoing challenges. If there were

significant issues of concern identified during the year which needed addressed urgently, these issues would be escalated by the Cancer MDT Chair to the Divisional Medical Director for Cancer and Clinical Services (post previously known as the Associate Medical Director), Clinical Director for Cancer and Clinical Services or the Assistant Director for Cancer Services. For example, the Chair of the Urology Cancer MDT (Mr Tony Glackin) raised concerns with the Cancer and Clinical Services Division about quoracy and specifically gaps in consultant Radiologist cover at the MDT. Actions taken to address this issue are detailed in my response to question 40 above.

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 The system in place to monitor performance against the 31 and 62 cancer access targets are described in my response to questions 7 and 12 above. In my view, the systems in place to monitor performance against the 31 and 62 day cancer access targets are robust. The SHSCT has performed reasonably well against the 31 day target as detailed in the table in my response to question 41. The Trust however continues to struggle to meet the 62 day cancer access targets due to the ongoing high volumes of red flag referrals being received each month. It is my understanding that all Trusts in Northern Ireland are not meeting the 62 day cancer access target.

42.2 During my tenure as Assistant Director for Cancer and Clinical Services from 1 June 2018 to date, the systems in place for tracking each patient on cancer pathways has remained the same, and this is consistent with all other Trusts in Northern Ireland.

42.3 Performance against the 31 and 62 cancer access targets, including for urology, is reviewed at a monthly Cancer Performance meeting. During the COVID 19 pandemic (from April 2020 to May 2022), the Cancer Performance meeting was replaced by a Cancer Checkpoint meeting. I established these meetings in order to work more closely with the clinical leads for each cancer tumour site during the pandemic. These meetings were also attended by the Acute Assistant Directors and Heads of Service who manage specialties that deliver cancer services. These meetings moved to monthly during the later stages of the pandemic and were stood down in May 2022. The monthly Cancer Performance meetings will recommence from July 2022.

42.4 At the beginning of 2022, the Cancer Multidisciplinary Team Meeting (MDT) Chairs, including Mr Tony Glackin who is the chair of the urology MDT, requested more bespoke performance information for their own specific specialty rather than the overarching Cancer performance report and Cancer Checkpoint meeting report. In future, the MDT chairs (including Urology) would like the monthly Cancer Performance report changed with a section specific to each tumour site. The report will contain the same information but will have it all in one section for ease of reference. The Cancer and Clinical Services Division are currently working to reformat the monthly Cancer Performance reports and they will be in place by July

2022. Given that the Cancer Checkpoint meetings ceased in May 2022, the team are focussing on re-establishing the monthly Cancer Performance meetings from July 2022 with the new format report. This will take until July as the team is currently working to establish the new monitoring for the Cancer MDTs.

42.5 The Cancer and Clinical Services Division support the running of eight Cancer Multidisciplinary Teams (MDT), including Urology, as outlined in my response to question 7 above. In the context of the concerns that have now been identified in the Urology Service, I believe the measures previously in place to assess the effectiveness of each Cancer MDT were not sufficiently robust for the following reasons:

a. There was no commissioned post to oversee the effectiveness of each of the MDTs (Cancer MDT Administrator)
b. There were no monthly reports in place to show how each MDTs was working – including information on quoracy
c. There was no audit support in place to check that actions agreed at MDT where implemented
d. There was no way of recording that the key worker had been allocated for each patient at MDT
e. There was no way of checking if a Cancer Nurse Specialist was involved with each patient and that information was shared with each patient in terms of their cancer diagnosis, their treatment plan and support available
f. Information from the pathology department, including cancers confirmed through laboratory tests, was not being cross referenced back to cases presented to each cancer MDT

42.6 Previously the Cancer and Clinical Services Division did not have the resources in place to monitor the effectiveness of each MDT and were dependant on the Chair of each MDT to raise issues by exception – for example, if there was an urgent issue that the MDT chair felt needed to be addressed immediately as it was having a negative impact on the running of the MDT. There was previously insufficient support in place to support the MDT Chairs and to provide ongoing assurances with regard to the effectiveness of each Cancer MDT as noted above. Additional measures have now been established to makes these processes more robust and these are detailed in my response to question 68 below with regard to learning.

42.7 In terms of the efficacy of the systems and processes in place to deal with issues of concern in Urology, the findings outlined in the Dermot Hughes report show that these arrangements were not sufficiently robust to identify these issues at an early stage and to resolve them.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

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 During my tenure in SHSCT I have held a number of management posts as outlined in my response to question 5 above. During this time I have worked closely with consultant medical staff in the services that I have managed, however I have never managed the Urology Service.

43.2 Consultant medical staff report to the Clinical Director for their specialty. It is my understanding that each consultant will have an annual appraisal with the Clinical Director or another designated appraiser (managed through the Medical Director's Office). During my tenure I have not been involved in this process as it is for consultant medical staff and their medical managers, therefore I am not able to say if this is done well or not. In my opinion, the Clinical Directors and Divisional Medical Directors are best placed to comment on this process.

43.3 Since taking up my Assistant Director role in Cancer and Clinical services on 1 June 2018, I have monitored performance against the 31 and 62 day Cancer access targets. The targets apply to eight tumour sites including Urology. The Cancer access targets are national targets set by UK Government, which have been adopted by Department of Health in Northern Ireland since April 2010.

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 tenure in SHSCT, I have never managed the Urology Service therefore, I have no knowledge of job planning and appraisal processes in the Urology Service. I have however held Assistant Director roles in the Acute Directorate from March 2010 and I can comment on job planning and appraisal in that context.

44.2 In terms of job planning, the Clinical Director and Associate Medical Directors (now Divisional Medical Directors) lead on job planning discussions as part of an annual cycle (April to March). During the job planning discussions, the Clinical Director or Divisional Medical Director may speak to the Assistant Director to get an update on service pressures, for example, if there is a need for more outpatient clinics or theatres lists in order to better meet elective access targets, including the 31 and 62 day cancer targets. The Clinical Director or Divisional Medical Director will then consider if there can be any changes to allocation of the sessions in the consultant job plan to better address service pressures. This will only be in the context of changing existing funded sessions. If additional sessions are required, a business case will be needed to secure additional funding from the commissioner. During my tenure in SHSCT, job plans have been recorded on the Zircadian system. From April onwards, each consultant records their draft job plan on the system following discussion with the Clinical Director. The job plan is then reviewed by the Divisional Medical Director and if they are content, they will approve it on the system. In Cancer and Clinical Services Division, I will then complete the final sign off for each job plan on the Zircadian system. At this stage in the process, the job plan will be finalised and if they were any operational issues, such as changes to clinical

sessions, these changes would have already been made and reflected in the job plan. If there were any such changes, I would confirm that these were included in the job plan before signing it off. In terms of job planning, I believe this process works well in the Cancer and Clinical Services Division, however as detailed in my response to question 53, I have never been involved in the job planning process for Urology.

44.3 In terms of appraisal, this process is managed through the Medical Director's Office through the Divisional Medical Director and Clinical Director. During my tenure in SHSCT, I have not been involved in this process as it is for consultant medical staff and their medical managers, therefore I am not able to say if this is done well or not. In my opinion, the Clinical Directors and Divisional Medical Directors are best placed to comment on this process.

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 Within the Acute Services Directorate, there are a number of process and procedures through which governance is reviewed. The Acute Director chairs a number of meetings focussed on governance as follows:

Monthly Acute Clinical Governance meeting

45.2 This meeting is attended by the Acute Divisional Medical Directors, Clinical Director, Assistant Directors and Governance Lead for the Acute Directorate (Mr Chris Wamsley). The purpose of this meeting is to review and approve Serious Adverse Incident reports (SAIs) which have been prepared by SAI teams. Other key information will be shared at this meeting including the Acute and Divisional Risk registers, incidents trend reports and updates on complaints and Ombudsman cases ongoing

Monthly Acute Senior Management Team meeting

45.3 This meeting is attended by the Acute Assistant Directors and the Acute Governance Lead (Mr Chis Wamsley). This meeting focusses on a range of governance papers including:

a. Serious Adverse Incidents which are ongoing
b. Directorate and Divisional risk registers
c. Total number of incidents under review in each Division
d. Medication incidents
e. Clinical audits which are planned or ongoing

f. Patient safety report, looking at a range of issues including trends in patient falls, skin care / pressure ulcers, stroke thrombolysis figures, and omitted critical medicines
g. Complaints and Ombudsman cases
h. Mandatory Training figures for each Division
i. Safeguarding

Monthly Standard and Guidelines meeting

45.4 This meeting is attended by the Acute Assistant Directors, the Acute Governance Lead (Mr Chis Wamsley) and the Acute Lead for Standards and Guidelines (Mr Chris Warr). The purpose of this meeting is to review newly issued Standard and Guidelines and to agree which clinician is best placed to review the new guidelines (based on the subject) to determine compliance or any other additional resources required to become compliant.

45.5 In addition to the processes at Directorate level, each Division within Acute Services will also have processes and procedures through which governance concerns are reviewed specifically for their Division. The Assistant Director for each Division will chair a number of meetings focussed on governance as follows:

a. Divisional Governance meetings (usually held quarterly)
b. Weekly Heads of Service meetings, one of which each month will focus on governance
c. Specialty meetings which will have governance as a set agenda item. These meetings are usually held monthly at which the following will be discussed:
    i. Review of clinical incidents, including Serious Adverse Incidents and Significant Event Audits
    ii. Review of risk registers – corporate, acute and divisional
    iii. Review of complaints and compliments
    iv. Review of compliance against key quality standards – for example, Infection Prevention Control and Nursing Quality Indicators
    v. Review of compliance against standards and guidelines, e.g., guidelines issued by National Institute for Clinical Excellence (NICE) or other guidelines issued by Department of Health

45.6 With specific reference to Urology, this specialty is managed within the Surgery and Elective Care Division as it is a surgical specialty. The Assistant Director for the Surgery and Elective Care Division would chair the Divisional meetings as described above in the same way as I would chair similar meetings in my Division which is Cancer and Clinical services. The Assistant Director for Surgery and Elective Care was Mrs Heather Trouton 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date.

45.7 In my role as Assistant Director for Cancer Services, I received an email from Mrs Fiona Reddick (Head of Cancer Services) on 27 November 2018 – email attached for reference. 58a. ***20181127 Q40 Email from Fiona Reddick Re Radiology Attendance at Urology MDT located in S21 16 of 2022 Attachments***.

The email was from Mr Tony Glackin, Chair of the Urology Cancer MDT. The email was sent to Dr Imran Yousuf (Clinical Director for Radiology) and Dr David McCaul (Clinical Director for Cancer). In his email, Mr Glackin raised concerns in relation to consultant Radiology gaps in attendance at the Urology MDT. Mrs Reddick shared the email with me for discussion at our next 1:1 meeting with a view to me following this issue up with Dr Imran Yousuf as I am also the Assistant Director for Radiology Services. The actions taken following receipt of this email are detailed in my response to question 40 above.

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 As the Assistant Director for Cancer and Clinical Services from 1 June 2018 to date, I work closely with my Divisional Medical Director (Dr Shahid Tariq) and three Clinical Directors. The three Clinical Directors in the Cancer and Clinical Services Division are:

a. Cancer Services - currently vacant (previously Dr David McCaul from April 2021 up to December 2021)
b. Radiology Services - Dr Imran Yousuf
c. Laboratory Services - Dr Clare McGalie

46.2 During my tenure as Assistant Director for Cancer and Clinical Services and in my previous Assistant Director posts from March 2010, I have felt supported by the medical line management hierarchy. The Divisional Medical Director and the Clinical Directors work alongside me in my Assistant Director role in a collective management model. The Divisional Medical Director and Clinical Directors will attend key meetings including those focussed on governance as described in my response to question 45 above. The Divisional Medical Director and Clinical Directors will lead on job planning and appraisal for the consultants in my Division. Other examples of how the Divisional Medical Directors and Clinical Directors support me are:

a. Dr Shahid Tariq – co-chairs the SAI Task and Finish Group along with the Assistant Director of Surgery and Elective Care (R Ronan Carroll) which is currently overseeing the implementation of the eleven recommendations arising from the Dermot Hughes report.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A
b. Dr Imran Yousuf has worked closely with me to secure the appointment of a Consultant Radiologist with expertise in Urology in January 2021 who eventually took up post in April 2022
c. Dr Clare McGalie has worked closely with me to secure an additional locum Consultant Cellular Pathologist from 6 April 2022 to improve pathologist cover to all Cancer MDTs, including 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.

47.1 I have held a number of senior manager role as described in my response to question 5 above. From March 2010 to May 2018, these posts focussed mainly on Medical specialties and other strategic roles, none of which related to Urology Services, as Urology is a surgical specialty and managed within the Surgery and Elective Care Division.

47.2 I have been an Assistant Director from March 2010 and a member of the Acute Senior Management Team (SMT). During 2016 (I cannot recall the exact date for this), I was aware that a Serious Adverse Incident review process was underway looking at a number of Urology cases , including some patients that Mr O Brien had managed. Although I cannot recall exactly how I became aware of this, I presume this must have been stated at one of the Acute Directorate Senior Management Team governance meetings by the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). At this time however I was not aware of any other details in relation to the Serious Adverse Incident review. Also at this time, I was aware that there were some issues regarding Mr O'Brien and his patient's charts. Again, I cannot state exactly when I became aware of this, but I believe it was raised by Mrs Anita Carroll at one of the Acute Senior Management Team meetings during 2016.

47.3 Since taking up my role as Assistant Director for Cancer and Clinical Services / Integrated Maternity and Women's Health from 1 June 2018 (subsequently Cancer and Clinical Service only from 1 June 2021), I have engaged with the Urology Service and other specialties that deliver cancer services, through monitoring performance against the 31 and 62 day Cancer access targets. This happened through monthly Cancer Performance meetings. The Head of Service for Urology

attends these meetings. During my tenure this has been Mrs Martina Corrigan up to September 2020 and Ms Wendy Clayton from October 2020 to date.

(i) The Chief Executive(s);

47.4 In my role as Assistant Director for Cancer and Clinical Services, I have not met with any Chief Executive specifically to discuss concerns in the Urology Unit or concerns in relation to Urology governance. During my tenure as Assistant Director for Cancer and Clinical Services, the Chief Executive was Mr Shane Devlin. Dr Maria O Kane replaced Mr Devlin as Chief Executive from April 2022.

47.5 The Chief Executive is updated on performance against the 31 and 62 day Cancer access targets, including for Urology, through regular reports shared and discussed through Trust Senior Management Team (SMT). These reports are prepared by the Performance and Reform Directorate. During my tenure as Assistant Director for Cancer and Clinical services, Mrs Aldrina Magwood was the Director of Performance and Reform. Mrs Magwood left the Trust in January 2022 and has been replaced by Mrs Lesley Leeman as the Interim Director for Performance and Reform.

47.6 The Chief Executive is also updated on performance against the 31 and 62 day cancer access targets through the Trust Performance Committee. Cancer performance is summarised in a performance dashboard. See document attached for reference (page 1)
50. 20220510 Q35 Corporate CPD Performance Scorecard
51. 20220519 Q35 Corporate CPD Performance Scorecard Narrative
Documents located in S21 16 of 2022 Attachments

47.7 At the request of the Director of Acute Services (Mrs Melanie McClements), I attended Trust Performance Committee with the Clinical Director for Cancer Services (Dr David McCaul) on 20th May 2021 to provide an update to the Committee on Cancer performance. The Chief Executive (Mr Shane Devlin) was present at this meeting. During this meeting, we highlighted the pressures faced by some specialties including Urology in meeting the Cancer access targets. The presentation I gave to Trust Performance Committee is attached for reference.
18. 20210520 Q12 Performance Committee Cancer Presentation located in S21 16 of 2022 Attachments

(ii) the Medical Director(s);

47.8 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I have not met with any Medical Director specifically to discuss concerns in the Urology Unit or concerns in relation to Urology governance. During my tenure Dr Maria O'Kane has held the post of Medical Director.

47.9 The Medical Director is updated on performance against the 31 and 62 day cancer targets in the same way as described for the Chief Executive above. The Medical Director (Dr Maria O'Kane) was also present at the Performance Committee presentation on 20th May 2021.

47.10 Dr Maria O'Kane formally became Chief Executive in April 2022. The role of Medical Director is currently being shared by Dr Aisling Diamond and Dr Damian Gormely whilst recruitment is underway to fill the post on a permanent basis.

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

47.11 I have had responsibility for Cancer and Clinical Services as Assistant Director from 1 June 2018 to date. From June 2018 to June 2019, Mrs Esther Gishkori was Director of Acute Services. Mrs Melanie McClements took over as Director of Acute Services in June 2019 and continues in this role to date.

47.12 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I have not met with any Director of Acute Services specifically to discuss concerns in the Urology Unit or concerns in relation to Urology governance.

47.13 The Director of Acute Services is updated on performance against the 31 and 62 day Cancer access targets, including Urology, through regular reports shared and discussed through Acute Senior Management Team Performance (SMT) and Trust SMT. I attend the Acute SMT meetings but I do not attend the Trust SMT meetings,

47.14 The Director of Acute services also attends bi-monthly Cancer Performance meetings with Health and Social Care Board (HSCB) and now the Strategic Planning and Performance Group (SPPG) to review cancer performance for all tumour sites, including Urology.

(iv) the other Assistant Director (s);

47.15 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I have not met with any other Assistant Directors specifically to discuss concerns in the Urology Unit or concerns in relation to Urology governance.

47.16 The other Assistant Directors in Acute Services are updated on performance against the 31 and 62 day Cancer access targets, including Urology, through regular reports shared and discussed through Acute Senior Management Team Performance (SMT). Assistant Directors also attend monthly Cancer Performance meetings in the Directorate and attend bi-monthly Cancer Performance meetings with Health and Social Care Board (HSCB) and now the Strategic Planning and Performance Group (SPPG) to review cancer performance for all tumour sites, including Urology. I attend all these meetings in my role as Assistant Director for Cancer and Clinical Services.

(v) the Associate Medical Directors;

47.17 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I meet monthly with the Associate Medical Director for Cancer and Clinical Services (Dr Shahid Tariq). During these meetings there were no concerns raised

about the Urology Unit apart from gaps in Radiology cover for the Urology Cancer Multidisciplinary Team meeting (MDT) which was raised by Mr Tony Glackin (Consultant Urologist and Chair of the Urology Cancer MDT). My actions to address this issue is detailed in my response to question 40 above.

47.18 During my tenure as Assistant Director for Cancer and Clinical Services from 1 June 2018, I have not met with the Associate Medical Director for Surgery and Elective Care to discuss concerns in relation to the Urology Unit of any concerns in relation to Urology governance. During my tenure as Assistant Director for Cancer, Mr Mark Haynes was Associate Medical Director for Surgery and Elective Care. Mr Haynes has now been replaced by Mr Ted McNaboe in this role from January 2022

(vi) the Clinical Director(s);

47.19 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I met monthly with the Clinical Director for Cancer Services (Dr David McCaul) up to December 2021 when he stood down from his role. The Clinical Director for Cancer role is currently vacant.

47.20 The Clinical Director for Cancer Services was aware of capacity and demand challenges within the Urology Unit and how this was impacting on delivery against Cancer access targets. The Clinical Director for Cancer Services was also aware of the issues relating to Radiology cover at the Urology Cancer MDT and the actions taken to address these issues.

47.21 In my role as Assistant Director for Cancer and Clinical Services, I did not meet with the Clinical Director for Cancer Services in relation to any other concerns about the Urology Unit or any concerns in relation to Urology governance.

(vii) the Head of Service;

47.22 In my role as Assistant Director for Cancer and Clinical services from 1 June 2018, I chair monthly Cancer Performance meetings. The Head of Service for Urology attends these meetings. During my tenure this has been Mrs Martina Corrigan up to September 2020 and Ms Wendy Clayton from October 2020 to date. The details of these meetings are noted in my response to question 27 above.

47.23 During these meetings the capacity challenges facing Urology Services were evident. The Head of Service for Urology would have outlined any actions being taken to recruit staff to increase capacity within the service. Apart from the capacity challenges facing the Urology Service, the Head of Service raised no other issues about Urology governance.

(viii) the consultant urologists.

47.24 During the COVID 19 Pandemic, I established fortnightly Cancer Checkpoint meetings (which replaced the monthly Directorate Cancer Performance meetings)

and invited all Cancer Multidisciplinary Team Meeting (MDT) Chairs, Assistant Directors, Heads of Service, Operational Support Leads and representatives from the Trust Performance Team.

47.25 The purpose of these meetings was to enable me to maintain closer contact with the Cancer MDT chairs and the operational teams to minimise the impact of COVID19 on the delivery of Cancer Services. Mr Tony Glackin was invited to these meetings in his role as Chair of the Urology Cancer MDT. Mr Glackin attended some of these meetings and provided updates through the Urology Head of Service at others. These meetings were held at 2pm on Friday and this often clashed with Mr Glackin's operating list.

47.26 During my tenure as Assistant Director for Cancer and Clinical services, or in any of my previous senior manager roles from March 2010, I had no other meetings with any of the Consultant Urologists in relation to concerns in the Urology Unit or any issues relating to Urology governance.

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: -

48.1 I have held a number of senior manager role as described in my response to question 5 above. From March 2010 to May 2018, these posts focussed mainly on Medical specialties and other strategic roles, none of which related to Urology Services, as Urology is a surgical specialty and managed within the Surgery and Elective Care Division. From 1 June 2018, I have been the Assistant Director for Cancer and Clinical Services. It is in this role where my links commenced with Urology Services.

(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.

48.2 Since taking up my Assistant Director role in Cancer and Clinical Services on 1 June 2018, I have monitored performance against the 31 and 62 day Cancer access targets for all tumour sites, including Urology. In addition to monitoring performance against the 31 and 62 day cancer access targets, I also provide cancer tracking support to eight Trust Cancer Multidisciplinary Teams (MDTs) including the Urology Cancer MDT. Each Cancer MDT will have an allocated Cancer Tracker/MDT co-ordinator. The Cancer Tracker/MDT co-ordinator will co-ordinate the information required for discussion at and attend each cancer Multidisciplinary Team Meeting (MDT) to support the logging of outcomes onto the Regional Cancer Patient Pathway System (CAPPS). They also record Cancer MDT Meeting attendance. Following the Cancer MDT meeting, the cancer tracker/MDT co-ordinator will record the outcome

of discussion and record progress against the agreed plan for each patient. Where there are delays, against the 31 day and 62 day pathways, the Cancer Tracker/MDT co-ordinator (or Cancer MDT Administrator) will escalate these to the Head of Service for Urology for resolution, where possible.

48.3 Through the monitoring of the cancer access targets, and especially the 62 day target, the information showed that the Urology Service were struggling to meet this target. This was not unique to Urology, as other tumour sites were also not able to meet this target. Performance against the cancer access targets was reviewed at a monthly Cancer Performance meeting which I chaired. The Head of Service for Urology attends these meetings. During my tenure this has been Mrs Martina Corrigan up to September 2020 and Ms Wendy Clayton from October 2020 to date.

48.4 Where there are delays, against the 31 day and 62 day pathways, the cancer tracker/MDT co-ordinator (or Cancer MDT Administrator) will escalate these to the Head of Service for Urology for resolution, where possible. Once the issue has been escalated to the Head of Service, they are responsible for following this up with their clinical team. The Head of Service will then provide an update back to the tracker (or Cancer MDT Administrator).

48.5 Before I took up post as Assistant Director for Cancer and Clinical Services, the challenges the Trust was facing in meeting the cancer access targets were logged as a high graded risk on the Acute Risk register from 3 September 2012 by the Head of Cancer Services at that time, Mrs Fiona Reddick. This risk related to all eight cancer tumour sites, including Urology. All eight tumour sites were performing reasonably well against the 31 day target, however all tumour sites, including Urology, were unable to meet the 62 day target. The common challenge which all tumour sites were facing was that they were unable to deal with all the red flag referrals being received within the required timeframes, ensuring the patients were triaged, seen, investigations completed, surgery completed (if necessary) and treatment commenced within 62 days. See attached copy of the Acute Risk Register. ***57. 202204 Q40 Acute Directorate Risk Register located in S21 16 of 2022 Attachments***

48.6 Since 1 June 2018, I have also been concerned about the Oncology Cover for the eight Cancer MDTs. SHSCT do not employ any Oncology Consultants, therefore this resource is provided from Belfast HSC Trust to cover the MDTs and also to provide Oncology Clinics in the Mandeville Unit. It is my understanding that there is a regional shortage of Consultant Oncologists in Northern Ireland and for this reason, Belfast HSC Trust have not been able to provide full cover to SHSCT during my tenure as Assistant Director for Cancer and Clinical Services. This risk was added to the Head of Service Risk register by Mrs Fiona Reddick (Head of Cancer Services). My actions to address this concern are detailed in my response to question 40.

48.7 On 27 November 2018, received an email from Mrs Fiona Reddick (Head of Cancer Services) - email attached for reference. *58a* ***20181127 Q40 Email from Fiona Reddick Re Radiology Attendance at Urology MDT located in S21 16 of 2022 Attachments.*** The email was from Mr Tony Glackin, Chair of the Urology Cancer MDT. The email was sent to Dr Imran Yousuf (Clinical Director for

Radiology) and Dr David McCaul (Clinical Director for Cancer). In his email, Mr Glackin raised concerns in relation to consultant Radiology gaps in attendance at the Urology MDT. Mrs Reddick shared the email with me for discussion at our next 1:1 meeting with a view to me following this issue up with Dr Imran Yousuf as I am also the Assistant Director for Radiology Services.

48.8 The concerns in relation quoracy (attendance at MDT) was also raised in the Urology MDT Annual Report in 2019 – see attached, section 3 of the Annual Report which refers to Oncology and Radiology gaps at MDT meetings.
Relevant to Acute, Document Number 28, 20201105 Urology MDT Annual Report 2019

48.9 I received the Dermot Hughes report in February 2021. The report detailed a number of areas which needed to be addressed in relation to the Urology Cancer MDT. I was previously aware of the issues in relation to gaps in attendance / quoracy at the MDT and the need for additional audit support, however I was unaware of the following issues:

a. Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer Multidisciplinary Team (MDT) meeting
b. Not all patient with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)
c. Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

48.10 A copy of the Dermot Hughes report is attached for reference.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

48.11 A Task and Finish Group was established in August 2021 to implement the recommendation outlined in the Dermot Hughes report. Work is ongoing to address these issues and an update on this work is provided in my response to question 68 below.

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

48.12 In my role as Assistant Director for Cancer and Clinical Services, I monitor performance against the 31 and 62 day cancer access targets for eight tumour sites, including Urology. Where there are delays for patients on cancer pathways including Urology, the following steps are taken. The Cancer Tracker/MDT co-ordinator (or the Cancer MDT Administrator) escalates the delay to the Head of Service in the relevant specialty for review and action accordingly. The Head of service for each specialty will review cancer performance at their specialty meetings and consider risks / mitigation where possible. The Head of Services for Urology, (Mrs Martina Corrigan up September 2020 and Ms Wendy Clayton from October 2020 to date) are

best placed to update on the actions taken to address performance against the 31 and 62 day cancer targets in Urology.

48.13 In terms of the functioning of the Urology Cancer MDT, it is my responsibility to monitor quoracy. Previously this was done through the Annual Report for the Urology MDT which was produced by the Chair of the MDT (Mr Tony Glackin). It is also my responsibility to take the necessary actions to ensure attendance is as good as it can be to support effective multidisciplinary discussion at the MDT. The actions that I have taken to improve quoracy at the Urology Cancer MDT as detailed in my response to question 40 above. The gaps in attendance at the Urology MDT and other MDTs have not been assessed through a formal risk assessment, however this will be completed in June 2022 by the Interim Head of Cancer Services (Mrs Clair Quin).

(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.

48.14 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I monitored performance against the 31 and 62 day cancer access targets. This monitoring showed that Urology and other specialties were unable to consistently meet the 62 day access targets. The inability to meet the 62 day cancer access targets has been logged as a high risk on the Acute Risk register from September 2012 (logged by the Head of Cancer services, Mrs Fiona Reddick). As the Assistant Director for Cancer, I know that timely access to treatment for patients that may have cancer is important. My role was to monitor performance and to escalate any delays to the Head of Service for Urology. The Head of Service for Urology was responsible for working with the clinical team to consider how delays could be resolved in order to ensure patients completed their pathway to first definitive treatment as soon as possible, if not within the 62 access target.

48.15 In my role as Assistant Director for Cancer and Clinical Services from 1 June 2018, I was also aware that the Cancer Multidisciplinary Team (MDT) meetings, including Urology, were not always quorate. This issue had been raised through the Cancer MDT Annual Reports for the majority of the MDTs. In terms of the Urology Cancer MDT, there were significant challenges in relation Radiology, Pathology and Oncology attendance at the MDT due to consultant vacancies in these areas. I was aware that the gaps at MDT could potentially delay some patients progress along their cancer pathway. My actions to address these issues are detailed in my response to question 40 above.

(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?

48.16 The inability to meet the 62 day cancer access targets has been logged as a high risk on the Acute Risk register from September 2012 (logged by the Head of Cancer services, Mrs Fiona Reddick). As the Assistant Director for Cancer, I know

that timely access to treatment for patients that may have cancer is important. My role was to monitor performance and to escalate any delays to the Head of Service for Urology. The Head of Service for Urology was responsible for working with the clinical team to consider how delays could be resolved in order to ensure patients completed their pathway to first definitive treatment as soon as possible, if not within the 62 access target.

48.17 My actions to address the quoracy concerns at the Urology Cancer MDT are detailed in my response to question 40 above.

(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?

48.18 As noted above, I was concerned that the Trust were unable to meet the cancer access targets, and especially the 62 day target. All of the eight tumour sites were unable to meet this target, including Urology.

48.19 In order to address the underperformance, I continued to chair monthly Cancer Performance meetings (and fortnightly Cancer Checkpoint meeting – during the COVID 19 Pandemic). Monthly cancer performance information was produced and shared with the Heads of Service and Assistant Directors for sharing with the clinical teams. At the performance meetings we focussed on patients that were in excess of day 62 on the pathway to consider how the pathway for these patients could be completed. The actions to address the long waiters would be taken by the Head of Service for each tumour site, including Urology. The impact of these actions would be reviewed at the next monthly performance meeting through a report which focussed solely on the patients that were waiting longest on each tumour site pathway.

48.20 In terms of attendance at the Cancer MDTs, previously this information was only available to me annually through the Annual Report for each Cancer MDT. Given the concerns raised in relation to attendance, I needed to see attendance information more regularly. As one of the actions to address the eleven recommendations in the Dermot Hughes report, the Trust appointed a Cancer MDT Administrator in January 2022 (at financial risk pending funding from the commissioner).
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

48.21 Recognising that quoracy is an important element of the effectiveness of Cancer MDTs, the MDT Administrator now runs monthly quoracy reports. These reports are shared with the Divisional Medical Director for Cancer services (Dr Shahid Tariq), the Clinical Director for Cancer Services (post currently vacant), the Assistant Director for Cancer Services (Mr Barry Conway - myself) and the Interim Head of Cancer Services (Mrs Clair Quin). This provides monthly updates on quoracy and an earlier opportunity to address issues. For example, the new monthly reports are now showing improved attendance at the Urology Cancer MDT for

Oncology, Radiology and Pathology. This provides me with assurances with regards to attendance at MDT by all members.

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

48.22 Through the monthly Cancer Performance meetings, actions would be agreed for each Head of service to address issues raised, for example, actions to deal with patients waiting longer than 62 days on the 62 day pathway. I would review the impact of these actions at the next Cancer Performance meeting. This is how I am assured that actions agreed have been implemented.

48.23 In terms of gaps at Cancer MDTs impacting on quoracy, since February 2022, I now receive a monthly attendance report which outlines attendance for each member at the MDT. This report is produced by the Cancer MDT Administrator (Mrs Angela Muldrew). The report is populated through attendance information which is recorded by the Cancer Tracker/MDT co-ordinator at each MDT.

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

48.24 In terms of performance against the 62 day cancer access target, the Trust are still unable to meet this target. For the year 21/22, the Trust only achieved an average of 49.75% against this 95% target for all tumour sites (Urology achieved 27.13%). I expect performance to gradually improve through 22/23, however I do not believe Urology will meet the 95% target due to consultant workforce gaps.

48.25 In terms of attendance at the Urology Cancer MDT, and specifically challenges in relation to Oncology, Radiology and Pathology cover, the May 2022 attendance report shows the following improvements against the Urology MDT Annual Report 2019.

a. Oncology – 100% attendance (was previously 5%)
b. Radiology – 100% attendance (was previously 70%)
c. Pathology – 0% attendance (was previously 95%) – **Note** – this was due to Consultant Pathologist Personal Information redacted leave, however the pathology reports were all provide to the MDT in advance of the meeting

48.26 This shows that the actions put in place to address the gaps in attendance at the Urology Cancer MDT have been successful. I now need to ensure that this improvement is sustained.

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

48.27 In terms of Cancer performance, we measure performance against the 31 and 62 day target as a monthly percentage figure. For example, the target for 62 days is

95%; therefore we count how many Urology patients completed their 62 day pathway in a given month and how many of the patients completed their pathway in less than 62 days. The figure completed in less than 62 days is then shown as a percentage against the total figure that is the performance figure for Urology for that month. In addition to the monthly performance figure, we also monitor how many patients remain on the cancer pathway as incomplete and are waiting longer than 62 days.

48.28 In terms of Cancer MDT quoracy, from February 2022, I now receive a monthly attendance report which provides an overview of MDT attendance for that month for each MDT, including Urology. The report shows a total attendance figure for the MDT as whole (i.e. if there are 10 members and 10 attend each MDT, then the attendance figure will be 100%. If eight attend, the figure will be 80%). As well as the attendance percentage for the MDT as a whole, there is also an attendance figure for each member of the MDT for that calendar year. Allowing for annual leave / study leave, I would expect each MDT member to attend 42 weeks out of 52 in that year. The target attendance figure for each member is therefore 80% (42/52). This figure is shown as a rolling attendance percentage figure for each member of the MDT in the monthly report. A sample MDT attendance report is attached for reference.

59. 20220617 Q48 MDM Attendances Report May 2022 located in S21 16 of 2022 Attachments

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 terms of performance against the 31 and 62 day cancer access targets, I chaired monthly Cancer Performance meetings and the Cancer and Clinical Services Division produced monthly cancer performance reports. In my view, these systems and processes were and are effective in that they provided each Head of service with information on how their service was performing against the targets. The report also provides information on red flag referral trends, longest waiters and typical reasons for delays. My role is to bring issues in terms of cancer performance to the attention of each Head of Service as appropriate. The Head of service is responsible for engaging with the team to take any corrective action where possible and to assess potential risk to patients that are waiting longer than 62 days to complete their cancer pathway.

49.2 In terms of quoracy and attendance at Cancer MDT, previously attendance was summarised in the Annual Report for each MDT, unless a specific concern was raised by the Chair of MDT during the year. As noted in my response to question 40 above, Mr Tony Glackin raised concerns in relation to Radiology attendance at the Cancer MDT in November 2018. See email from Fiona Reddick which was sent to me on 27 November 2018.

58a 20181127 Q40 Email from Fiona Reddick Re Radiology Attendance at Urology MDT located in S21 16 of 2022 Attachments

In my view, Mr Glackin was right to raise this concern and to seek support in improving Radiology attendance to the Urology Cancer MDT. The impact of gaps in attendance at the Urology Cancer MDT and other MDTs has not been formally assessed through a risk assessment. I have asked the Interim Head of Cancer Services (Mrs Clair Quin) to complete this risk assessment and it will be completed by the end of June 2022.

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 As noted in my response to question 49 above, the main concerns that I was aware of in relation to Urology, were the under performance against the 31 and 62 day cancer access targets and the gaps in attendance at the Urology Cancer MDT.

50.2 In terms of support provided in relation to cancer performance, I chaired a monthly Cancer Performance meeting and also provided monthly cancer performance reports. During the month, the Cancer Tracker/MDT co-ordinator (or the Cancer MDT Administrator) would also escalate any delays for patients on cancer pathways to the Head of Service for Urology. During my tenure as Assistant Director for Cancer and Clinical Services from 1 June 2018, this was been Mrs Martina Corrigan up to September 2020 and Ms Wendy Clayton from October 2020 to date.

50.3 In terms of attendance gaps at the Urology Cancer MDT, I have worked with the Clinical Director for Radiology (Dr Imran Yousuf) and the Clinical Director for Pathology (Dr Clare McGalie) to improve attendance for Radiology and Pathology. I also worked with the Head of Cancer Services (Mrs Fiona Reddick) to part fund the appointment of an additional Consultant Oncologist in Belfast HSC Trust. These actions have supported the Urology staff in terms of improved quoracy at the Urology Cancer MDT.

50.4 Following receipt of the Dermot Hughes report (February 2021), and to address the recommendations contained within this report relating to Cancer MDTs, I have been working to secure funding for additional resources to support all the Cancer MDTs including Urology. A new Cancer MDT Administrator commenced in the SHSCT in January 2022. This is the first post of this kind in Northern Ireland. The Cancer MDT Administrator will support all the Cancer MDT Chairs (Including Urology) by producing new monthly reports focussing on the following:

a. MDT attendance / quoracy
b. Audit of actions taken at Urology MDT – confirming agreed actions have been completed
c. Cross referencing pathology confirmed Urology Cancer cases to those presented at the Urology Cancer MDT

d. Allocation of key worker for each Urology Cancer patient (this will now be the Cancer Nurse Specialist)
e. Any other reports which the MDT Chair requests

50.5 I have also now received approval to appoint a Cancer Information and Audit Officer to support all the Cancer MDTs (including urology) with clinical audits that they wish to undertake. Recruitment for this post is underway and I hope to have this new postholder in position by September 2022.

50.6 In terms of quality improvement, I also provide a Macmillan Service Improvement Lead (Mrs Mary Haughey) to support all the cancer tumour sites (including Urology) with any improvement work that they wish to progress. Examples of work progressed are summarised in the response to question 51 below.

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

51.1 All Trusts in Northern Ireland, including SHSCT have a Macmillan Service Improvement Lead. During my tenure as Assistant Director for Cancer and Clinical Services from 1 June 2018, Mrs Mary Haughey has held this post in SHSCT. The Macmillan Service Improvement lead works with all cancer tumour sites, including Urology to:

a. Identify and implement service improvement initiatives with the chairs of the Cancer MDTs, including Urology
b. Work with the Head of Cancer Services, the Assistant Director for Cancer and Clinical Services and the Clinical Director for Cancer Services to implement service improvement initiatives by working with clinical teams, including Urology
c. Develop and take forward improvement initiatives across a number of specialist teams, including Urology
d. Work with clinical teams (including Urology) to review current patient pathways; identifying areas for modernisation and improvement, in line with cancer reform and benchmark best practice.

51.2 For example, when the regional Urology Clinical Reference Group (part of the Northern Ireland Cancer Network) produced new guidelines for Nurse Led Assessment and Follow Up of patients with stable prostate cancer in March 2016, the Macmillan Service Improvement Lead worked with the Urology Service to implement this guidance in SHSCT.

51.3 This Macmillan Service Improvement post has been in place from 1 October 2015**.** With specific reference to the Urology Department, the Macmillan Service Improvement Lead has worked with the Urology Department on the following:

1. **Peer review**: supporting the Urology Cancer MDT in their preparation for peer review (2016 and 2017) including:
e. a. the review and update of the MDT Operational Policy
f. b. completion of the MDT Annual Report and Work-plan

g. c. collating the evidence folder which contains the following:
    i. Evidence of advanced communications training
    ii. Information pack which is shared with patients when they receive a cancer diagnosis, including cancer information leaflets
    iii. Evidence of audits completed
    iv. Patient experience survey results
h. completion of the self-assessment matrix required
i. provision of ongoing support is provided in relation to updating the MDT documents as required.

2. **Co-production and patient experience**: Dissemination of the Trust and site-specific results from the Northern Ireland Cancer Patient Experience surveys (2015 and 2018) and development of a local action plan arising from the results.

51.4 For example, following on from the 2018 Cancer Patient Experience Survey, the Urology Cancer MDT reviewed the survey results for Urology patients at their Annual Business meeting held on 23 January 2020. Following discussion at the Urology Cancer MDT, an action plan was produced and this is attached for reference.
60. 2020 Q51 Urology Local Action Plan

51.5 The team have linked with the Trust's Cancer Service User Group in relation to the development of patient information. A number of local patient experience surveys have been undertaken to seek patient feedback in relation to:

a. The Information pack provided to newly diagnosed patients
b. Pilot of a patient record of management
c. Prostate follow-up community pilot
d. Urology service patient experience

51.6 Work is ongoing with Macmillan Cancer Support to get feedback from Urology patients on their experience of using the Urology Service. This process is supported by Peer Facilitators, who are people who have also been affected by cancer, have received training to enable them to engage with Urology patients to get feedback on their experience of using the Urology Services, and to get their views on how services could be improved. A report will be will be completed by August 2022 and this will be fed back to the Urology Service to support future service development / improvement.

Implementation of Cancer Reform as set out in Transforming Your Care strategy published by Department of Health in NI in December 2011:

51.7 In December 2011, a Cancer Reform programme was published by Department of Health in Northern Ireland. The program was included within the 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland' document – attached for reference.
61. 201112 Q51 Transforming Your Care Review of HSC NI Final Report located in S21 16 of 2022 Attachments
Transforming Your Care was focussed on ensuring patients received the right care, at the right time from the right healthcare professional. One of the examples of the

work which was implemented linked to Transforming Your Care, was the Nurse Led follow Up of patients with stable prostate cancer.

Local review of MDT systems and processes:

51.8 The Macmillan Service Improvement Lead (Mrs Mary Haughey) has worked with the Urology MDT Lead (Mr Tony Glackin) to complete the National Cancer Team (NCAT) MDT baseline assessment between June and August 2021. An action plan to strengthen MDT processes and systems has also been produced see attached for reference.
62. 202206 Q51 MDT Service Improvement Action Plan located in S21 16 of 2022
Attachments
Work is underway to implement the actions in the attached action plan with all the Cancer MDTs, including the Urology MDT.

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 During my tenure in SHSCT, I have never managed the Urology Service nor have I met with Mr O'Brien with regard to any issues.

52.2 In my opinion, the collective leadership team for the Surgery and Elective Care Division (Assistant Director, Divisional Medical Director, Clinical Director and Head of Service for Urology) would be best placed to provide information on the members of staff who had roles or responsibilities in relation to Mr. O'Brien.

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 During my tenure in SHSCT I have never managed the Urology Service or worked as part of the collective leadership team for Surgery and Elective Care.

53.2 In my opinion, the Clinical Director and Divisional Medical Director for Surgery and Elective Care would have been responsible for working with Mr O'Brien to agree his job plan. The Assistant Director for Surgery and Elective Care may also have been consulted as part of this process and have been required to sign off the job plan on the Zircadian system.

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 detailed in my response to question 5 above, I have been an Assistant Director in Acute Services since March 2010. Between March 2010 and May 2018, my work focussed on Medical specialties or strategic work; therefore I was not involved with Urology during this period as it is a surgical specialty which is managed in the Surgery and Elective Care Division. During 2016 (I cannot recall the exact date for this), I was aware that a Serious Adverse Incident review process was underway looking at a number of Urology cases , including some patients that Mr O Brien had managed. Although I cannot recall exactly how I became aware of this, I presume this must have been stated at one of the Acute Directorate Senior Management Team governance meetings by the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). At this time however I was not aware of any other details in relation to the Serious Adverse Incident review. Also at this time, I was aware that there were some issues regarding Mr O'Brien and his patient's charts. Again, I cannot state exactly when I became aware of this, but I believe it was raised by Mrs Anita Carroll at one of the Acute Senior Management Team meetings during 2016. I am not are how long these issues were in existence.

54.2 In autumn 2020 (I cannot recall the exact date), I was aware of a further review being undertaken by Dr Dermot Hughes looking at a number of Urology Cancer cases. I was aware that this review was being progressed as one of my Heads of Service (Mrs Fiona Reddick – Head of Cancer Services), was a panel member on this review and she made be aware. At this time, I was not aware of the details of the cases or any issues that were being raised. When the review was completed, I received a copy of the Dermot Hughes summary report from the Director of Acute services (Mrs Melanie McClements) in February 2021.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

54.3 The outcomes from the report were also presented at the Acute Clinical Governance meeting on 9 April 2021 by the Medical Director (Dr Maria O'Kane), however I was not in attendance at that meeting as I was on annual leave. See attached copy of the minutes from this meeting for reference.
Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Document No 2L, Acute Clinical Governance Notes, 2021, 20210409, Acute Clinical Governance Action Notes

54.4 The Dermot Hughes report detailed a number of areas which needed to be addressed in relation to the Urology Cancer MDT. I was previously aware of the issues in relation to gaps in attendance / quoracy at the MDT and the need for additional audit support, however I was unaware of the following issues:

a. Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer Multidisciplinary Team (MDT) meeting
b. Not all patient with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)

c. Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

54.5 I am not aware how long these issues were in existence before I became aware of these through the Dermot Hughes report.

54.6 A Task and Finish Group was established in August 2021 to implement the recommendations outlined in the Dermot Hughes report. Work is ongoing to address these issues and an update on this work is provided in my response to question 68 below.

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 During my tenure in SHSCT and as far as I can recall from 2007 to date, I have never attended a meeting where Mr O Brien was present.

55.2 As described in my response to question 54 above, I have been an Assistant Director and a member of the Acute Senior Management Team since March 2010. During 2016 (I cannot recall the date or at which specific meeting), I became aware that there was a Serious Adverse Incident review process underway looking at a number of Urology cases , including some patients that Mr O' Brien had managed. Although I cannot recall exactly how I became aware of this, I presume this must have been stated at one of the Acute Directorate Senior Management Team governance meetings by the Assistant Director for Surgery and Elective Care (Mrs Heather Trouton). At this time, however I was not aware of any other details in relation to the Serious Adverse Incident review. Also at this time, I was aware that there were some issues regarding Mr O'Brien and his patient's charts. Again, I cannot state exactly when I became aware of this, but I believe it was raised by Mrs Anita Carroll at one of the Acute Senior Management Team meetings during early 2016.

55.3 The members of the Acute Senior Management Team at this time were:

Mrs Esther Gishkori - Director of Acute Services
Mrs Heather Trouton – Assistant Director, Surgery and Elective Care
Mr Ronan Carroll – Assistant Director, Cancer and Clinical Services / Anaesthetics and Intensive Care
Mrs Anne McVey – Assistant Director, Integrated Maternity and Women's Health
Mrs Anita Carroll - Assistant Director, Functional and Support Services
Dr Tracey Boyce – Director of Pharmacy (and Governance Lead for Acute services)
Mr Simon Gibson – Assistant Director, Medicine
Mr Barry Conway – Assistant Director, Unscheduled Care

55.4 A Task and Finish Group was established in August 2021 to implement the recommendations outlined in the Dermot Hughes report. The Terms of Reference for this group, including the membership are attached for reference.

64. 20211011 Q55 TOR Trust Task and Finish Group into Urology SAI Recommendations located in S21 16 of 2022 Attachments

Also attached are the minutes from this Task and Finish Group

65. 20210913 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

66. 20211011 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

67. 20211108 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

68. 20211206 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

69. 20220207 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

70. 20220307 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

71. 20220404 Q55 Notes from SAI Recommendation Implementation Super Group Meeting

Documents located in S21 16 of 2022 Attachments

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 During my tenure in SHSCT I have never managed the Urology Service or worked in the Surgery and Elective Care Division, therefore I have not been involved in any meetings where concerns were discussed regarding Mr O'Brien or any actions agreed to deal with concerns raised.

56.2 In my opinion, the collective leadership team for the Surgery and Elective Care Division (Assistant Director, Divisional Medical Director, Clinical Director and Head of Service for Urology) are best placed to provide this information.

56.3 The Head of Service for Urology was Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date. The Assistant Director for Surgery and Elective Care was Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date.

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

57.1 During my tenure in SHSCT I have not been involved in any meetings where concerns were discussed regarding Mr O'Brien.

57.2 After the Dermot Hughes report was shared in February 2021, I took time to consider the issues raised in the report and the recommendations that were relevant to cancer services.
Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

57.3 In my opinion, the key points for the Cancer and Clinical Services Division in the Dermot Hughes report were:

a. Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer Multidisciplinary Team (MDT) meeting
b. Not all patients with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)
c. Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

57.4 From February 2021, I started to meet with my team in Cancer Services to consider the issues raised through the Dermot Hughes report and to discuss why the issues had occurred, and what we could do to avoid such issues in the future. The team members were:

a. Divisional Medical Director, Dr Shahid Tariq
b. Clinical Director, Dr David McCaul
c. Interim Head of Cancer Services, Mrs Clair Quin
d. MacMillan Service Improvement Lead, Mrs Mary Haughey
e. Cancer and Clinical Services operational Support Lead, Mrs Sharon Glenny

57.5 Through these discussions, we agreed that a baseline assessment should be completed to determine if the Cancer MDTs were functioning in line with recognised national best practice. Given that the national peer review process was suspended; we agreed that our MacMillan Service |Improvement Lead (Mrs Mary Haughey) would complete an assessment using the National Cancer Action Team (NCAT) tool. This work was progressed between June and August 2021 by Mrs Mary Haughey working with the chairs of each of the eight Cancer MDTs. A Cancer MDT improvement plan was produced to improve Cancer MDT processes on completion of the NCAT baseline exercise. A copy of the MDT Improvement plan is attached for reference.
62. 202206 Q51 MDT Service Improvement Action Plan located in S21 16 of 2022
Attachments

(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.

57.6 After the NCAT baseline assessment of the Cancer MDTs was completed, an improvement plan was agreed with the Chairs of the eight Cancer MDTs. A key part of the MDT improvement plan was the development of a principles document which described key principles through which the Cancer MDT would function. Examples of the principles agreed were:

a. A proforma would be established for each MDT, outlining the information needed to support discussion of cases at the MDT
b. Each patient case presented would have a key worker allocated and this would be the Cancer Nurse Specialist
c. The key worker details would be recorded in the Cancer Patient Pathway System (CAPPS)

57.7 See attached, Cancer MDT Principles Document for reference.

53. 202201 Q37 MDT Principles Document located in S21 16 of 2022 Attachments

57.8 In addition to the work undertaken to produce the MDT Improvement Plan, it was clear to me that additional resources would be required, to meet the recommendations in the Dermot Hughes report. The report recommended that SHSCT appoint a Cancer MDT Administrator and provide clinical audit support to the Cancer MDTs. To the best of my knowledge, the Cancer MDT Administrator role did not exist in any Trust in Northern Ireland.

57.9 In order to support the implementation of work to address the recommendation in the Dermot Hughes report and to mitigate the concerns raised in relation to the working of the Urology MDT, SHSCT agreed to appoint a Cancer MDT Administrator, this post has not yet been commissioned by HSCB/SPPG. Mrs Angela Muldrew was appointed to the role in January 2022. This is the first role of this type in Northern Ireland.

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 During my tenure in SHSCT, I have not been involved in any meetings where concerns were discussed regarding Mr O'Brien as I do not work in the Surgery and Elective Care Division. In my opinion, the collective leadership team for the Surgery and Elective Care Division (Assistant Director, Divisional Medical Director, Clinical Director and Head of Service for Urology) are best placed to provide this information.

58.2 The Head of Service for Urology was Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date. The Assistant Director for Surgery and Elective Care was Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date.

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 As detailed in my response to question 57 above, I received the Dermot Hughes report in February 2021 from the Director of Acute services (Mrs Melanie McClements). Up to that point, I had not been involved in any process that was looking into the concerns raised in relation to Mr O Brien. In my opinion, Mrs Heather Trouton and Mr Ronan Carroll are best placed to comment on metrics used before my involvement. The recommendations in the Dermot Hughes report identified the need for greater monitoring of the Urology Cancer MDT especially in relation to:

a. Attendance
b. Audits to confirm that actions agreed by the MDT were implemented
c. Confirmation that a key worker had been identified and documented
d. Confirmation that the Cancer Nurse Specialist (CNS) was involved with patients with a confirmed cancer
e. Establishing a cross check mechanism with the Cellular Pathology Laboratory in Craigavon Area Hospital to ensure that, patients with a laboratory confirmed cancer, were brought to the MDT by their consultant for discussion

59.2 Previously attendance at MDT was recorded at each MDT but no reports were produced or shared. The attendance information was included only within the Annual Report for each Cancer MDT, including Urology.

59.3 In relation to the audit of actions, recording of key worker, confirmation of involvement of CNS and the use of a Cellular Pathology Cross check mechanism; none of these arrangements were previously in place.

59.4 In order to support the implementation of work to address the recommendations in the Dermot Hughes report and to mitigate the concerns raised in relation to the working of the Urology MDT, SHSCT agreed to appoint a Cancer MDT Administrator. Mrs Angela Muldrew was appointed to the role in January 2022, this post has not yet been commissioned by HSCB/SPPG. From January 2022, I have been working with the Interim Head of Cancer Services (Mrs Clair Quin), the Macmillan Service Improvement Lead (Mrs Mary Haughey) and the Cancer MDT Administrator (Mrs Angela Muldrew) to establish new metrics to provide monthly monitoring of how the Urology Cancer MDT is working. These metrics are being applied to all eight Cancer MDTs.

59.5 The new metrics in the process of being established are as follows:

a. A monthly MDT attendance report
b. Audit of MDT actions – I am in the process of recruiting a new Clinical Audit and Information Officer post. I expect the new post holder to be in post by September 2022. When in post, the Clinical Audit and information Officer will produce a monthly report for each tumour site to confirm actions agreed at MDT have been implemented. In the interim, the Cancer MDT Administrator has started from April 2022, to audit the actions from the Urology MDT (one MDT per month)

c. SHSCT have requested a regional change to the Cancer Patient Pathway System (CAPPS) to enable key worker information to be recorded and reports produced. We do not yet have confirmation when this change will be completed. In the interim, from May 2022, we are now recording the key worker on an existing field on CAPPS and monthly reports are being produced from June 2022 onwards
d. The Cancer MDT Administrator is working to establish a cross check mechanism between cancer cases confirmed in the Cellular Pathology Laboratory and cases presented to the Cancer MDTs. They purpose of this report is to ensure that all laboratory confirmed cancer patients are being presented to the appropriate Cancer MDT. This is a technically complex exercise, however we are aiming to have this in place by the end of July 2022.

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 As detailed in my response to question 59, I was not involved any process looking into concerns relating to Mr O Brien before February 2021. In my opinion, Mrs Heather Trouton and Mr Ronan Carroll are best placed to comment on systems and agreements that were established before February 2021.

60.2 The new reports that are now in place and under development as outlined in my response to question 59 above, will be shared with myself, the Interim Head of Cancer Services (Mrs Clair Quin), the Clinical Director for Cancer Services (currently vacant), the Divisional Medical Director for Cancer and Clinical Services (Dr Shahid Tariq) and the chairs of the Cancer MDTs on a monthly basis for review.

60.3 I am currently reviewing these reports to assure myself that the concerns raised through the Dermot Hughes report are being addressed. Where I see an issue, I address this myself where I can, or bring it to the appropriate MDT Chair or Senior Manager for review and action. For example, I received the monthly MDT attendance report on 17 June 2022 from the MDT Administrator (Mrs Angela Muldrew). This report showed that there was no pathologist in attendance at the Urology MDT during May [redacted] All pathology reports however were provided in advance to the Urology MDT to support discussion to mitigate the absence of the Pathologist at the meeting.

Personal Information redacted by the USI

60.4 The monthly reports and the review of the information contained within them, is the process that I will use to assure myself that the actions being taken are sufficiently robust and comprehensive in addressing the issues relating to the MDTs as highlighted in the Dermot Hughes report. The standards against which I measure how robust the actions are, will be different in each report. For example, for allocation of key worker, I expect this to be 100%. In terms of core members attendance at MDT, I expect this to be 80% (i.e. 42 weeks out of 52 in the year allowing for annual leave). In terms of the audits of actions at MDT, I expect this to

be 100%, and were any issue is not progressed; this will be brought back to MDT for further discussion or update.

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 As detailed in my response to question 59, I was not involved any process looking into concerns relating to Mr O Brien before February 2021. In my opinion, Mrs Heather Trouton and Mr Ronan Carroll are best placed to comment on systems and agreements that were established before February 2021.

61.2 As detailed in my response to question 40 above, I took a number of actions to improve the attendance of Radiology, Pathology and Oncology at the Urology MDT. From January 2022, I have also established a monthly report to monitor attendance at all the Cancer MDTs, including urology. The monthly reports are now showing evidence of improved attendance for these core members.

61.3 I am only able to get these monthly reports as the new Cancer MDT Administrator was appointed in January 2022 and this is one of her key roles. Before January 2022, MDT attendance information was recorded in the Annual Report for each Cancer MDT. The Annual Reports were shared with Head of Cancer services (Mrs Fiona Reddick) and I did not receive these reports. This changed from April 2021 and I now receive all the MDT Annual Reports.

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 During my tenure in SHSCT, I have not been involved in any meetings were concerns were discussed regarding Mr O'Brien. I can also confirm that Mr O'Brien has never raised any issues with me, including issues in relation to patient care, patient safety or clinical risks during my tenure in SHSCT.

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 During my tenure in SHSCT, I have never worked within the Surgery and Elective Care Division (which includes Urology Services) or managed Urology Services; therefore I would not have been in contact with Mr O'Brien. For this reason, I did not raise any concerns about the conduct or performance of Mr O'Brien.

63.2 During my tenure in SHSCT, including my current role as Assistant Director of Cancer and Clinical Services from 1 June 2018, I have never raised any issues about the conduct or performance of Mr O'Brien. I would however have raised issues in relation to Urology performance against the 31 and 62 day cancer access targets with the Head of Service for urology during this period.

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 During my tenure in SHSCT, I have never been involved in any meetings regarding concerns identified by Mr O'Brien or others, therefore I have had no involvement in offering support to Mr O'Brien or been in contact with Human Resources in that regard.

64.2 As detailed on my response to question 50 above, from February 2021, I have been working to secure funding for additional resources to support all the Cancer MDTs including Urology. A new Cancer MDT Administrator commenced in the SHSCT in January 2022.

64.3 I have also now received approval to appoint a Cancer Information and Audit Officer to support all the Cancer MDTs (including Urology) with clinical audits that they wish to undertake. Recruitment for this post is underway and I hope to have this new potholder in position by September 2022.

64.4 In terms of quality improvement, I also provide a Macmillan Service Improvement Lead (Mrs Mary Haughey) to support all cancer tumour sites (including Urology) with any improvement work that they wish to progress. Examples of work progressed are summarised in the response to question 51 above.

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 Within the Acute Services Directorate, there is an overarching risk register for the Directorate and a Divisional Risk Register for each Division. The Acute Director

works with the governance lead for the Acute Directorate to maintain the Acute Risk Register. The Assistant Directors for each Division manage their Divisional Risk Register. For example, I am the Assistant Director for Cancer and Clinical Services, and I maintain the Divisional Risk Register for my Division with input from the Heads of Service in my division.

65.2 The Acute Director chairs a monthly Senior Management Team focussed on governance. The Acute Risk Register and the Divisional Risk Registers are shared in the papers for these meetings. At these meetings we review the risks on the Acute Risk Register but not the Divisional Risk Registers, as the Divisional Risk Registers are reviewed within each division.

65.3 I have been a member of the Acute Senior Management Team since March 2010. During this time, I have no recollection of any risk relating to Mr O'Brien being listed on the Acute Risk Register. I would not be aware of any risks logged on the Surgery and Elective Care Divisional Risk Register (which would include Urology), as this would be reviewed at their divisional meetings.

65.4 In terms of the Cancer and Clinical Services Divisional Risk Register, I can confirm that during my tenure as Assistant Director for this area (from 1 June 2018), there were no risks logged on this risk register relating to Mr O'Brien.

65.5 In my opinion, the collective leadership team for the Surgery and Elective Care Division (Assistant Director, Divisional Medical Director, Clinical Director and Head of Service for Urology) are best placed to provide this information and to advise if risks were logged on the risk register or not.

65.6 The Head of Service for Urology was Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date. The Assistant Director for Surgery and Elective Care was Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date.

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 I am now aware of a number of governance concerns relating to the Urology Service that I was not aware of before I received a copy of the Dermot Hughes report in February 2021.

Relevant to Acute, Evidence after 4 November Acute, Document No 77, Melanie McClements, 20210604 E Re SAI Uro Overarching A

66.2 The concerns relating to the Urology Cancer Multidisciplinary Team Meeting (MDT) processes are as follows:

Not all patients with a cancer diagnosis were brought by Mr O'Brien for discussion at the Urology Cancer MDT meeting

66.3 It is the responsibility of the consultant in charge of patients to ensure they are brought to the Cancer MDT for discussion. Previously there was no mechanism to confirm that all patients that should have been brought to the Urology Cancer MDT had been brought; therefore, there was no mechanism to alert this issue to me.

Not all patients with a cancer diagnosis brought by Mr O'Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)

66.4 Through the Dermot Hughes report, it became apparent that Mr O'Brien did not always allocate a CNS to his cancer patients. The Urology CNSs are managed within the Urology Service in the Surgery and Elective Care Division. This issue should have been escalated within the Urology Service and to the Assistant Director for Surgery and Elective Care but to my knowledge, this did not happen.

Having presented and agreed a specific plan for cancer patients at the Urology Cancer MDT, Mr O'Brien deviated from the agreed plan in the delivery of cancer care for some of his patients

66.5 It is the responsibility of the Consultant in charge of patients to ensure they are brought to the Cancer MDT for discussion. A plan for each patient will be agreed at the MDT and it is the responsibility of the Consultant to follow through with this plan. If there was to be significant deviation from the agreed plan, the Consultant must bring the case back to the MDT for further discussion.

66.6 Each Cancer MDT has an assigned Cancer Tracker/MDT co-ordinator. The Cancer Tracker/MDT co-ordinator will track a patient on their cancer pathway from the point of referral until first definitive treatment. The role of the Cancer Tracker/MDT co-ordinator is consistent across all HSC Trusts in Northern Ireland and these posts were previously commissioned by the Health and Social Care Board (HSCB). The Cancer Tracker/MDT co-ordinator will not record any deviation from a plan agreed at the Cancer MDT as this is not in their job description, which is a regionally agreed role and consistent in all Trusts.

72. ***202107 Q66 Cancer Tracker-MDT Co-Ordinator JD located in S21 16 of 2022***

Attachments

There was therefore no mechanism to highlight significant deviation from the plan agreed at MDT. I was therefore unaware that this was an issue with Mr O'Brien.

Ineffective working of the Cancer Multidisciplinary Team meeting due to quoracy / job planning / lack of support

66.7 The role of chair of the Cancer MDT is a challenging one. There is time allocated for this role in consultant job plans, however this time is often insufficient. Although clinicians would ideally want more time set aside for this role, they are mindful that there are only a set number of hours in the week for clinical work

(typically 40) and any increase in time for Cancer MDT work, would mean less time for other clinical work.

66.8 Quoracy at Cancer MDT has always been a challenge during my tenure as Assistant Director for Cancer and Clinical Services from 1 June 2018. Previously a summary of attendance at each MDT would be included within the MDTs Annual Report, with any significant quoracy challenges highlighted by the MDT Chair during the year (which was the case for Radiology attendance to the Urology MDT as noted in my response to question 40 above.)

66.9 Support to Cancer MDT was previously limited. Nationally, new roles have emerged to support Cancer MDTs such as Cancer MDT Administrators. SHSCT have now appointed a Cancer MDT Administrator (Mrs Angela Muldrew) from January 2022. This is the first role of this kind in Northern Ireland.

66.10 Up to April 2021, I did not receive a copy of the MDT Annual Reports as these were sent to the Head of Cancer Services (Mrs Fiona Reddick) and not to me. From April 2021, however, I now receive these reports from the Macmillan Service Improvement Lead (Mrs Mary Haughey). Up to April 2021, I was aware of gaps in attendance relating to Oncology, Radiology and Pathology. These issues and the actions taken to address them, are detailed in my response to question 40 above.

Lack of audit support to Cancer Multidisciplinary Team

66.11 During my tenure in SHSCT, there has been a lack of clinical audit capacity. There is a small clinical audit team within the Medical Director's Office, however the team cannot support the number of audits that the clinical team would wish to do. This issue has been highlighted in Cancer MDT Annual Reports, including Urology. Through attendance at Acute Senior Management Team (SMT), the Director of Acute Services (Mrs Melanie McClements) advised that work was ongoing through the Medical Directors office to increase the size of the clinical audit teams to better support clinical teams. Acute SMT was advised that this would happen gradually as funding became available and that audit support to Cancer MDTs would be prioritised. Subsequently I received approval in June 2022 to appoint a new Clinical Audit and Information Office post that would be dedicated to audits in Cancer MDTs, including Urology. I expect the new postholder to be in post by September 2022.

66.12 As detailed above, I was aware of some of the above issues as they were brought to my attention as described. Some of the other issues, for example in relation to the allocation of CNSs to patients or deviation from actions agreed at the Urology Cancer MDT, I was not aware of as there was no process or resource in place to collect this information.

66.13 During my tenure, I was not aware of any triaging issues relating to Mr O'Brien.

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

67.1 During my tenure in SHSCT, I have never managed the Urology Service or worked within the Surgery and Elective Care Division within which Urology is managed. For that reason, I am not aware of the full details of the concerns relating to Mr O'Brien or what went wrong and why.

67.2 As detailed in my response to question 54 above, I have been a member of the Acute Senior Manager Team (SMT) from March 2010 to date. From 2016 onwards, I was aware that there was a Serious Adverse Incident (SAI) review underway looking at a number of Urology Cases involving Mr O'Brien's patients, however at that time I was not aware of the issues that were under review. I have no recollection of being made aware of the findings of the review which was completed in 2016. It is now my understanding that the issues in the 2016 review are similar to those addressed through the Dermot Hughes report.

67.3 As outlined in question 54 above, I was also aware of issues regarding Mr O'Brien and his patient's charts. I had knowledge of this as it was raised by the Assistant Director of Functional and Support Services (Mrs Anita Carroll) at an Acute Senior Management Team meeting during 2016 (I cannot recall exactly when this happened). Mrs Carroll had advised that charts had been tracked on the Patient Administration System to Mr O'Brien's office but could not be located. Mrs Carroll subsequently discovered that Mr O'Brien had taken the patient charts home. I do not know why Mr O'Brien took the patient charts to his home, but in my opinion this should not have happened as the patient charts need to be available in the hospital in the event that a patient is admitted as an emergency and the clinical team need to access the patient chart.

67.4 In February 2021, I received a copy of the Dermot Hughes report which detailed a number of issues relating to the Urology Cancer MDT and how Mr O'Brien's patients were managed through the MDT processes or not. The Dermot Hughes report detailed a number of areas which needed to be addressed in relation to the Urology Cancer MDT. I was previously aware of the issues in relation to gaps in attendance / quoracy at the MDT and the need for additional audit support; however I was unaware of the following issues:

a. Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer Multidisciplinary Team (MDT) meeting
b. Not all patient with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS)
c. Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

67.5 In my view, each consultant is personally responsible for delivering optimum care for his or her cancer patients and they are accountable to their Clinical Director. This includes bringing patient cases for discussion to the Cancer MDT, availing of the support of the Cancer Nurse Specialist and implementing the plan agreed at the

Cancer MDT. It would now appear that in respect to Mr O Brien's practice for delivering care for his Cancer patients, this was not always the case.

67.6 Having had the opportunity to reflect on the issues that have been raised through the Dermot Hughes report in relation to the Urology Cancer MDT, I believe Mr O'Brien chose to do things his own way rather than to follow the processes that were in place. Mr O'Brien was an experienced Consultant and respected by his colleagues in the Urology Service and in the Trust. Mr O'Brien was also a previous chair of the Northern Ireland Cancer Network Clinical Urology Reference Group. In my view, Mr O'Brien was seen as a figure of authority in the Urology Service, in the Trust and regionally. In that context I can see how it may have been difficult to challenge Mr O'Brien with regard to his practice, however this should have been done at an earlier stage and a conclusion reached earlier.

67.7 It would appear that the review into the care provided by Mr O'Brien to some of his patients has been ongoing from 2016 when the first review was undertaken, up to February 2021 when the Dermot Hughes report was completed. As a Trust, we need to understand why it took five years to complete this process. I have not been involved in these reviews, therefore those that were involved are best placed to advise why the process took this long to complete.

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 In my view, the main learning from the issues of concern within the Urology Services are the recommendations outlined in the Dermot Hughes report that relate to the Urology Cancer MDT. As the Assistant Director for Cancer and Clinical Services, it is my job to ensure that the Cancer MDTs are effective and correctly supported. There are a number of recommendations in the Dermot Hughes report that require additional resources to be put in place to better support the Cancer MDTs and to provide increased monitoring and assurances that the MDTs are working correctly. I am working with my staff in the Cancer and Clinical Services Division to implement the recommendations in the Dermot Hughes report that relate to the Urology Cancer MDT and also applying these to all eight Cancer MDTs. The work being progressed is detailed in my response to questions 57 and 59 above.

68.2 In terms of the learning regarding concerns relating to Mr O'Brien in particular, I have not been involved in any of processes looking into the Mr O'Brien's practice. In general, however, I would say that the processes have taken too long and the issues should have been resolved at an earlier stage. As a Trust, we need to understand why the processes took from 2016 up to February 2021 to complete.

68.3 In my view, another key learning point is that all Trust employees in the Trust should follow the rules that are in place. If any employee does not follow the rules (regardless of their position of authority), they should be held accountable for that at an early stage and corrective action taken.

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 During my tenure in SHSCT, I have never managed Urology Services or worked with the Surgery and Elective Care Division (which includes the Urology Service). As an Assistant Director working in other parts of the Acute Directorate, I would not know how the Urology Service functioned as a specialty team or how they engaged with their Head of Service, Assistant Director of Clinical Director. I would therefore not know if there was a failure to fully engage or not.

69.2 As far as I was aware, the Urology Service was managed through a collective leadership model in the same was as all other specialties in the Acute Directorate. The collective leadership team consists of an Assistant Director, Divisional Medical Director, Clinical Director and Head of Service. The Head of Service for Urology was Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date. The Assistant Director for Surgery and Elective Care was Mrs Heather Trouton from 2010 to March 2016 and Mr Ronan Carroll from April 2016 to date.

69.3 I would expect that significant issues within the Urology Service would have been discussed at Urology Specialty meetings and at Surgery and Elective Care Divisional meetings. Given that I did not work in the Urology Service or within the Surgery Elective Care Division I did not attend these meetings. I am not aware if these discussions happened at these meetings. In my view, the best person to confirm if this happened is the Head of Service for Urology (Mrs Martina Corrigan from 2010 to September 2020 and Ms Wendy Clayton from October 2020 to date.

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 During my tenure in SHSCT, I became Assistant Director for Cancer and Clinical Services / Integrated Maternity and Women's Health from 1 June 2018. This was a large Division of around 1,300 staff and a budget of £62m. There were five Heads of Services reporting to me as the Assistant Director as follows:

a. Head of Cancer Services - Mrs Fiona Reddick
b. Head of Acute Allied Health Professionals - Ms Cathie McIroy
c. Head of Radiology, Neurophysiology and Audiology – Mrs Jeanette Robinson
d. Head of Laboratory Services - Mr Geoff Kennedy
e. Head of Midwifery and Gynaecology - Mrs Patricia McStay

70.2 Each of these five service areas had major challenges at this time. For example, in Maternity Services there were a number of clinical incidents [redacted]. This meant that I had to allocate more of my time to this part of my portfolio, which meant I had less time to focus on the other areas including Cancer Services. I believe this is an important point by way of context – i.e. at any time, I was dealing with many complex issues across the Division.

70.3 The Integrated Maternity and Women's Health Division was a standalone Division from April 2007 up to March 2016, when the Acute Directorate was re-structured by the Director of Acute Services at that time, Mrs Esther Gishkori and then Integrated Maternity and Women's Health was coupled with Cancer and Clinical Services in April 2016, creating the large Division that I took over from 1 June 2018. Early in 2021, I escalated work pressures to the Director Acute Services (Mrs Melanie McClements) and she agreed with me that the Division needed split in two. Mrs McClements was supportive and she secured approval from the Chief Executive (Mr Shane Devlin) to adjust the structure and from 1 June 2021, Integrated Maternity and Women's Health reverted to being a standalone Division, with Cancer and Clinical Services Division becoming a smaller but still a busy Division.

70.4 In my view, the decision taken by Mrs Esther Gishkori in April 2016 to couple Cancer and Clinical Services with Integrated Maternity and Women's Health as a large acute Division was a mistake.

70.5 During my tenure as Assistant Director for Cancer and Clinical Services, I worked with the Head of Service for Cancer Services (Mrs Fiona Reddick) to support her in managing these services. As detailed in my response to question 7 above, the Head of Cancer Services focussed on four broadareas as follows:

a. Delivering against the access standards for cancer patients on 14 days, 31 days and 62 days pathways
b. Providing the Cancer Tracking function and multi-disciplinary team (MDT) meeting co-ordinator support to Cancer Multidisciplinary Teams Meetings.
c. Supporting the Peer Review process
d. Delivery of local Oncology Outpatient Services in Mandeville unit supported by Oncologists outreaching from Belfast Trust

70.6 During my tenure as Assistant Director for Cancer Services, my primary focus was on performance against the 14, 31 and 62 Day targets. I had a clear line of sight to performance information through monthly reports and the monthly Cancer Performance meetings. With regards to the Cancer MDTs however, I did not have a clear line of sight, as I did not receive the Annual Reports from the Cancer MDTs and there was no monthly reports to show me how the Cancer MDTs were working. The absence of monthly reports from the Cancer MDTs was not a mistake as such, as the processes in place were the same as they were since the establishments of the Cancer MDTs in 2007.

70.7 The concerns that have emerged in the Urology Services however have shown that additional monitoring of the Cancer MDTs was needed. Linked to the implementation of the recommendations in the Dermot Hughes report, I now receive monthly reports showing how the Cancer MDTs are working. This provides me with greater assurance and highlights issues to me at an earlier stage that need to be resolved.

70.8 I believe the arrangements previously in place to support the Cancer MDTs in SHSCT were broadly in line with those arrangements in place in other Trusts – i.e. Annual report for each Cancer MDT, no monthly reports and no MDT Administrator in post. As detailed in my response to question 57 above, the National Cancer Audit Team (NCAT) baseline audit completed between June and August 2021 highlighted areas for improvement. Other Trusts are currently completing the NCAT baseline audit tool to benchmark the effectiveness of their Cancer MDTs and they are looking to the improvement work in SHSCT to see what learning is transferable across Northern Ireland.

70.9 During my tenure as Assistant Director for Cancer and Clinical Services, the Peer Review process has been a rolling programme of independent review of how cancer services are being delivered in each Trust. It is my understanding that the schedule of Peer Reviews are set by the Northern Ireland Cancer Network (NICAN) and focus on a specific cancer tumour site when completed. To the best of my knowledge, no Peer Review has focussed specifically on MDT processes and with hindsight; this would have been helpful and may have highlighted some of the issues that have arisen in the Urology Service at an earlier stage.

70.10 The Peer Review process was stood down at the start of the COVID 19 Pandemic in April 2020 and has not yet recommenced.

70.11 In terms of mistakes made by others, as stated in my response to question 68 above, I have not been involved in any process looking into the practice of Mr O'Brien. I am aware that these processes have been ongoing since 2016. As a Trust, we need to understand why the processes took from 2016 up to February 2021 to complete. In my opinion, it would have been better if this process could have been completed sooner.

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 Given the concerns that have emerged in the Urology Service, and the length of time it has taken to complete the review in the practice of Mr O'Brien, it is clear that the governance arrangements have not been fit for purpose in this case.

71.2 I have been an Assistant Director in Acute Services and a member of the Acute Senior Management Team since March 2010. During this time, it is my view that the governance arrangements worked reasonably well.

71.3 All the Assistant Directors were concerned that the resources in place to support governance were insufficient to ensure that incidents are reviewed in a timely way, learning identified and actions taken to make improvements. This has been an ongoing challenge in the Acute Directorate and has been raised with Directors of Acute during my tenure. The current Director (Mrs Melanie McClements) appointed two additional Band 7 staff in August 2021 to support the Assistant Directors in matters relating to governance. More recently, Mrs McClements has also approved the appointment of four Band 5 Governance staff to provide additional governance support to the Acute Divisions with an expected start date of October 2022.

71.4 Clinical audit is a key part of any governance system as this is one way which we provide assurance that services are being delivered to a high standard. Clinical audit is also used to provide assurance that learning from incidents has been embedded into clinical practice. Concerns about the lack of clinical audit support to the Cancer MDTs has been noted in the MDT Annual Reports, including for the Urology MDT. I raised this issue with the Director of Acute Services in May 2022 and approval was given to appoint a new post to provide clinical audit support to the Cancer MDTs. The recruitment process is underway and I hope the postholder will be in place by September 2022.

71.5 More generally, there continues to be a deficit in clinical audit capacity in the Trust. It is my understanding that work is ongoing to expand the Trust clinical audit team which sits within the Medical Director's Office. The Medical Director (Dr Aisling Diamond and Dr Damian Gormley covering currently as the post is vacant – recruitment underway) are best placed to provide more detail on this.

71.6 In the context of the issues of concern which have emerged in the Urology Service linked to the Urology Cancer MDT, I believe the previous governance arrangements relating to the Cancer MDTs were not sufficiently robust to identify the issues in Urology. The governance arrangements were not sufficiently robust because:

a. Attendance information was recorded at each MDT meeting, however this information was only summarised in the Annual Report, which was not always shared with the Assistant Director of Cancer and Clinical Services
b. Key worker information was not recorded for each patient
c. No information was recorded to show if a Cancer Nurse Specialist was allocated to each patient
d. There was no cross check mechanism to confirm that all cancer cases diagnosed in the Cellular Pathology Laboratory are brought to the MDT for discussion
e. There was no Cancer MDT Administrator role commissioned to oversee the working of the Cancer MDTs

71.7 A Cancer MDT Administrator (Mrs Angela Muldrew) was appointed in January 2022. They are now leading on establishing robust governance arrangements around the Cancer MDTs as detailed in my response to question 59 above.

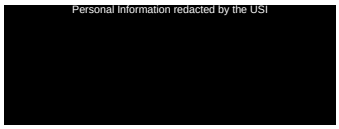
72. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

72.1 I have nothing further to add.

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 

Date: 30/06/2022

Section 21 Notice Number 16 of 2022

Witness Statement of Barry Conway

Attachments

Attachment	Name
1	20070906 Q5 JD Head of Service Emergency and Unscheduled Care
2	20110201 Q5 JD Assistant Director for MUSC
3	20160401 Q5 JD Assistant Director for Strategy and Service Improvement
4	20070301 Q5 JD Assistant Director for Function and Support Services
5	20070301 Q5 JD Assistant Director for IMWH & CCS
6	20120621 Q5 TYC Unscheduled Care Update Barry Conway
7	20220401 Q8 Acute Directorate Risk Register
8	20220516 Q12 31 and 62 Day Cancer Performance for Urology Tumour Site
9	- 20210730 Q12 Cancer Rebuild Plan Update
10	- 20210730 Q12 New GP Red Flag Referrals Report
11	- 20210730 Q12 New GP Red Flag Longest Waiters Report
12	20210730 Q12 Longest Waiters by Tumour Site Report
13	- 20190117 Q12 Lynn Lappin Internal Notes HSCG Cancer Performance Meeting 2019-2021
14	- 20201125 Q12 ST Cancer Performance Meeting Presentation
15	- 20210318 Q12 Approved Performance Committee Minutes
16	- 20210318 Q12 Performance Committee Diagnostics Presentation
16a	16a20210318 Q12 Performance Committee Agenda
17	- 20210520 Q12 Approved Performance Committee Minutes
18	- 20210520 Q12 Performance Committee Cancer Presentation
19	- 20210520 Q12 Performance Committee Agenda
20	- 20181127 Q12 Acute SMT Performance Meeting Minutes
21	- 20190326 Q12 Acute SMT Performance Meeting Minutes
22	- 20190625 Q12 Acute SMT Performance Meeting Minutes
23	- 20200128 Q12 Acute SMT Performance Meeting Minutes
24	- 20210322 Q12 Acute SMT Performance Meeting Minutes
25	- 20210920 Q12 Acute SMT Performance Meeting Minutes
26	- 20211004 Q12 Acute SMT Performance Infographic Phase 6 August SDP
27	- 20211018 Q12 Acute SMT Performance Infographic October 2021
28	- 20200626 Q12 Cancer Reset Cell Terms of Reference
29	- 20210115 Q12 Cancer Reset Cell Record of Discussion Action Points
30	- 20210226 Q12 Cancer Reset Cell Record of Discussion Action Points
31	- 20210722 Q27 Performance and Personal Development Review Policy
32	20120905 Q27 Barry Conway PDP 2012
33	20170201 Q27 Barry Conway PDP 2017
34	20191204 Q27 Barry Conway PDP 2019
35	20210504 Q27 Barry Conway PDP 2021
36	20181218 Q28 Email Urology Escalation
37	20190919 Q28 Email Urology Escalation
38	20220126 Q28 Email Urology Escalation
39	20220704 Q28 Email Urology Escalation

40	20220304 Q28 Minutes Cancer Checkpoint Meeting
41	20220401 Q28 Agenda Cancer Checkpoint Meeting
42	20220401 Q28 Cancer Rebuild Plan Update
43	20220401 Q28 New GP Red Flag Referrals Report
44	20220401 Q28 New GP Red Flag Longest Waiters Report
45	20220401 Q28 Longest Waiters by Tumour Site Report
46	201906 Q28 Pen Portrait – CCS & IMWH Division
47	20181018 Q35 Cancer Performance Meeting Agenda
48	20190117 Q35 Cancer Performance Meeting Agenda
49	20210924 Q35 Cancer Checkpoint Meeting Agenda
50	20220510 Q35 Corporate CPD Performance Scorecard
51	20220519 Q35 Corporate CPD Performance Scorecard Narrative
52	202105 Q37 MDT Administrator and Projects Officer JD
53	202201 Q37 MDT Principles Document
54	201502 Q37 Cancer Information Pathway Recording Form
55	202205 Q37 Cancer Information and Audit Officer JD
56	202205 Q37 MDM Attendances 2022
57	202204 Q40 Acute Directorate Risk Register
58	20210505 Q40 Email confirmation of additional cellular pathologist
58a	20181127 Q40 Email from Fiona Reddick Re Radiology Attendance at Urology MDT
59	20220617 Q48 MDM Attendances Report May 2022
60	2020 Q51 Urology Local Action Plan
61	201112 Q51 Transforming Your Care Review of HSC NI Final Report
62	202206 Q51 MDT Service Improvement Action Plan
64	20211011 Q55 TOR Trust Task and Finish Group into Urology SAI Recommendations
65	20210913 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
66	20211011 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
67	20211108 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
68	20211206 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
69	20220207 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
70	20220307 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
71	20220404 Q55 Notes from SAI Recommendation Implementation Super Group Meeting
72	202107 Q66 Cancer Tracker-MDT Co-Ordinator JD

General Manager - Medicine and Unscheduled Care

Ref: 88207133
Closing Date: 11 July 2007 12:00
Location: To be confirmed
Contract: Permanent
Salary: Band 8B (£39,346 - £50,733)
Hours: Full-time / Job Share
Interview Dates: To be confirmed

Southern Health and Social Care Trust

Job Description:

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE: General Manager – Acute Clinical Services

BAND: 8b

REPORTS TO: Assistant Director of Acute Services – Medicine & Unscheduled Care

JOB SUMMARY

- The General Manager is accountable to the Assistant Director of Acute Services – Medicine & Unscheduled Care (M&UC) for the leadership and direction of staff within the relevant specialities.
- The post holder has overall responsibility for the operational management of the services, to ensure that programmes are identified and managed to improve the service provided to patients through improved performance, improved quality and an improved patient experience.
- The post holder will be responsible for budget and for delivering financial balance within their area of responsibility and the management of cost improvement programmes to support the achievement of balanced budget.
- The post holder will ensure that staff are fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals are fully involved at the forefront of service improvement initiatives.
- The post holder will provide Managerial Leadership for the staff within the relevant speciality(s) in order to support the delivery of high quality clinical services for patients.
- The post holder will work in collaboration with the Lead Clinician(s) and Lead Nurse (s) and develop a team approach to the clinical services for which they are accountable.

KEY RESULT AREAS

Service Delivery

1. Provide leadership and direction to staff so that agreed objectives and policies set are achieved.
2. Be accountable for the effective and efficient operation of clinical services.

3. Ensure that management is provided with advice and information required to formulate policies, decide priorities, set and achieve objectives and monitor progress in collaboration with the Lead Clinician(s).

4. Review service provisions defining priorities and objectives in order to maintain and further develop the services.

5. Undertake mapping of existing strategy services and policies and outline appropriate action plans for improvement in collaboration with the Lead Clinician(s).

6. Lead service change working with key stakeholders to redesign plan and deliver improvements to patient care pathways in collaboration with the Lead Clinician(s).

7. Empower and engage all staff and ensure involvement at all levels to achieve new ways of working and implement alternative models of service delivery.

8. Responsible for management of all staff including medical staff, ensuring good systems are in place for annual leave, sick leave and appropriate plans in place for replacing staff including short notice absences.

9. In line with regional guidance review access and waiting times, agree key target priorities and ensure targets are met both locally and regionally.

10. Be responsible for the development, implementation and ownership of effective information and communication systems and co-ordinate working practices between staff within the clinical service(s).

11. Contribute to the continuing success of the Acute Services Directorate, assisting in the delivery of the Corporate agenda by way of specific objectives, projects and initiatives.

12. Work in collaboration with key stakeholders to enhance and improve services.

13. Respond to patient complaints, learn lessons and implement improvements as a result of such complaints

14. Monitor and regularly review the flow of patients and staffing levels/mix to improve productivity and efficiency applying the principles of lean. Lead the implementation of necessary actions to develop, implement and maintain a flow system which "pulls" patients through.

Quality

1. Ensure that the needs of the patients and their carers are at the core of the way M&UC deliver their services.

2. Ensure that practice and service developments are underpinned by the most up to date evidence based research.

3. Work in partnership with the Lead Clinician(s) to ensure that M&UC services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

4. Work in partnership with the Lead Clinician(s) and working with the full range of staff groups, lead innovation and change to underpin the modernisation within M&UC.

5. Establish and maintain clear systems and processes for accountability and performance management within M&UC.

6. Monitor and support the use of clinical guidelines and protocols for staff within the M&UC.

7. Ensure public involvement of users and carers in the planning of services within the M&UC.

8. Actively seek and encourage feedback from users to enable continuous improvement plan for implementation with the support of the Lead Clinician(s).

9. Participate in quality initiatives such as eg: Investors in People and any relevant Charter standards.

10. Work in partnership with the Lead Clinician (s) to ensure robust clinical governance and risk management systems are in place within M&UC ensuring corrective action plans are developed and implemented.

11. Work in partnership with the Trust Governance management to support the quality and clinical & social care governance agenda.

Strategic Planning and Development

1. Support to Assistant Director Medicine & Unscheduled Care with the development of the strategic plan for the delivery of Medicine & Unscheduled Care services in line with regional, Ministerial and HSCA priorities.

2. Assist with corporate initiatives aimed at cost effectiveness and improving patient flow

Financial and Resource Management

1. Manage the M&UC budget and ensure the meeting of all financial targets

2. Develop and promote staff understanding of the financial requirements in order to ensure opportunity to maximise income generation potential in the delivery of services

3. Lead the achievement of cash releasing schemes within M&UC for relevant specialties.

4. With the support of the Lead Clinician(s) to review demand and capacity within M&UC utilising the Real Capacity Model and implement a programme of service changes to improve the matching of demand, capacity and target performance.

5. Ensure the effective deployment of staff and skills to ensure all standards and targets are achieved to maximise staff performance and retention through training and development and modern employment practices.

6. Ensure the effective use of equipment and facilities within M&UC to optimise patient care and service delivery.

7. Lead on all relevant capital investment and service development proposals, liaising with multi-disciplinary colleagues as and when required.

People Management

1. Provide clear leadership to M&UC staff and ensure that highly skilled and motivated staff support M&UC where/when requested.

2. Lead the development and implementation of workforce reform and modernisation initiatives within M&UC, as and when required.

3. Ensure compliance with employment legislation, HPSS directions and Trust standard orders, policies, procedures and regulations by introducing appropriate systems, management and control processes within M&UC.

Corporate Management

1. Assist with Trust's corporate planning by supporting the Assistant Director, Acute Services – M&UC.

2. Develop and maintain working relationships with other General Manager colleagues and to ensure achievement of M&UC objectives and the effective functioning of all relevant services.

3. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure M&UC effectively discharges its functions

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

Leadership

1. Lead the operational management within M&UC ensuring priorities meet objectives

2. Provide leadership to staff within M&UC to ensure the delivery of safe, effective patient care and to enable effective sharing of knowledge, ideas and skills through the development of a culture of continuous improvement

3. Ensure all M&UC policies are operationalised appropriately and proportionately.

4. Promote positive working relationships within all relevant specialties and be empathetic to the implications of service developments or changes for other parts of the Acute Hospital services.

5. Ensure strong professional leadership across M&UC.

6. Ensure the development of robust mechanisms for consistent communication with M&UC staff to enable them to influence the health agenda.

7. Establish, implement and maintain standards of practice within all relevant specialties consistent with the standards of the relevant professional bodies.

Monitoring and Reviewing Performance

1. Responsible for developing robust performance indicators within M&UC, translating regional indicators/targets into speciality targets, ensuring monitoring control and remedial action systems are in place.

2. Responsible for the performance against the plan for M&UC, ensuring financial balance is achieved.

3. Manage M&UC inpatient and day case and outpatients access targets and ensure the required level of performance is achieved and that safe care is delivered at all times.

4. Lead on activities to review the effective use of resources and facilities within all relevant specialties and improvements that may be made in the achievement of the M&UC strategy or objectives

5. Ensure the M&UC plans are in place to monitor achievement against corporate objectives, eg: Junior Doctor compliance, waiting time targets for access and governance etc. Assess level of risk to delivery of required performance and address all relevant issues by expedient management action.

6. Ensure adherence across M&UC to all Trust policies and procedures and contribute to their formulation as appropriate.

7. Ensure that robust performance arrangements are development and implemented within M&UC.

General Management Responsibilities

1. 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 initiative, where appropriate, further training

2. Ensure that the review of performance identified above is performed for all levels of staff within the postholder's remit of responsibility in accordance with the Trust Board's policy

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

4. Review the organisational plan within the postholder's remit of responsibility and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate

5. 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 the outputs of the relevant services within the postholder's remit of responsibility.

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

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

8. 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

9. Ensure that the principle of public participation is adhered to through commitment to involving service users, their carers and the wider public in all decision making that affects them as individuals or as a community through a range of consultation processes

10. All staff have a responsibility to ensure that a high standard of cleanliness is maintained throughout Trust facilities as this is essential for the delivery of Health and Social Care 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

Personnel Specification:

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health & Social Care Trust and:

- university degree or relevant professional qualification and worked for at least 2 years in a senior management role*

OR

- worked for at least 5 years in a senior management role*

AND

- Delivered against challenging performance management programmes meeting a range of key targets and making significant** improvements.

- Possess excellent communication and interpersonal skills with a proven track record of having worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years within the last 6 years.

- A proven track record of people management, governance and organisational skills for a minimum of 2 years within the last 6 years.

**"senior role" is defined as experience gained as Head of Service, Team Manager or Team Leader or equivalent.

***"significant" is defined as contributing directly to key corporate objectives of the organisation.

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 extent 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, details of which can be accessed at nhsleadershipqualities.nhs.uk.

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
- Collaborative working

June 2007

Other Information:

Informal and confidential enquiries about the post may be made to Mr Lindsay Stead, Assistant Director of Medicine & Unscheduled Care.

Downloads: SHSCT rpa + pocva

Instructions: Instructions for Completing Application Form

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]

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[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

Assistant Director of Acute Services

Strategy, Reform and Service Improvement Band 8C

Job Description

JOB SUMMARY

The post holder will be responsible to the Director of Acute Services for setting the Strategic Direction for Acute Services. The post holder will lead on the development and implementation of a rolling program for Strategic Reform and Service Improvement for the Acute Services. The post holder will work in partnership with the operational Assistant Directors and their teams to lead major strategic reform and service improvement projects in the Directorate as well as across other Directorates in the Trust.

The post holder will lead on the development of an Acute Strategy for the Directorate and will ensure Strategic Reform and Service Improvement work undertaken is in line with the Acute Strategy and Trust's Three Year Strategic Plan – *'Improving Through Change*' and key regional strategy papers including *'Quality 2020'* and *'Transforming Your Care'*.

As an Assistant Director, the post holder will be a key 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

Strategic Direction and Reform

- To lead on the development of an Acute Strategy which will set the strategic direction for the Acute Directorate for the next ten years

- Within the context of the Acute Strategy and the Trust's Three Year Strategic Plan – '*Improving Through Change*', to lead on the development of a 3 year rolling Strategic Reform and Service Improvement work plan for Acute Services
- To set a clear strategic direction for the future of acute services across Craigavon Area Hospital, Daisy Hill Hospital and South Tyrone Hospital sites. This will include being the Acute Services lead for major capital development projects
- To scope, design, plan and deliver significant Strategic Reform Projects in partnership with Operational Divisions, the Planning Directorate and other key stakeholders. This will include the use of key project management methodologies, project plans, risk logs and quality impact assessments
- To ensure Strategic Reform Projects are based on a solid foundation of clinical engagement and are supported by best practice
- To ensure appropriate data collection systems are in place or established to ensure major changes are evidence-based and expected improvements can be quantified and monitored
- To use excellent analytical skills to interpret and evaluate complex information / problems to support difficult discussions with key stakeholders, leading to key decision making to deliver against corporate objectives
- To represent the Trust and the Acute Directorate at key Strategic forums both within the Trust and regionally
- To continuously 'horizon scan' for key reform opportunities for the Directorate and to lead of progressing key work to improve the quality and efficiency of service provided to patients

Service improvement

- To ensure service development projects are in the context of Acute Strategy
- To foster a culture of Service Improvement at all levels in the Acute Directorate
- To work with senior operational managers to ensure timely delivery of projects in line with project plans and key deliverables
- To ensure alignment of projects to patient experience, patient safety, and organisational objectives
- To apply creative and innovative techniques to service improvement, drawing on work from a range of sectors including non-healthcare
- Ensure evidence based practice is fully and effectively deployed where possible in all service improvement projects

- To continuously 'horizon scan' for key reform opportunities for the Directorate and to lead of progressing key work to improve the quality and efficiency of service provided to patients

Service Planning and Development

- To ensure service planning and development are progressed in the context of the Acute Strategy and the Trust's Three Year Strategic Plan – '*Improving Through Change*'
- To ensure service planning and development are progressed in the context of key regional strategies such as '*Quality 2020'* and '*Transforming Your Care'*.
- To promote innovation and change to underpin the modernisation of the Acute Directorate's Services and oversee the implementation of such initiatives in partnership with other Assistant Directors in the Directorate
- To lead discussions with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- To lead discussions 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.
- To be a key member of the Directorate's senior management team and contribute to its policy development processes.
- To deputise for the Director at Trust Senior Management Team or key regional meetings when requested to do so

Financial and Resource Management

- To support operational Assistant Directors to bring forward plans for Strategic Reform and Service Improvement which deliver service improvements and deliver financial savings
- To 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 across the Directorate 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 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 Medicine and Unscheduled 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.

Southern Health and Social Care Trust
Assistant Director of Acute Services

Strategy, Reform and Service Improvement

Personnel Specification

Knowledge, skills and experience required:

Applicants must have:

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

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

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 organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational 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 extent 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 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;

“significant” is defined as contributing directly to key corporate objectives of the organisation.

April 2016 v2

Southern Health and Social Care Trust
Assistant Director of Acute Functional and Support Services

Band 8C

Job Description

JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality support services to patients in the Trust's acute hospital sites i.e. Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. As the divisional assistant director, he/she will oversee the operational management of a range of functional and support services which will include hospital administration, laundry, facilities management, telephony, CSSD, catering, health and safety and mortuary services. He/She will collaborate closely with senior colleagues and clinicians to implement the objectives of the Trust's Delivery Plan and ensure effective team 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 teams of staff in functional and support services and oversee the co-ordination of all processes to facilitate the delivery of high quality and equitable care to patients in the Trust's acute hospitals.
- ensure all support and functional services are delivered in accordance with best value principles and Trust service priorities with a particular emphasis on those relating to patient/visitor safety and user experience.
- establish effective working relationships with other senior staff in the Trust's community based settings to ensure the effective use of Trust resources.
- ensure effective engagement with patient user groups so as to enable their input to improved facilities for patients and their families.

Quality and Governance

- ensure that the needs of patients and their families are at the core of how all support services are delivered and are in accordance with DHSSPS *Quality Standards for Health and Social Care* and other relevant requirements.
- ensure high standards of governance to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's *Safety First* framework.
- ensure all support services comply with regulatory and requisite standards.
- work closely with senior colleagues to ensure high standards of ambience and environmental cleanliness in the hospital.
- 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 and Trust complaints 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 for support services.

Service Planning and Development

- promote innovation and change to underpin the modernisation of the hospital's support services and oversee the implementation of associated initiatives.
- work closely with relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning and estates staff on minor works 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 service.
- 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.

- 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 services 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 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.

- 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 Functional and Support Services 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
Assistant Director of Functional and Support Services

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of either Armagh and Dungannon, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

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

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

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 organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational 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 extent 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 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;

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

March 2007

Southern Health and Social Care Trust
Acute Services Directorate

Assistant Director of Integrated Maternity and Women's Health and Cancer and Clinical Services
Band 8C

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 Division. S/he will be responsible for the operational management of all specialties and departments in the Division which will include gynaecology, maternity, obstetrics, cancer, radiology, pharmacy and laboratories services in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. S/he will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. S/he 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 maternity and women's health 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 patient safety and access targets.

- work closely with senior clinicians and other senior managers in the Trust to ensure effective co-operation and seamless service delivery in maternity and neonatal services.
- 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 and Trust complaints 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 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 Integrated Maternity and Women's Health 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
Assistant Director of Integrated Maternity and Women's Health

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of either Armagh and Dungannon, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

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

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

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 organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational 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.

Workstream update as at **[insert date]**

Transforming Your Care - PCP Unscheduled / Scheduled Care Action Plan			
Issue	**Agreed action**	**Action owner**	**Action status-update**
GPs requesting pathway required for acute musculoskeletal cases (< 1 week)	Dr Maiden to be approached for her views on potential pathway for acute musculoskeletal cases. Dr Rankin and Angela McVeigh also to be approached	B Conway	
Back Pain pathway	Back pain pathway to be shared with Dr McCollum once agreed through sub group. Clarification also to be sought from R Carroll on the timescales within which referrals will be dealt with.	B Conway	
Direct access MRI for GPs	Dr Hall and R Carroll to be asked to consider how GPs could be given direct access to MRI for specific cases.	B Conway	
Same day investigation and report for plain film chest x-rays	Radiology MCN to be asked to consider making a service available to GPs for same day investigation and reports for plain film chest x-rays.	B Conway	
GP access to specialist opinion	AMDs to consider how telephone access can be provided (Monday-Friday) to the following: - Surgeon - Cardiologist - Geriatrician - Paediatrician - Gynaecologist - Emergency Department	B Conway H Trouton	
Assessment of chest pain	ED consultants, physicians and Cardiologists to consider an improved pathway for the management of patients with chest pain	B Conway	

Venesection activity in CAH Day Clinical Centre	Dr McCollum to link with LCG to establish a LES for Venesections in A&D and C&B localities	K McCollum	
Headache pathway	Dr Forbes to be asked to provide a pathway for GPs for headache. In the first instance, Dr Forbes to meet with Dr McCollum.	K McCollum	
Dermatology – nurse-led Acne virtual clinic	Dr McCollum to send test referrals to Jeannette Collins to test the process B Conway to link with K Carroll / Jeanette to put processes in place to support this clinic (including Personal Information redacted by the USI [redacted])	K McCollum B Conway	
Ambulatory Paeds	Clarification to be sought from G Maguire – is a paediatric doctor available to take calls from GPs requesting advice or admission	B Conway	
Post-operative complications	Where appropriate, patients with post-operative complications should be streamed from ED triage to the specialty. Processes to be put in place for ENT and Gynae in the first instance	H Trouton	
Surgical assessment unit in CAH	Surgical assessment unit to be established in 4 North. Referral pathway to be agreed	H Trouton	
USC MCN GP referral reports	Latest USC MCN GP referral reports to be shared with Dr McCollum. Barry to progress through Seanin Ward	B Conway	
GP referral audit	Spreadsheet to be compiled with all the details of the ED GP referral audit information	B Conway	
Primary Care Joint injection	Dr Evans leading a sub group to establish a primary care joint injection service.	A Evans	
ENT			

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

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

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

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4196	ACUTE	16/12/2021	Safe, High Quality and Effective Caref Effective organisational governance	Limited implementation and adherence to MCA NI 2016, completion of required STDO and TPA for all patients who lack capacity	Limited Implementation and adherence to the MCA NI 2016 , COMPLETION OF REQUIRED STDO and TPA for all patients whom are deemed to lack capacity in specific decisions .	The DOH training is available to all MDT staff and a live register is maintained of all MDT staff whom can complete the required statutory assessments and documentation , however due to all MDT staff workload capacity and also confidence there is minimal identification of these patients and therefore very low numbers of STDO IN Acute Hospitals .Lead Nurses have been asked to ensure when 1-1 ARE BEING REQUESTED AT WARD LEVELS THESE ARE NOT APPROVED FOR PERSONS WHOM LACK CAPACITY UNLESS A STDO process has commenced .MCA should form part of all daily WBM discussions .The current SOP is not fully implemented as these patients are not being identified early in their journey from ED also. All MDT should agree which staff member / profession is best placed to take forward the MCA process STDO / TPA, this should be shared equally among professions The current STDA are under the management of MHDD Additional bespoke training is available within the SHSCT for any MDT staff group to develop skills and knowledge	18/12/2021- Plan in 2022 that the STDA Team (4.0 wte staff) will come under the operational management of Acute / Non Acute and will suit within HSW management structure's , this will allow more focused work and support to wards , however the challenge will be developing MDT staff to take forward this work as part of their day to day duties	HIGH
4184	ACUTE	04/10/2021	Safe, High Quality and Effective Caref Effective organisational governance	Misuse of POCT devices and non compliance with clinical governance procedures across the Trust	POCT demand has increased exponentially across the Trust, particularly in response to the Covid pandemic. Mistakes made during the course of POCT analysis and incorrect results acted on by the clinical team can have life-threatening consequences for the patient. The risk is not limited to the POCT team; the risk is applicable to all of the clinical teams across the Trust who are performing POCT and relying on the results to inform patient management. All of the following will cause incorrect results to be produced which, if acted upon, could be fatal for the patient and leave the Trust open to litigation: -Poor sampling technique resulting in poor quality of sample. -Lack of training or knowledge on the part of the operator regarding proper and correct use of the POCT device. -Lack of knowledge or reluctance regarding how to perform internal quality control and calibration (this checks if the machine is producing the correct results). -Inadequate compliance with external quality assurance procedures (this checks that the entire procedure from sampling through to result transmission is working as it should). -Lack of understanding of what will adversely affect results e.g. haemolysis, icterus, lipaemia, incorrect storage temperature for reagents. -Poor cleanliness and maintenance of the device and surrounding area. -Use of incorrect or out of date IQC/calibration or test cassettes. Other risks for the patient -Not using the correct H&C number - result will not transmit to NIECR. -Patient HCN mix up, results going into the wrong patient file. -Staff sharing barcodes - risk of an untrained operator using the device incorrectly. -Lack of POCT team support to deal with issues such as poor IQC/EQA performance and -troubleshooting. -Lack of IT support for issues such as devices losing connectivity. In addition, not all devices are able to connect to the Trust network so there is an increased risk with such devices where the POCT team are unable to adequately monitor their performance. -Users not informing POCT of issues with devices when they arise. Risk of faulty device being used to generate inaccurate results that are acted on by the clinical team. The risks to the user and patient are significantly more substantial than risks associated with performing tests in the main laboratory which is staffed by fully trained laboratory staff. Staff performing POCT have basic training in operating the devices and must adhere fully to the rules set out by the POCT team. Mistakes can have serious, fatal outcomes for the patient if the results produced are incorrect or misinterpreted and subsequently acted upon by the clinical team. Staff not adhering to the rules and standard operating procedures as laid down by the POCT team are open to disciplinary procedures. Mistakes made during the course of POCT analysis can leave the Trust open to litigation from the patient. The POCT team regularly audits aspects of the POCT devices and operators. There are repeated instances of staff sharing barcodes, not using H&C numbers, poor maintenance and cleanliness of equipment, failure to run IQC and EQA, poor sampling technique affecting sample quality, incorrect test cassettes being used,	- Online and/or face to face training available for all devices - training sessions are organised and readily available on request from the POCT team. - POCT staffing - POCT staffing has been extended but staffing levels have fluctuated with staff leaving and being replaced. There is a requirement for a Band 6 BMS to provide support to the POCT Band 7 and robustness across the service, particularly with the continuing increase in demand for POCT across all sites. - SOPs and information are available for all devices on the laboratory website and Sharepoint. - Regular audit of POCT in clinical areas is highlighting problems with regards device maintenance, compliance with IQC/EQA etc, and this information is regularly disseminated to all Heads of Service and Lead Nurses in areas of the Trust that use POCT. The emphasis is on these individuals to enforce the compliance with POCT rules within their teams in order to satisfy clinical governance requirements. - IT support is a constant issue within POCT and causes serious delays in troubleshooting and installation of POCT devices. We are currently recruiting a Band 6 IT person for labs, but they will require proper access and administration rights to IT systems (particularly cyber-security) in order to complete their work. This could be a problem if IT are unwilling to co-operate in this respect. These controls are effective to a certain extent, but non-compliance with POCT regulations within the clinical teams is a critical ongoing issue that is possibly not being taken seriously enough across the Trust. The risk to the patient is significant. Removal of devices from clinical areas where non-compliance with POCT rules has been identified as a serious issue - this will only be as a last resort, particularly in areas such as ED where POCT is essential for patient flow (e.g. Covid testing). However, this leaves the Trust open to litigation in the event of errors. Permanent blocking of users who consistently fail to comply with POCT regulations - this is not feasible in practice, particularly with many clinical areas short staffed. All we can do is ensure the individual's line managers are aware of non-compliance issues, and that they both sign an official form committing to compliance with regulations, and undergo re-training procedures.	17/12/2021- "Update Senior Management (CCS) on developments by Jan 2021 "Create a potential structure to provide further support to the Trust by end of Jan 2021 "Secure additional resource to plug the identified weaknesses in current structure TBA "Seek further investment in POCT Governance structure TBA "Reinforce adherence to protocols through existing governance structures Feb 2021 20/09/2021- ED has stated that no additional funding given to provide POC service in ED- directly impacts on timing of results. High risk of agency staff. Consideration should be given to commissioning of mini lab in ED managed by main labs. 18/08/2021- this is monitored and issues escalated to Dept manager and LN and HOS. June 2021Re-started the Medical Devices and Equipment Management Group meetings. This group will have the role of promoting the safe use of medical devices and equipment throughout the Trust, providing assurance for the life cycle of all medical devices which includes procurement, use, decontamination, maintenance and disposal by the organisation of all medical devices, to ensure their use and application does not create a risk to patients, clients, staff and visitors. June 2021Expression of interest interviews taking place 04/06/2021 for Rapid Covid Tester in ED, using Lumira devices. May 2021 Requisition in place for POCT Assistant to replace staff member which has moved on. April 2021Re-commencement of user audits by Patient Safety and Quality Manager. This audit looks at barcode sharing. POCT are involved in a regional training programme for both Clinitek and Glucometers for any staff member who needs it. This allows a staff member from another Trust (bank nurse) to use device and would therefore reduce user error. Roche are currently working on a regional INR training structure. July 2021 POCT have developed a barcode sharing	HIGH
4157	ACUTE	06/05/2021	Provide safe, high quality cand Make the best use of resources	MRI Capacity	MRI inpatient demand has significantly increased with an impact on the capacity for red flag, urgent and routine outpatient examination. There has been a 72% increases in inpatient MRI demand comparing March 20 and March 21. Currently there is no MRI facility available on the Daisy Hill Site and patients have to transfer to CAH for MRI imaging. Increased outpatient waiting list and waiting times. Potential for additional queries regarding inpatients to MRI staff adding additional pressures.	Currently some MRI referrals are being outsourced to the Independent Sector. However due to image quality the more complex outpatient MRI referrals remain in the Southern Trust	6/4/22 The MRI options paper is to be presented to SMT on Tuesday 12th April to seek approval to look at non Trust locations for a modular MRI unit. There is also an ongoing MRI optimisation project being facilitated by Siemens and the initial review of the service has occurred and we are currently awaiting feedback. 14/12/2021- brought to CW to raise with Director re corporate register move. The Department are working with planning on a Business Case for a low field strength MRI Scanner to be located at DHH. The Current MRI scanners located in CAH are due for replacement in 2023 and 2024 which are currently on the equipment replacement plan. The costs of low field MRI scanner for DHH has yet to be finalised	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH
4142	ACUTE	24/02/2021	Provide safe, high quality care Be a great place to wor Make the best use of resources	Recruitment and Retention issues- Trust Wards	Patient safety risk. Identification the deteriorating patients, risk on escalation of same, lack of knowledge of in house processes, potential treatment/management/discharge delays. Increased pressure placed on core team, risk of burn out/work related stress. Potential lack of escalation/risk deteriorating patient not escalated. Potential risk of failed discharge/transfer due to lack of knowledge regarding processes. Risk of non-compliance with appropriate documentation required to manage patients holistic needs.	currently focusing prioritising recruitment to this area. Complete all outstanding e-reqs Internation nurse recruitment Target year 3 nursing students to this area to attract uptake Offer all bank and agency permanent positions Daily review and redeployment of staff to support the skill mix and staff levels with 2 South.	19/4/22. Still ongoing issue with recruitment and retention of Staff. Staffing levels reliant on Bank and Agency to fill gaps at ward level. 20/09/2021- 6 new start band 5 in DHH ED October 2021. 22 New start Band 5 CAH ED October 2021 28.06.2021- ATICS ongoing Band 5 recruitment drive. 8 x band 5 posts from peri-operative work stream. Applications closed 23.06.2021 Action plan completed working collaboratively with the AD from workforce to address this	HIGH
4156	ACUTE	19/08/2021	Provide safe, high quality car Make the best use of resources	Referrer MRI Safety	MRI is potentially hazardous and involves significant risk to patient safety. During the period 2019-2021 there has been an average occurrence (one every 3 weeks) of incidents involving incorrectly completed MRI safety referral information. These incidents have involved referrers stating that patients do not have any potential contraindications to undergo MRI(implants) however it is later identified by MRI Team that implants are in-situ. If these events keep occurring at the current rate there is an increased risk of morbidity and mortality because the source of risk has not been reduced.	The MRI Team screen and check all patients and completed questionnaires to attempt to ensure these errors are captured. E Learning MRI safety for referrers is available on HSC E Learning. Where possible notifications are sent to referrers involved to highlight the error and request that they complete the MRI safety training.	03/12/2021 - A national MR Safety training module is being developed and will be released in 2022. This module will replace the current MR Safety module on ELearning. A trend analysis report has been collated over the past 4 months which has not indicated any reduction in the number of incidents. 14/09/2021- requirement for a 3rd scanner, electrical infrastructure in DHH is an issue- cannot be brought forward. Modular MRI scanner on DHH currently. Cannot be progressed by division. To be discussed with Director of Acute Services t to have this risk moved back onto Directorate register. 16/08/2021- memo has been circulated by the medical director to all medical staff regarding the importance of correct protocol when filling out safety questionnaires for MRI. MD has asked for compliance audit data to be shared with MD and AMD to allow this issue to be addressed. A learning letter was sent out with the memo to be shared at the M&M meetings and Governance Co-coordinators to be raised at directorate governance fora and the AMD and DMD for sharing within teams. Posters to be placed on Trust desktops via Communications team by June 2021 The Department would like Referrer MRI Safety Training to become mandatory for MRI referrers by August 2021	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
4143	ACUTE	11/03/2021	Best use of resources3. Provide safe, high quality care	Replacement programme for Radiology Equipment on all Sites to replace equipment on unsupported operating systems and provide mai	A radiology equipment replacement programme is required to ensure that ongoing high quality diagnostic imaging services can be provided for patients within the Southern Trust. New Imaging equipment ensures maximum diagnostic capability with minimum radiation dose. There is equipment currently running on Microsoft Windows XP - the support ended in April 2014 leaving risks of ransomware attacks or hacking..Failure to patch as per schedule could result in the ability to access clinical systems on radiology equipment and server infrastructure. This has been highlighted by Tenable programme and could result in the loss of essential services.	Equipment replacement plan has been drawn up. A Capital Investment stream is required to be identified for Diagnostic imaging.Patching arrangement needs to be formalised. This needs developed with 3rd party agreement. All 3rd party contracts to be reviewed and amended to include patching - regional project looking at 3rd party suppliers being led by BSO. Targeted staff awareness, devices to be replaced, upgraded or if not possible must be segregated. IT working with Radiology to highlight all devices. "	10/02/2022 -In the financial year 21-22 the following equipment was replaced via Capital Monies: "3 Endoscopes "Technegas "3 General Ultrasound units "2 Breast Ultrasound units "2 Fluoroscopy units Capital priorities for the coming year are: "Funding for a 2nd CT Modular unit at DHH "Second CT scanner CAH "Replacement of 1 MRI scanner CAH "Replacement of DXA scanner and DR room at STH - this is in preparation for a Diagnostic Centre 14/09/2021- 10 year plan drawn up-investment per year shared with Regional Imaging Board- understand that SHSCT needs priority. "The equipment plan has been tabled at Trust SMT. Radiology have also presented to SMT to highlight the issues. This presentation has highlighted specific urgent requirements including breast imaging and fluoroscopy across both sites to include the required ventilation. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. There is ongoing review with IT regarding patching. " ongoing review with IT in relation to patching. All 3rd party contracts to be reviewed and amended to include patching- regional project. "To be amalgamated with 8, 10 and 11. The equipment plan has been presented at Trust SMT. Unfortunately at this time capital funding is not available within the Trust to meet the needs of the plan. Equipment records are kept up to date with records of breakdowns and quality assurance testing. "	HIGH
4185	ACUTE	12/10/2021		Risk of not being able to provide a round the clock blood sciences service on both CAH & DHH sites	There is a risk that that the critical provision of Blood Sciences may not be available on one of the main hospital sites. An inability to provide "round-the-clock" cover would compromise the provision of high quality care and in the case of Blood Bank could result in the requirement to close (temporarily) Daisy Hill to emergency admissions. In addition Obstetrics and other specialties, including Theatres would be put at unacceptable risk. Contingency measures that could be brought into operation in Chemistry could compromise patient flow and potentially compromise clinical care. Current contingencies within Haematology / Blood Bank carry even higher risks than Chemistry due to the critical nature of blood bank in particular. The stretching of staff across the 24 hour period and two sites together with the constantly increasing demand for laboratory services is also putting accreditation at risk. Type 1 Emergency Departments and Obstetrics have an absolute requirement for a Blood Bank. If the Blood Bank could not be operated at any stage of a twenty four hour period the Daisy Hill Hospital would not be able to maintain the Emergency Department and patients would need to be directed to other Emergency Departments with potential for delay and significant patient harm or death. It is sobering to reflect that critical hospital services are supported by rotas that are extremely limited and vulnerable to short notice illness with the potential for no available backfill. Unlike nursing agency bank staff are not readily available. In short inability to cover a gap could result in the emergency department having to close and patients on the Daisy Hill site being exposed to significant risk. Therefore the impact could be regarded as a catastrophic. The number of staff available on the Haematology / Blood Bank in the SHSCT is very limited, partly due to the very stringent requirements required to operate autonomously in this discipline. Currently the twenty four hour cycle is covered by too few staff and by utilising substantial overtime. Increased demand on staff has also the potential to increase sickness and stress further compounding the problem. Rotas are effectively so limited that even a few absences could cause one of the rotas to fail. The COVID pandemic has placed significant additional pressures on staff - increased demand and reduced availability of staff. Very tight rotas are highly vulnerable to these issues. Laboratory accreditation (UKAS ISO15189) is at risk where the focus is maintaining a service at the cost of maintaining a rigorous Quality Management System.	"Cross - cover from corresponding site (i.e. CAH cover for DHH) "Cross cover from other departments where relevant and safe "Additional staff in training (two staff due to complete training in the next six months) "Additional support staff through the 24 hour period "Agency support staff These controls have been enabled service provision to continue but they are insufficient to reduce the risk to an acceptable level "Additional Agency Biomedical Scientists - very limited supply (if they can be sourced at all) and likely to be off framework. Introduce additional risk - in terms of competency and experience. "Transferring Blood Bank samples to Craigavon - but there would be an unacceptable delay "Remote release of blood - unacceptable in a Major Haemorrhage scenario "Routinely providing remote Chemistry Biomedical Scientist support from the CAH site with support staff running samples on the DHH site	April 2022-Seek approval to recruit against overtime expenditure. Granted and in progress Discuss contingency with Clinical Leads/ senior staff. - Contingency is limited and has the potential to compromise patient safety Expedite training of B5 Biomedical Scientist. Despite best efforts training is slow due to the obvious constraints and COVID etc limiting further the supply of staff to train and be trained Expedite Chemistry training of Haematology / Blood Bank Biomedical Scientists. Recruit additional Biomedical Scientists and Support Staff. As above but additional staff slowly being recruited - training extremely challenging Discussion with HR around appropriate T&C for working shifts - especially at late notice etc. Procedure to describe the contingency. Completed and has provided some mitigation - however formal sign off from HR pending Plan to ensure return to schedule on all aspects of the Quality Management System. Dependent on above Remote release of results has been introduced where suitable.	HIGH
4049	ACUTE	07/08/2019	Provide safe, high quality care	Due to the staffing situation in Maternity there is an inability to accept Inutero Transfers from other Units for Neonatal Cots	The Trust is currently intermittently unable to accept inutero transfers for neonatal cots from other units. This is due to current maternity staffing level difficulties. Possible harm to mothers and babies who require a neonatal cot due to specific health needs and imminent delivery, therefore requiring transfer to this specialised facility. Potental for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	9/4/22 . Due to gaps at ward level difficult to release staff to undertake training either Face To face or Virtual e learning. 18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	6/4/22 There has been a further meeting with HSCB to look at the options - there are currently 2 suppliers have submitted bids through PALS procurement. Only one supplier is within original budget. Still awaiting funding stream Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x X-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	19/4/22. All wards DHH have 3 consultants aligned to them so all patients are seen daily. Need To review middle tier rota to support additional Medical Beds opened on DHH site. Recruitment in progress for substantive consultant posts. 20/09/2021- unable to secure acute physician for DAU. 18/08/2021- COW model in place and patients reviewed daily. New patients discussed at daily handover at 8.30am and also weekend handover at 12.45 on Fridays. 07/06/2021- There are 5 substantive Consultant post in DHH across Med/ Stroke/Respiratory and Gastroenterology. 4 out of 5 contribute to the 1:8 medical rota. The remaining posts are filled by Locum Consultants. there is a 1:12 weekend/bank holiday rota which is supported by colleagues from OPPC. There is now a substantive 1:8 middle tier rota. From August 2021 there will be a full middle tier out of hours rota with no locum's. At weekend/bank holidays there is an additional Consultant, registrar and SHO who work from 09:00-14:00 hours. 24/02/2021- review of medical staffing on DHH site currently taking place. E- Req in system for specialties. 13/05/20. Zoning introduced but issues identified with this system. Audit carried out. Medical rota is sufficient to provide daily senior review. 24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD
3929	ACUTE	12/12/2017	Provide safe, high quality care Make the best use of resources	Declaratory Orders for patients who lack capacity	Decisions sought from the court in those cases when someone lacks capacity and wherein a deprivation of liberty is likely to exist. The risk is that for those cases not taken to the court for a declaration order, there is a risk that the Trust could be challenged through judicial review for the best interests decisions it makes obo individuals without capacity.	Advice is that in all cases where a DoL is evident for individuals assessed as lacking capacity, the Trust should seek a decision from the court. This is neither achievalbe not affordable. This paper proposes that Multi-disciplinary teams agree only the most difficult cases are taken to the court for a decision.	30.07.19 There will be partial implementation of Mental Capacity Act NI on 1 October 2019. This may aleviate some of the declarattory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
4099	ACUTE	11/08/2020	Provide safe, high quality care Make the best use of resources	Neurophysiology- Due to insufficient staffing levels risk of occasional department closure days	Occasional risk to inpatients as no staff to provide service. There is the occasional inability to provide an inpatients service for EEG. EEGs are an aid to diagnosis. there is no on call/weekend or bank holiday cover	As a rule x2 staff not permitted to have annual leave at the same time however in exceptional circumstances this can occur when staffing levels are insufficient. Change the working pattern for x1 P/T member of staff which will reduce lone working days and therefore reduce risk of closure days	03/12/2021 - A Band 5 MTO commenced in October which alleviates some of the departments staffing pressures. 14/09/2021- Lead has now retired. A new interim lead has been appointed. Continue to train 2 staff- progressing through the 2 year training programme currently. March 2021 - Lead due to retire in August 2021. 1 member of staff has taken a career break for 2 years. Another member of staff will shortly be going off on maternity leave. The remaining member of staff will increase their hours and be assisted by the trainee posts. Staff levels should be 3.22WTE	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW
4090	ACUTE	09/03/2020	Provide safe, high quality care Make the best use of resources Improving Health and Wellbeing	Prescribing of valproate not in line with valproate Pregnancy Prevention (PREVENT) Programme	Valproate is associated with teratogenic risks (congenital malformations, neuro-developmental disorders) in children exposed to valproate during pregnancy. Children exposed to valproate in utero are at increased risk of lower IQ and of risk of developing neurodevelopmental disorders. In 2017 and 2018 the DoH issued a number of circulars in relation to the risks of prescribing valproate in women of childbearing age (HSC (SQSD) 19/17, HSS (MD) 8/2018 and HSS (MD) 27/2018) highlighting new resources to support the safety of girls and women who are being treated with valproate. Among the recommendations to Trusts was the requirement to develop an action plan to ensure all girls and women of or nearing childbearing age taking valproate are systematically identified so that all relevant resources can be used to plan their care. In addition, all relevant resources are to be embedded in clinical practice for current and future patients, by revising local training, procedures and protocols.	Currently valproate is prescribed to a small number of patients under the care of SHSCT Consultants, all of whom have been made aware of the various DoH circulars and associated recommendations. A number of SHSCT Consultants sit on the Regional Valproate Group, chaired by PHA. The Trust has also recently established a task and finish group to address outstanding risks in relation to the recommendations in the circulars, namely the systemic identification of all girls and women who may be prescribed valproate. The Drugs and Therapeutics Committee also monitors the implementation of the recommendations within the circulars through the Medicines Governance Pharmacist, also a member of the Regional Valproate Group.	9 March 2020 Consultants manage their own registers of girls and women on vaproate.	LOW

31 Day Cancer Performance Target = 98% (Red denotes breach of target) Urology Tumour Site													
Fiscal Year	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Full Year Cumulative Performance**
2018/2019	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%	100.00%	100.00%	100.00%	**99.41%**
2019/2020	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	91.30%	100.00%	100.00%	100.00%	100.00%	95.83%	**98.93%**
2020/2021	92.86%	94.44%	100.00%	94.44%	94.44%	83.33%	100.00%	100.00%	91.67%	84.62%	100.00%	100.00%	**94.65%**
2021/2022	95.65%	100.00%	100.00%	100.00%	100.00%	100.00%	92.31%	100.00%	100.00%	85.71%	100.00%	100.00%	**97.81%**

62 Day Cancer Performance Target = 95% (Red denotes breach of target) Urology Tumour Site													
Fiscal Year	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Full Year Cumulative Performance**
2018/2019	80.00%	50.00%	65.85%	68.00%	65.22%	81.48%	45.71%	35.29%	26.09%	44.44%	53.85%	37.04%	**54.41%**
2019/2020	84.21%	50.00%	59.09%	41.18%	66.67%	33.33%	27.03%	34.38%	26.09%	25.81%	29.63%	21.62%	**41.59%**
2020/2021	13.04%	10.53%	60.00%	45.83%	64.29%	53.33%	40.74%	33.33%	8.70%	9.09%	16.67%	29.63%	**32.10%**
2021/2022	29.63%	6.67%	33.33%	66.67%	48.00%	16.67%	20.00%	27.27%	23.06%	21.05%	12.50%	20.69%	**27.13%**

Information Source - Business Objects, Completed Waits Report ran at 16/05/2022

Cancer Rebuild Plan

Tumour Site	Position as at 01/05/2020 Red Flag Waiting List Volumes	Baseline as at 09/02/2021 Red Flag Waiting List Volumes	Position as at 09/03/2021 Red Flag Waiting List Volumes	Position as at 30/03/2021 Red Flag Waiting List Volumes	Position as at 20/04/2021 Red Flag Waiting List Volumes	Position as at 07/05/2021 Red Flag Waiting List Volumes	Position as at 18/05/2021 Red Flag Waiting List Volumes	Position as at 01/06/2021 Red Flag Waiting List Volumes	Position as at 16/06/2021 Red Flag Waiting List Volumes	Position as at 29/06/2021 Red Flag Waiting List Volumes	Position as at 13/07/2021 Red Flag Waiting List Volumes	Position as at 27/07/2021 Red Flag Waiting List Volumes
Breast	63	121	137	158	138	107	99	52	50	64	71	63
Dermatology	83	298	294	229	73	50	71	61	76	87	137	191
H&N	1	34	51	79	4	2	4	2	10	5	1	18
Gynae	48	152	127	162	151	130	143	141	155	51	9	10
Haematology	26	33	24	31	24	23	20	17	20	27	29	26
Lung	24	31	16	9	8	12	11	9	16	15	7	10
Lower GI (Surgery & Gastro)	95	818	461	499	426	395	361	348	422	471	432	57
Upper GI (Surgery & Gastro)	91	175	76	159	87	56	45	66	71	80	60	45
Urology - Prostate	99	48	42	26	39	38	30	16	32	62	74	69
Urology - Haematuria	148	199	221	190	189	198	209	169	104	163	153	150
Urology - Other	24	34	37	55	10	11	11	4	9	17	15	15
Urology - Testicular	7	4	3	6	4	3	6	0	2	2	4	3
General Surgery - Other	6	15	14	10	7	19	9	8	11	11	8	5
Gastro - Other	1	2	2	1	0	0	0	0	0	2	2	0
Neurology	0	4	0	6	0	0	0	0	5	1	1	2

Tumour Site	Position as at 01/05/2020 Red Flag Longest Waiter (Days)	Baseline as at 09/02/2021 Red Flag Longest Waiter (Days)	Position as at 09/03/2021 Red Flag Longest Waiter (Days)	Position as at 30/03/2021 Red Flag Longest Waiter (Days)	Position as at 20/04/2021 Red Flag Longest Waiter (Days)	Position as at 07/05/2021 Red Flag Longest Waiter (Days)	Position as at 18/05/2021 Red Flag Longest Waiter (Days)	Position as at 01/06/2021 Red Flag Longest Waiter (Days)	Position as at 16/06/2021 Red Flag Longest Waiter (Days)	Position as at 29/06/2021 Red Flag Longest Waiter (Days)	Position as at 13/07/2021 Red Flag Longest Waiter (Days)	Position as at 27/07/2021 Red Flag Longest Waiter (Days)
Breast	63	21	21	21	28	28	21	28	21	21	21	28
Dermatology	56	189	217	238	147	161	98	112	126	98	105	126
H&N	1	42	21	28	91	105	42	21	21	28	28	42
Gynae	70	63	84	105	126	49	42	140	70	70	70	42
Haematology	98	91	98	105	126	112	126	140	154	112	126	140
Lung	77	49	28	21	21	35	35	105	49	49	70	42
Lower GI (Surgery & Gastro)	70	385	343	364	385	399	364	357	371	385	399	399
Upper GI (Surgery & Gastro)	77	287	259	245	238	252	322	280	294	608	259	238
Urology - Prostate	133	77	210	98	112	126	77	91	84	98	84	98
Urology - Haematuria	112	399	245	266	287	301	315	329	343	357	371	385
Urology - Other	70	49	175	49	28	42	49	63	56	56	70	84
Urology - Testicular	56	35	35	35	28	42	35	49	14	28	42	56
General Surgery - Other	56	119	70	84	105	119	133	147	161	175	189	203
Gastro - Other	63	7	7	7	49	35	0	0	0	7	21	35
Neurology	0	7	0	14	0	0	7	21	14	7	21	35

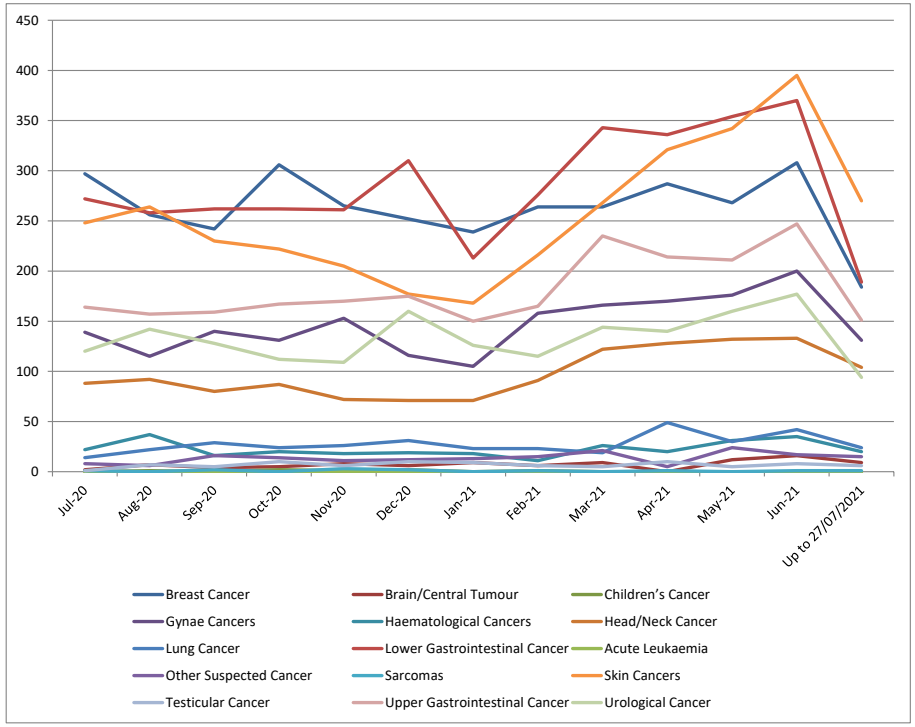
Tumour Site	Position as at 06/05/2020 62 Day Active Pathway Waiters	Baseline as at 09/02/2021 62 Day Active Pathway Waiters	Position as at 09/03/2021 62 Day Active Pathway Waiters	Position as at 30/03/2021 62 Day Active Pathway Waiters	Position as at 20/04/2021 62 Day Active Pathway Waiters	Position as at 07/05/2021 62 Day Active Pathway Waiters	Position as at 18/05/2021 62 Day Active Pathway Waiters	Position as at 01/06/2021 62 Day Active Pathway Waiters	Position as at 16/06/2021 62 Day Active Pathway Waiters	Position as at 29/06/2021 62 Day Active Pathway Waiters	Position as at 13/07/2021 62 Day Active Pathway Waiters	Position as at 27/07/2021 62 Day Active Pathway Waiters
Breast	126	190	213	247	259	275	277	334	409	310	373	451
Dermatology	141	489	545	532	553	606	664	731	807	832	914	944
H&N	31	64	98	139	149	154	140	165	123	109	113	115
Gynae	83	207	203	217	221	221	229	226	263	232	196	179
Haematology	40	51	50	61	53	48	50	52	60	70	68	60
Lung	15	47	32	34	34	40	41	42	38	37	39	40
Lower GI (Surgery & Gastro)	526	1139	1172	1294	1371	1415	1532	1617	1754	1818	1840	1884
Upper GI (Surgery & Gastro)	257	439	476	503	617	647	645	673	737	733	809	863
Urology - Prostate	308	354	397	420	388	380	399	376	364	379	400	409
Urology - Haematuria												
Urology - Other												
Urology - Testicular	18	8	7	8	9	11	11	11	9	6	12	11
General Surgery - Other				8	5	12	7	29	24	14	22	16
Gastro - Other				1	0	3	2					
Neurology			5	6	1	0	5	6	10	12	12	14

Tumour Site	Position as at 06/05/2020 62 Day Longest Waiter (Days)	Baseline as at 09/02/2021 62 Day Longest Waiter (Days)	Position as at 09/03/2021 62 Day Longest Waiter (Days)	Position as at 30/03/2021 62 Day Longest Waiter (Days)	Position as at 20/04/2021 62 Day Longest Waiter (Days)	Position as at 07/05/2021 62 Day Longest Waiter (Days)	Position as at 18/05/2021 62 Day Longest Waiter (Days)	Position as at 01/06/2021 62 Day Longest Waiter (Days)	Position as at 16/06/2021 62 Day Longest Waiter (Days)	Position as at 29/06/2021 62 Day Longest Waiter (Days)	Position as at 13/07/2021 62 Day Longest Waiter (Days)	Position as at 27/07/2021 62 Day Longest Waiter (Days)
Breast	76	92	102	124	144	150	83	77	61	63	76	91
Dermatology	102	376	403	425	445	450	357	372	387	400	413	428
H&N	61	75	62	76	83	96	110	125	140	153	55	55
Gynae	85	146	173	161	172	110	124	203	107	118	104	119
Haematology	126	180	207	168	188	201	215	230	182	195	208	223
Lung	118	119	96	106	127	119	133	148	131	99	112	127
Lower GI (Surgery & Gastro)	258	413	440	462	439	453	442	457	472	469	482	497
Upper GI (Surgery & Gastro)	192	361	410	432	452	433	447	462	477	391	404	419
Urology - Prostate	230	389	418	440	460	474	474	428	443	456	469	484
Urology - Haematuria												
Urology - Other												
Urology - Testicular	76	55	45	67	56	40	52	48	62	62	62	77
General Surgery - Other				84	84	119	11	91	96	109	122	54
Gastro - Other				29	84	35	111					
Neurology				435	13	0	12	27	42	30	43	58

Tumour Site	Key Pathway Pressures	Action Agreed	Action Owner	Outcome	Measurement
Breast	**New Outpatients:** New Patient Referrals – are at or above pre-COVID levels Many patients are not seen face to face by GP prior to referral Clinic numbers reduced to maintain social distancing, therefore struggling to maintain red flag 2ww (30% last week) – additional clinics required, this had been discussed and agreed pre-3rd surge ~900 other symptomatic referrals are out to >12 months we know 1-2% cancers within this group. **Review:** Virtual/telephone consultation follow up where possible of symptomatic review patients (eg. patients on primary hormone therapy for cancer) Annual review mammogram continues (& mammographic recall) No capacity for clinical annual review **Screening:** Screening has continued throughout third surge after 3 month pause during first surge. As a result screening "catch-up" and additional screening assessment clinics in parallel, with an increased number of screen detected cancers diagnosed. **Theatre:** Theatre capacity is significantly reduced. Much of the available capacity for breast is in the private sector. Compromises are therefore being made in terms of access to radioisotope (many more blue-dye only SNB's), specimen imaging and access to breast care nursing support. High risk patients are waiting much longer for surgery since unsuitable for surgery in private sector. ONLY FSSA Priority 2 patients can be listed for surgery. Some breast cancers fall into FSSA 3 and are therefore not currently being offered surgery. The majority of ER positive cancers are commenced on bridging hormone treatment. (20% of these patients would be upstaged by surgery. 20% of patients will not have a response to hormone therapy, so effectively will not be treated.) There is a perception that we are seeing more advanced disease when patients do get to surgery with more returns to theatre for ANC. (Audit ongoing to quantify this). Discussions whether we should be re-imaging prior to surgery after long delays but limited capacity to do this and with late allocation of lists risk further delays with re-biopsy etc. **Immediate Breast Reconstruction** Very limited breast reconstruction due to theatre capacity **Breast Care Nursing/Nursing support for clinics:** All Breast care nurses and clinic nurses redeployed. Consultants managing all queries, post-op care of patients including wound dressings, drain removal and prosthesis fitting post-op. Tentative plan for return of nursing staff 1st March. **Staffing:** Team have been a clinician down since March. A consultant has covered this gap since then. An additional non-consultant grade breast clinician is required to bridge this shortfall. There will be no ability to resume non-urgent outpatients without additional staffing. Succession planning is required with another key staff member due to retire soon.				
Dermatology	Cessation of OP activity. No capacity to see routine/ reviews. Accomodation a huge negative factor. RF patients increasing all the time - hope to have clinics back W/C 22/02/21	Move to new accomodation in Ramone building imminent.			
H&N	Access to theatres remains a concern. Continue with only one urgent bookable session for all specialities Mon-Fri in CAH only. ENT also utilises theatre sessions in LVH for Priority 2 cases				
Gynae	Reduction of OP activity. Limited OPH activity. Reduced elective activity				
Haematology					
Lung	Cessation of OP activity. Wards are extremely busy. Very difficult to asess lung patients virtually. Dr Hayes leaving the trust will impact ability to see new patients. Work being done at LF lab. Respiratory Clinics are operational now across 3 sites Bronch lists were cancelled unfortunately as no Patients Ct guided biopsy being facilitated				
Lower GI (Surgery & Gastro)	Cessation of OP activity. Virtual activity ongoing though large numbers need F2F appts. Access to theatres. Staffing issues around the Qfit process. Qfit validation will lead to extra pressure on scope W/L's when patients are more accurately assessed. (767 Qfit tests currently out) Introduction of new NICaN referral guidance and pathway will require adaption, including redistribution of referrals across Colorectal and Gastroenterology Majority of consults have been virtual - F2F OPC have recommenced March 2021 eTriage outcomes • Weekly prioritisation of P2 operative cases • Caseload submitted via Trust rep to RPG • UBL lists allocated accordingly Resectional surgery on CAH UBL Emergency CR Cancer surgery and stenting at CAH Some Diagnostic surgery eg EUAs performed in IS - Potential capacity at DHH/STH for P2 daycase/GA scopes. RF Endoscopy ongoing via: • Trust lists(reduced number/ capacity) • IS lists at UIC/KPH/THC qFIT used to prioritise scheduling of RF tests and reduce unnecessary OPC (as per our COVID mitigation pathway)	Trying to improve theatre access - especially around scope procedures in DHH/STH in coming weeks. Surgical clinics are returning to Ramone OPD. Combined use of Virtual & F2F clinics for RF New and Cancer RV Job-planned 'Enhanced Triage' to be addressed To continue Will need to maintain access to IS lists to supplement reduced in-house capacity and investigation of 'low qFIT' but persistently symptomatic patients Continue until qFIT Primary Care (EDC May 2021), plus transition phase			
Upper GI (Surgery & Gastro)	Cessation of OP activity				
Urology - Prostate	Cessation of all OP activity for approx 6 week period (surge 3 Jan - March 2021) F2F red flag clinics recommenced in Thorndale end of March / April 2021 Continue with only one urgent bookable session for all specialities Mon-Fri in CAH only. Urology also utilises theatre sessions in UIC Concern over backlog of TP biopsy patients, STH daycase sessions have recommenced on a Tuesday				
Urology - Haematuria	Cessation of all OP activity for approx 6 week period (surge 3 Jan - March 2021) Haematuria sessions recommenced in Thorndale, to clear red flag backlog running approx 4 haematuria sessions per week (9pts each session)				
Urology - Other	Cessation of all OP activity for approx 6 week period (surge 3 Jan - March 2021) Clinics recommenced end of March / beginning of April 2021				
Urology - Testicular					
General Surgery - Other					
Gastro - Other					
Neurology					

62 DAY REFERRALS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Up to 27/07/2021
Breast Cancer	297	256	242	306	265	252	239	264	264	287	268	308	184
Brain/Central Tumour	2	7	4	5	8	6	9	6	9	0	12	16	9
Children's Cancer	0	1	0	2	1	2	0	1	0	0	0	0	0
Gynae Cancers	139	115	140	131	153	116	105	158	166	170	176	200	131
Haematological Cancers	22	37	16	20	18	19	18	11	26	20	31	35	20
Head/Neck Cancer	88	92	80	87	72	71	71	91	122	128	132	133	104
Lung Cancer	14	22	29	24	26	31	23	23	19	49	30	42	24
Lower Gastrointestinal Cancer	272	258	262	262	261	310	213	276	343	336	354	370	189
Acute Leukaemia	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Suspected Cancer	8	6	16	14	11	12	13	15	21	5	24	17	15
Sarcomas	1	0	2	0	3	2	0	1	0	1	0	1	1
Skin Cancers	248	264	230	222	205	177	168	216	268	321	342	395	270
Testicular Cancer	1	7	5	10	6	10	9	6	5	10	5	8	6
Upper Gastrointestinal Cancer	164	157	159	167	170	175	150	165	235	214	211	247	151
Urological Cancer	120	142	128	112	109	160	126	115	144	140	160	177	94
62D Total	1376	1364	1313	1362	1308	1343	1144	1348	1622	1681	1745	1949	1198

31 DAY REFERRALS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Up to 27/07/2021
Breast Cancer	32	26	27	20	38	13	13	30	64	20	35	42	24
Brain/Central Tumour	0	0	1	2	1	0	0	0	0	4	0	1	1
Children's Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynae Cancers	11	11	10	8	13	12	8	22	10	11	13	14	11
Haematological Cancers	9	4	18	11	5	9	5	10	6	11	18	17	7
Head/Neck Cancer	12	15	16	12	13	6	13	9	16	17	20	19	11
Lung Cancer	16	24	25	19	19	13	11	16	20	18	18	23	14
Lower Gastrointestinal Cancer	41	29	38	27	24	19	20	24	16	24	36	42	23
Acute Leukaemia	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Suspected Cancer	2	30	0	1	2	3	2	2	4	13	5	4	1
Sarcomas	0	0	0	0	0	1	0	0	0	0	0	0	0
Skin Cancers	1	1	2	6	5	9	0	3	4	2	4	4	3
Testicular Cancer	0	0	0	2	1	4	0	0	0	2	0	0	0
Upper Gastrointestinal Cancer	18	15	14	10	10	17	12	18	15	12	16	19	18
Urological Cancer	33	25	20	25	35	25	22	22	27	28	28	36	26
31D Total	175	180	171	143	166	131	106	156	182	162	193	221	139



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Specialty	Table Total	Breakdown of patients on PTL report					Total number of patients on PTL	Longest Waiter (including those delayed due to COVID-19)					Hospital Number	Comment
		Awaiting Triage Outcome	Awaiting appointment	Information on patients waiting appointments	With appointment dates in past (attendances to be recorded)	Appointed for today or in the future		Weeks	Days					
Breast	100	5	63	N/A	0	32	**100**	4	28	LONGEST WAITER:	4	WEEKS	Personal Information redacted by the USI	Patient currently on holidays - await return before appointing
										NEXT LONGEST:	2	WEEKS		Appointment planned for 30.07.21
Dermatology	271	52	191	175 Requires F2F Appt's	0	28	**271**	18	126	LONGEST WAITER:	18	WEEKS		Patient DNA'd Telederm - Added to waiting list for RF F2F OPD
										NEXT LONGEST:	17	WEEKS		Appointment planned for 29.07.21
ENT	83	29	18	N/A	0	36	**83**	6	42	LONGEST WAITER:	6	WEEKS		Appointment planned for 29.07.21
										NEXT LONGEST:	6	WEEKS		Appointment planned for 28.07.21
Gynae	62	17	10	N/A	1	34	**62**	6	42	LONGEST WAITER:	6	WEEKS		Patient had a fall and wants appointment in late August
										NEXT LONGEST:	5	WEEKS		Awaiting MDM 27.07.21 then appoint
Haematology	44	11	26	4 PINK Referrals	0	7	**44**	20	140	LONGEST WAITER:	20	WEEKS		Appointment planned for 30.07.21
										NEXT LONGEST:	17	WEEKS		Awaiting appointment
Lung	36	5	10	6 AWAITING CT/CT Complete - A/W Cons Update	0	21	**36**	6	42	LONGEST WAITER:	6	WEEKS		Appointment planned for 02.08.21
										NEXT LONGEST:	5	WEEKS		Appointment planned for 27.07.21
General Surgery - Lower GI	467	75	29	335 QFIT	1	27	**132**	57	399	LONGEST WAITER:	57	WEEKS		Awaiting Qfit
										NEXT LONGEST:	15	WEEKS		**Non Qfit Longest waiter -** Awaiting OPD
General Surgery - Upper GI	55	28	4	15 QFIT	0	8	**40**	33	231	LONGEST WAITER:	33	WEEKS		Awaiting Qfit
										NEXT LONGEST:	7	WEEKS		**Non Qfit Longest waiter -** Awaiting OPD after scope
General Surgery - Other	17	3	5	7 QFIT	0	2	**10**	29	203	LONGEST WAITER:	29	WEEKS		Awaiting Qfit
										NEXT LONGEST:	5	WEEKS		**Non Qfit Longest waiter -** Appointment planned for 28.07.21
Gastro - Lower GI	53	7	28	21 QFIT	2	16	**53**	48	336	LONGEST WAITER:	48	WEEKS		Awaiting Qfit
										NEXT LONGEST:	9	WEEKS		**Non Qfit Longest waiter -** Awaiting virtual or F2F OPD
Gastro - Upper GI	78	10	41	4 QFIT 58 Requires F2F	1	22	**74**	34	238	LONGEST WAITER:	34	WEEKS		Awaiting Qfit
										NEXT LONGEST:	7	WEEKS		**Non Qfit Longest waiter -** Awaiting OPD
Gastro - Other	2	0	0	N/A	0	2	**2**	5	35	LONGEST WAITER:	5	WEEKS		Appointment planned for 04.08.21
										NEXT LONGEST:	1	WEEKS		Appointment planned for 27.07.21
Neurology	3	1	2	N/A	0	0	**3**	5	35	LONGEST WAITER:	5	WEEKS		Awaiting appointment
										NEXT LONGEST:	2	WEEKS		Awaiting appointment
Urology - Prostate	102	0	69	N/A	0	33	**102**	14	98	LONGEST WAITER:	14	WEEKS		Awaiting PSA result before OPD can be booked
										NEXT LONGEST:	9	WEEKS		Appointment planned for 27.07.21
Urology - Haematuria	181	2	150	N/A	0	29	**181**	55	385	LONGEST WAITER:	55	WEEKS		Patient has dementia - awaiting OPD when patient can attend
										NEXT LONGEST:	30	WEEKS		Patient is pregnant and wants OPD in November 2021
Urology - Testicular	7	2	3	N/A	1	1	**7**	8	56	LONGEST WAITER:	8	WEEKS		Appointment planned for 10.08.21
										NEXT LONGEST:	6	WEEKS		Appointment was on 26.07.21
Urology - Other	33	17	15	2 Awaiting CT	0	1	**33**	12	84	LONGEST WAITER:	12	WEEKS		Awaiting appointment
										NEXT LONGEST:	12	WEEKS		Awaiting appointment

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TimeBand 62 Day		0-7 Days	8-14 Days	15-21 Days	22-28 Days	29-35 Days	36-42 Days	43-49 Days	50-55 Days	56-62 Days	63-69 Days	70-76 Days	77-83 Days	84-90 Days	91-97 Days	98-105 Days	106-112 Days	113+ Days	Minus	Sum:
Suspect Tumour Site - Description	**Treatment Planned Y\N**																			
Brain/Central Tumour	**N**	2	3		2	1	3	1	1	1										14
Breast Cancer		45	62	27	55	55	63	62	37	34	10				1					451
Gynae Cancers		36	23	29	21	13	11	13	5	6	1	4	6	2	2	2		1		175
Haematological Cancers		4	4	2	5	4	6	6	3	5		3	2	3		2	2	9		60
Head/Neck Cancer		29	25	17	20	10	7	3	2											113
Hepatobiliary/Pancreatic							1		2		1	1								5
Lower Gastrointestinal Cancer		73	66	56	65	75	90	76	75	68	42	58	75	53	64	97	72	778	1	1884
Lung Cancer		5	9	8	6	4	3	1			1			2				1		40
Other Suspected Cancer		5	4	1	3	2			1											16
Sarcomas					1		1													2
Skin Cancers		83	67	44	76	87	87	88	64	55	67	66	48	10	28	19	13	28		930
Testicular Cancer		1		2	2	1	1	2	1											10
Thyroid Cancer							1			1										2
Upper Gastrointestinal Cancer		37	44	38	52	38	43	61	45	42	51	51	44	40	48	49	37	143		863
Urological Cancer		30	23	21	32	42	41	40	19	27	28	26	20	6	10	7	3	30		405
	N	350	330	245	340	332	358	353	255	239	201	209	195	116	153	176	127	990	1	4970
Gynae Cancers	**Y**							1		1				1			1			4
Skin Cancers													2	1	1	3	1	6		14
Testicular Cancer													1							1
Urological Cancer				1													1	2		4
	Y			1				1		1			3	2	1	3	3	8		23
	Sum:	350	330	246	340	332	358	354	255	240	201	209	198	118	154	179	130	998	1	4993

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB CANCER PERFORMANCE MEETING
THURSDAY, 17 JANUARY 2019 @ 1.00PM
VIDEOCONFERENCE FROM MEETING ROOM, TRUST HQ TO HSCB

Lynn; Ronan; Barry; Martina; Fiona; Sharon; Wendy
David; Lisa; Jill; Karen; Cara

- 14-day Breast breach - Patient will be a breach in January 2019 Subject - SHSCT did not raise at the meeting.

Papers for meeting below prepared by Sharon Glenny - individual patient breach reports in 2nd document down the list (1st Excel document) - LNL notes on each patient included.

- Lisa enquired about first appointment timeline for Urology - Sharon advised it was now D56

- Lisa enquired about wait time for CTC - Sharon advised that it was out at 53-weeks for other patients and patients had started to move now - Lynn advised that this was only for the >26-week cohort at 31/3/18

- Lisa enquired if other Trusts were having similar issues to SHSCT on the CTC prep presritpion and collection - Sharon noted Southern Trust is the only one fully compliant with the guidance for CTC prep - Sharon advised that other Trusts were still posting out prep - Barry noted that we are assisting patients to collect and Lisa noted that this may be seen soon in other Trusts

- David enquired about the Urology consultant sick leave and did we try to do anything else with the red flag patients booked for these clinics? Martina advised that she tried to rebook the patients sooner but all other clinics were already fully booked . Lisa noted that this would no doubt be picked up at the Urology at workshop next month.

  David noted Urology as our main problem area.

  David noted tht the letter was issued regarding redirection of BT80 patients and that an IPT was to be submitted by WHSCT to cover the Fermanagh patients that were to be redirected too. David advised that Southern Trust should no longer be accepting these referrals.
  File note - 18/1/19 - Martina clarified (see Subject) that it was only the BT80 patients that we could currently refuse to accept. The Fermanagh patients still have to be accepted until the IPT resources are in place within WHSCT.

- HSCB will be seeking the Trust to come forward proposals to improve capacity/performance.

  Lynn advised David, that our ability to increase capacity, especially within Urology and GI for operative requirements was extremely limited due to beds; theatres; theatre nursing limitations. Lynn advised that the elective capping was in place and therefore, the ability to do IHA was restricted throughout the Winter and likely through the 'non-Winter' periods too.

- David raised the Dermatology photo-triage pathway and that NHSCT were happy to share their findings. Daivd noted that we had advised him at the last meeting that we already had this in place. He noted that the NHSCT said their pathway was different. Lynn asked how? David advised that photo was taken in primary care and then electornically sent in via CCG and then the Medics triaged it. Lynn advised that this is the same process only our Dermatology trained nurses take the photo. Cara said if done in Primary Care then the nurses oculd be directed to other work. Lynn advised HSCB that the Dermatology nurses already undertook a wide variety of work including OP and DC and that the Dermatology team was well established with this. Lisa noted that it is the DHSSPS direction to push as much out to Primary Care to do as possible. Lynn suggested that reps come to meet with the Dermatology Team face to face rather than emailing findings. Lisa and David agreed. Lynn agreed to coordinate the meeting when HSCB send through the request.

Action - Lynn to co-ordinate meeting request

Lynn advised HSCB that Dermatology Staff Grade going off on long-term sick leave which may impact on triage and capacity which we would be estimating any impact.

- David think urology needs most of our focus - hopes that by end the february will have a direction on where we go with the long waits.

- Sharon raised to Cara the cancer tracker paper - feeling pressures when staff off on sick or annual leave - we are close to the wire - any more progression on this. Cara advised that HSCB have some recurent funding available but long list of things to be considered - Cara discussing with cancer commissioning colleagues then need to discuss with Lisa and Miriam and would try to get response asap.

- Barry raised Haematology risk - funding for team of 5 - Dr Hull retired December 2018, leaving 2 substantive haem cons, and 1 has indicated plan to retire within 6 months - Went out for replacement with no applicants - going out again for 3 haem cons - appreciate Regional deficit - working on locums - some medium term basis - will take time to get substantive team re-established.

  Fiona noted that they had done a lot of modernisation and transformed to nurse led review and work - trying to strengthen this.

  Lisa wanted to know if on corporate risk register? Barry advised that a paper was drafted and will be discussed within Acute and will then be submitted to SMT for discussion and risk to be considered for inclusion on corporate risk register.

- Sharon raised the tracking issue ie. Close off of episodes, as had been raised at previous meeting noting that Davinia as Regional lead will feed up to Cara. Sharon noted the issue of trackers closing down episodes on CAPPS on the presujption that it was the right action to take, however, the Trust felt that this should not be happening. Sharon advised that one other Trust has also stopped this and that we were contemplating the same.

  Cara said from a governance perspective it was better to have patients opened incorrectly and retrospectively closed off - Lisa felt that this was too much risk for the trackers - Sharon confirmed that following this meeting she was advised the trackers not to close off until formal direction to close by the Clinician.

  Cara will raise formally with all Trusts at cCncer A/D meeting .

- Barry noted the work the Trust had been undertaking in relation to the Escalation Plan - he noted that the Trust was trying to take every every opportunity to expedite the patient pathway - in place for a couple of months - more pressure for the trackers but looking at every opportunity to improve pathway - lisa will be asking others if they are doinig that

- David enquired if Mark was still Belfast- Martina confirmed 2nd and 4th Thursday in the month and every Friday except when he is on call.

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

Cancer performance HSCB meeting 28 March 2019
David McCormick, Jill Young, Karen McKay, Cara, Barry, Martina, Lesley, Maria , Vickki, Fiona, Louise Devlin, Wendy Clarke, Wendy clayton

Urology Discussion due to high level of breaches

BT80 to stop and work to establish current volume and wait time of patients from BT80 already on waiting lists to consider if these can be repatriated
Action - Martina to pull volumes by wait time for further conversation

Parallel process to improve include

- Elective centres Autumn for stone and 30-40% of TURBT work that can be done as DC
- Development of specialist nurse capacity - B7 spec nurses x 2; 1 for cancer and 1 for benign bid for via Urology Improvement Group

Action - clarification on funding ASAP - Martina to go ahead and work up job descriptions for nurse specialist and proceed to recruitment

- Expansion of service on DHH site and mirror Thorndale in DHH however No staffed theatres

Focus on West and South Eastern potentially taking some of our long waits to seek to equalise

West appointing additional consultant

Concern about urgent waits and routine long waits for Op and IP/DC -
Action - profile waits over 52 weeks by category for consideration re equalisation (Martina)
IP/Dc waits at end of Feb 19 800- 225 TURBT, some circ; etc
A**ction - David speak into SET as they have only 3 TURBT over 52 weeks to see if with additional funding the could take TURBT with CO-morbidities**
Action - IS capacity for circ 90 - 100 - general surgery EOI IS (Performance team - need high level specification from Martina)
Equipment £65k to allow us to undertake biopsy awaited - on Trsut capital bid
Testing for PSA - Trust is re-testing however position now agreed for sending back to GP for second test
RF 50 no dates -
Action - bring forward bid for validation (Martina Corrigan)
Action - David to share formal communication re PSA testing - need to check this has been shared with GPs
Action - Cancer Tracking pressures - put in in the mix - non recurrent cancer trackers - David suggested the Trust indicate in bid prepared to recruit permanently at risk pending funding (Barry to prepare)
Action - submit bid for breaking bad news clinic for consideration (Fiona and Amie developing)
Endoscopy - no decision yet re additionality
Action - Diagnostic Red flag requirements into Q1 bid (Lesley to re-submit and include in the Q1 RF and urgent elective bid)

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

Meeting 20 May 2019 HSCB cancer services meeting (Telecon)

Cara Anderson
Jill Young
David McCormick
Sara Haughian
Karen Lusk

Sharon Glenny, Barry Conway, Martina Corrigan, Wendy Clayton, Elaine Murphy Fiona Reddick, Amie Nelson

62 day target

Urology - 22.79% increase in urology referrals
SMT have agreed implement NG12 - revised guidance for 2nd PSA test - template to be undertaken
Option therefore to downgrade or send back
Action - guidance to follow; patients currently waiting - Cara to discuss with Miriam if can be applied retrospectively

Pt 1 - ITT to St 151 - Cancer tracker to pick up comment
Pt 2 - 3356 - MRI delay; radiology downgraded from RF to urgent ; MRCN - said Radiology could downgrade if he informed referring consultant
Actin - review of number of radiology issues ;
Pt 3 - 55671 - MRI requested as urgent - picked up by team and upgraded to RF
Pt 4 - lower GI - don't suspend out of pre-op normally;
Action - Sharon to check what other tests where an adjust comment
Pt 5 - 454 - check NIECR for 2nd PSA result -- if not done clinical team will write back out to GP; not currently closed down on CAPPS. Approach will change with new guidance which will close down on CAPPS
Action 0- Martina to talk to Mark about phoning to check patient attends fro 2nd PSA
Pt6 - 168 - comment re report changing -
Action - Sharon/Barry checking with Imhran

MRI and first OP test key issues
Additional capacity for new specialist nurses (band 7) (IPT in train) - significant training time line (50 cases to do in training for flexi cystoscopies, 1 year for prostate) - could be two years ago for full impact. May be potential to come from other Trusts.
Some regional discussion -

UROLOGY
HSCB Have not stopped referrals from WT yet - 150 patients already listed; 315 from Fermanagh new assessment on PTL. Waiting on IPT from WT;
Review patients should stay with surgeon post surgery (same as cookstown (BT80);
166 cookstown patients on new outpatient lists (backlog); new ones stopped now

Timescale - anticipate short timescale after IPT

Trajectories - Trust advised will be another few fees

Issues raised by Trust re ability to undertake additionality
BMA talks - conflicting information re pensions - Trust seek input for June meeting to clarify position
Impact on WLI and core sessions ;
Highlighted to Richard Pengally

Allocation for scopes coming out
Share of 10m to be allocated across Trusts
Elective Centres - once finalised - will go to one trust waiting Lists

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB CANCER PERFORMANCE MEETING
TUESDAY, 23 JULY 2019 @ 1PM
VIDEO-CONFERENCE VIA MEETING ROOM 1

LNL

ISSUES TO RAISE:

- **NG12 - Any update on timescale for consideration / adoption of new guidance?**
- **Like to note - conscious that Miriam is doing a stocktake with Medical Directors - the Trust is working through a detailed assessment of the impact on additionality (and potentially core activity) and red flag / waiting times etc associated with the pensions issue.**

Breast 14-Day - HSCB commended performance and service identified no risk at this time.

31-Day - HSCB commended performance and service identified no risk at this time.

62-Day - HSCB noted target, whilst challenging, the ST is one of the stronger Trusts across the Region.

62-Day -

- David noted that at Regional Gynae meeting there was no risk identified to the 62-day pathway and queried what was impacting/causing the problem now? Sharon advised that it was out patient hysteroscopy. She noted that this had been done via IHA and the two consultants that undertaken this have pulled back from additionality at the end of July. Sharon noted meeting with Aoife Currie to figure out from August how we maintain capacity? Sharon further noted that the gynae patients that breached were difficult to diagnose and required multiple diagnostics and then faced delays when ITT'd to BT.
- Upper and Lower GI impact from reduced/ceased IHA has been impacted from both OP and Endoscopy.

Impact of Pensions Issue on Capacity / Red Flag - Lynn noted that the Trust was conscious of the stocktake Miriam was doing via Medical Directors but the cessation of additionality is having an impact on access times etc. Jill noted that the Trust had not yet responded to her email, which was sent to Lesley. Lynn agreed to follow up with Lesley.
Action - Lynn

Issues raised during discussion on Patient Breach reports (see further notes on Breach Reports above - tabs highlighted yellow):

- HSCB significant concern regarding disagreement on red flag status between Consultant Surgeon and Consultant Radiologist and impact on red flag pathway timeline which was to be resolved after the last HSCB Cancer meeting;
- Concern on delays for 'vetting' radiology requests by Consultant Radiologists;
- Patient delay in getting GFRs done by GP for CTC in IS - Sharon sought direction from HSCB on ability to suspend patients during this time - Lisa confirmed that if a patient has been contacted twice then they could be suspended - Sharon to adjust CAPPS for these relevant patients;
  Action - Sharon;
- Concern around delay for cystoscopy - David seeking update from Martina on IPT for Consultant 7 - David sought confirmation of in-year spend for both CNS and Consultant. Martina confirmed no spend for Consultant and would confirm in-year spend for CNS;
  Action - Martina;

- CTC prescription issue still causing delays;
- CTC delays in booking with IS Provider;
- Lung delay associated with Private GP practice and acceptance of; and referral sent by Nurse Clinical Specialist;
- David queried an ITT at D158 - David to send the number through to Martina for review;
  Action - David and Martina
- David asked that no patient names or initials be included

Lesley asked if any slippage from CNS and Consultant 7 could be used for other elective IHA? David said that it would be considered. Lisa advised that she needed the Consultant 7 IPT asap to hold the funding.

NG12
Lisa confirmed that at this time the only element being rolled out is the 2nd PSA for prostate, as no point pushing other elements when capacity is already challenged and issues with pension put further pressure on capacity.

WHSCT Urology
David noted that the delay with WHSCT Urologist, to take back the referrals from ourselves, was with the WHSCT as they had not submitted the IPT yet.

- Meeting ended -

FILENOTE 1/8/19 (LNL)
Update requested from HSCB on patient's discussed - response sent 1/8/19 Subject

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST CANCER PERFORMANCE MEETING
THURSDAY, 19 SEPTEMBER 2019 @ 1.00PM
VIDEO-CON VIA MEETING ROOM 1, ADMIN FLOOR

LNL; JB;

Meeting cancelled by HSCB following HSCB/Trust Service Issues meeting

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST CANCER PERFORMANCE MEETING
WEDNESDAY, 20 NOVEMBER 2019 @ 11.00AM
MEETING ROOM 2, ADMIN FLOOR

LNL; Lesley; Angela; Martina; Ronan; Barry; Fiona; Jane
Apologies - Melanie

Amended breach reports

David; jill;

David breast ok

31 day looking good any pressures - bc facing pressures within gynae theatres -bc theatre capacity had been capped and limited in terms of options for increasing theatre sessions very limited -

Theatre nursing early alert - bc / les at this stage don't know any further impact - working through at the minute for this and in terms of the potential strike action - david no one else flagged at this stage - give heads up on theatre capacity - les on back of early alert lynn will be giving an impact on trajectories for orthopaedics etc

62-day
63.8% for october - david do we anticipate if this position will hold or will get worse - martina don't know for urology at this time - barry impact from theatres; strike; and ongoing usc pressures - doing everything we can to protect rf and urgent capacity - huge challenge - looking at all options available

Lesley queried reporting position - jill send to lisa and copy to david and jill - email for now - for any red flag cancellation - no phone calls required at the minute

David - martina plans for next year ?? How can you free up additional capacity for consultant 7 - mc still progressing but for that reason don't know how we will staff the dhh theatres - currently with finance for ipt costing - the 2 cns are going to advert today and lead in time for recruitmemt and training

David had several meetings with western trust re; fermanagh transfer - more or less agreed on cash envelope - mark gillespie has agreed to take some of the backlog patients bt80 and from fermanagh for backlog that are sitting on waiting list - once agreed they will meet with us to agree transfer process - david pushing OP and treatments - lesley can we set up a meeting - revised ipt sent through costed from hscb and western - matter of as soon as they can get signed - useful to preempt the allocation - david to sort meeting with martina; lynn; and jane - western not willing to accept review patients under the care of southern trust clinicians - martina yes agree on this - consultants will agree also

Lower and upper gi - david any hope on turning this around - ronan no as challenged on every part of the pathway - particularly exercised in IP theatres particularly cah almost at breaking point - rc doing theatre rota today for the next 6 weeks - losing theatre staff in twos - leaving for other reasons m/leave; retirement; closer to home - migration of staff out and staff that bring in are new registrants and takes a long time to train up - brought in ODPs from across the water - variable quality - stay for a bit and then go away - 16 through the doors and left with 4 - dc theatres have shortages but not as acute - had considered collapsing day surgery which would not be without consequences - issues for worklife balance for staff and also skill set - lead in time -

Martina if collapse dc then impacts ophthalmology regional centre

Ronan it is the first op appointment that is the main issue - david anything we can propose?? Ronan have had a number of surgeons not available over the last couple of months - to keep usc going we have sacrified elective - mr neill; mr lewis; mr weir; ms young leaving - of the 9 cah surgeons there will only be 5 providing surgical emergency

service - when they are surgeon of the week they don't do elective activity - have had to reduce the op etc they are having to do more surgeon of the week and oncall

Active ptl waits - for lgi significantly increase - ronan loss of wli - bit of both increased demand and less wli

Itt - at d161 for urology - martina was probably first appoint - out to d60 for first appt because we have changed the clinic templates - no urgents only red flag - had been d100 for first appointment - now only doing rf - martina problem with equipment etc - have changed to accommodate this - david I am sure you are concerned about incidental findings - is there a risk to not seeing urgents - yes, but it is the balance of risk - either rf out at d100 or d60 with no urgents

7th consultant - david can we not do anything with this money - martina cannot fill matthew tysons post - no one coming out of training -

David if we are holding money and you cannot do anythign with it ??? What is the point - martina advised matthew back in july so only a temporary situation - do not know if there is anyone out from across the water of further afied - martina already optimising backfilling sessions - ronan confirmed there are vacant theatres in dhh - have theatre; equipment; anaesthetics; but issue will be getting urologist and also the theatre nursing staff - les don't know that far in advance other than what ronan has said - constant churn no clear line of sight of when we think this will be fixed - ?? Can anyone help us out - another Trust - david saying that the western hope to recruit but martina advising that at the regional meeting that western were also having similar issues - david asking about is ?? Advised that NI have no options - for urology - only roi and ptoential is provider coming in to a hospita faciity

Angela - the acute leukemia is not right - it is a recording issue on capps
Haem - fiona explained that the consultants have been prioritisng the red flags - 'watch and wait' veruss the true red flags - good news story - offered 2 posts for consultants this week - cara have we the nursing siupport etc - fiona yes we have and specialist nurse also doing a course which will develop protocol around the lower risk rf

Karen re breach reports

David re; radiology triage issue - apologies for the prebious email issue - just confirming the 2-3 turnaround for triage

David asked about escaltaion processes - could we share with them - barry yes have one, had for some time, looked at it over the last 12 months and happy to share

Karen queried the haematology graded pink - fiona links back to the watch and wait programme which are less risk than the other acute red flag haem

Cara challenged the watch and wait - this is a first treatment - lnl advised that it is not adecision on first treatment it is a clincial risk strategy due to the limited capcity

David PIT - perfomring well and probably best in the Region - anything else to note or highlight - barry highlighting the modular CT on dhh site for safeguarding/contingency - incfreasingly the teams in dhh are saying that with the activity through dhh urgently need to consider a second scanner on the site - current modular facility can do IP etc - the trust is very keen to have the 2nd modular scanner remaining on site - protects hospuital and contingency and also opens up opportunity to address ct impacts ie. ctc. Barry had drawn this to maria's attention - have alerted maria - keen to get funding for the 2nd ct scanner - maria is supportive in principle but no funding stream - david queried the mobiel ct - barry said had the mobile but it could only do OP but then managed to secure the modular which can do the IP/ED etc. Bc if we were able to secure this on site then it would allow more CT cardiac/CTC - it was a site contingency - funded at risk

David would accept a high level proposal - see if the trust can put anything to it - lesley the trust would not prioritise funding at risk if the new ct scanner on dhh was in place - send through high level proposal

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

Lesley - any opportunity to take any of the breach reports off the table -pre this meeting - david happy for karen and angela to go through the breach reports and then give a high level summary at the meeting - angela will email karen and give the detais

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST CANCER PERFORMANCE MEETING
WEDNESDAY, 22 JANUARY 2020 @ 12NOON
CR1, 2ND FLOOR, LINENHALL STREET, BELFAST

LNL; LL;
Jill; Lisa; David; Karen; Romana
BC; RC; Amie; Martina; Angela; Fiona
HSCB Paper

Trust Breach Report

14-day - all due credit to this - LL in context of our routine waits we cannot see and are stretching out -AN 35-weeks expecting to come down as doing some super Saturday clinics - LL bit concerning for volume associated with this - DMC asked if we are helping NT - RC/AN said havent seen it formally - Lisa putting on the record formally.

31-day

62-day - December provisionally is 61%

62-days - 175 breaches to 534 - this is April to November

Active breaches - marked deterioration in UGI and LGI with Urology being challenging

ITTs 33>28-days and 23 >62-days

>85 day waits -

Longest waiters

KL went through top 5 with Angela

Main concern was first outpatient with Urology - Lisa - interesting the Urology london team don't do a first OP for prostate they go straight to MRI and then to Nurse specialist - they don't go to Consultant for prostate - LL Mark H is concerned and similar Regional position except WT - David the consultant has been appointed in WT and allocation letter going to them (the delay in that is the role has been extended for penile cancers and erective dysf for penile implants) - when the allocation goes they will have conversation around taking off our backlog and our new demand. LL no Regional action - Lisa says London might be the suitable option - the whole London teams work as a cohort so in 2weeks your are suspicious or not suspicious following MRI. Looking at it bitesize. Lisa has asked for their clinical guidance on triage and pathway.

Dmcc are calling a Regional workshop for DECC on 13th March - Martina not sure how many consultant we be free - David has agreed with joanne that if too many apologies the meeting will be rescheduled - this is our opportunity to resdesign how we deliver the services - LL martina advised that Mark had raised to Miriam

Urology - long first appointment wait - MRI ok - wait for biospies and review

Lower and Upper GI - current wait for CT colongraphy - 75 days to 102 day wait - Angela we are outsourcing CT Colons to IS - it is a capacity issue -
KL some delays down to scripts - some not ready; delays in patients collecting; Angela advised / BC said that these were the tail end of the issues -

BC in relation to cTC cross reference to modular CT on DHH - if we can keep this opens up opportunities for increased CTC capacity in the Trust - BC and Imran Youssaf are going to SMT. Lisa has it been used for CTC - not yet. The modular cannot do CTC but can move other scanning to the modular and then do CTC in core scanner.

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

Colonsocpy wait

UGI 3 days to 48 days for first appt - OGD 8 day to 32 days; CT 4 day to 13; ctc 77 and 88 days wait; colonos 32 day wait; PET

Karen emailed Angela this mornign re: some queries and angela has responded.

Lisa noted multiple escalations. KL advised that Angela noted staff shortage in tracking.

David - Urology - you know we are sitting on recurrent investment for another consultant - in Team of 6 do you still have a vacancy - it is not a vacancy it is Matthew Tyson on secondment to end of June in New Zealand for fellowship. He should be back mid july. If he comes back will that improve first appt - MC ?? Theoretical it should. MC the fellowship was in Stones and he might want to come back and do stones and drop out of MDT. David would like to hear Mark's take on it. MC you need to remember that these are patients who may lose a kidney because they are not getting their stones treated.

MC very hesitant that matthew not do stones. This seems to be their priority and his priority.

Ronan - constant theme is limiting factor for moving forward with extra urology lists in dhh due to theatre nursing.

David - has the Trust got a plan to secure the physical space in theatres. RC the physcical space is there; need capital for equipment; but the limiting factor is getting staff for threate. LL lot of work done

60 x Band 5 nurses short across theatres in CAH and DHH across all theatres.
Another 60 in surgical wards.

Lisa need to work through it as we have ear marked money for this consultant. David said that this would give more assessment capacity. MC concern is then the bottleneck for treatment. Lisa said you could also clear patients off the RF pathway if they are assessed and ruled out. DMCC we should be still pushing ahead on the appointment of the consultant and in parallel sort out the staffing. LL an IPT has been developed and costed and is going to Investment Committee. We are working through everuthing.

LL other issue around the stone work - this was a priority in the elective plans - it's a fine line to keep the consultants with their subspecialist interest and it is a balance. If we can link to the Regional work we would want to build onthis. STC is one of the DECCs plans and Regional waiting list.

Lisa - Haematology.

Anglea - the haem d160 is incorrect. It came in via surgical. It has been closed off and has started treatment.

AOB

LL - request from Primary Care to share the RF wait times with GPs - this is on the back of the PCC report - the RF waits is their priority over the other waiting time information - LL we are sharing with our AMD GPs and then will be sharing wider - want to make sure HSCB have sight of this - Lisa would like us to share with them also to see what we are sharing. LL we will send to you and AMD GPs. David - Ciara lloyd had been working on this and RF was not part of it. LL we usually go for the longest wait. This has been a specific request and our PCC have requested it.

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
19 MARCH 2020
VIDEOCONFERENCE

Meeting cancelled by HSCB

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
28 MAY 2020
VIDEOCONFERENCE

Meeting cancelled by HSCB

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
30 JULY 2020
VIDEOCONFERENCE

Meeting cancelled by HSCB

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
THURSDAY, 24 SEPTEMBER 2020 AT 2.00PM
VIDEOCONFERENCE

Meeting cancelled by HSCB - agreed by Trust

HSCB / TRUST CANCER PERFORMANCE MEETING
THURSDAY, 26 NOVEMBER 2020 AT 2.00PM
VIDEOCONFERENCE

? 31-day what is issue for skin – BC notes pressure with staffing and access to theatres – starting to deescalate and release some capacity back in to the system

LL – because of the volumes on the pathway – we will get worse before better
BC – previously would have been sitting at 2500 patients on pathway – now at about 4000

LMCW – important that this narrative is given to Trust Board and HSCB Board meetings

DMCC – 62-day breachers – looking at active 62-day there is 560+ on lower gi – Completed breachers – urology cancer about 40% - ? issue with TP biopsy – WC confirmed that we will be able to increase the capacity over the next couple of weeks – LL small numbers going to SET – no money required for any further work with Chris and SET

QFIT DMCC delays – ST is adding patients to the list before the QFIT is returned from the patient which is different to what other Trusts are doing – AN said delays can be between 3weks and 8weeks problems with patients not accurately completing the date of the sample. AN prioritising patietns based on high QFIT results and out of chronological order – if patient is less than 10 then the consultant contacts the patient to discuss and confirm if remaining on the pathway – has been debate about when the clock should start – when QFIT moves to GP then we will only add when the result in sent to us – LMCW noted also about the issue of what the threshold is for the GPs to refer on – picking this up through the endoscopy network. AN seeking a Regional position on what the Trusts will do if the patient does not return the QFIT. QFIT meeting chaired by Louise Herron.

LL – general capacity pressures across all pathways – challenged with accommodation issues – once get past diagnostics then issue is surgical capacity – even with de-escalation then we are severly limited with theatre
BC – CTC pressure point – need 25 a week to match demand and capacity – have done some internal work – some IS work – having to balance discussionsn with the Teams that CTC is not in lieu of a lengthy endoscopy waiting list –
BC ourselves and BT are the most challenged for theatre capacity – just meeting Category 2a and 2b – pre-covid working 30% under staff and now have been badly hit with the ICU escalation – speaking with consultants weekly and how we are gong to recover – is there a level playing field in the Region for these cases – would benefit from additional IS capacity –

DMCC – JT trying to be as transparent in share of capacity – at meeting before this looking at capacity within SWAH – could we maximise this for ST patients? Mark Haynes not keen.
LL for scopes anything with travel time if prep doesn't work – working with SET re: LVH – IS capacity is so small – our internal loss is our biggest issue. AN scope will increase to 19 per week from next week –
Breast – AN re: breast prioritisation – all other Trusts are using ??? versus what we use for categoriations – LMCW just had that conversation with the Department and PHA –
LMCW thinks the game is different – it is about the totality of the resource and how we would do this

MMCC – is it bigger than just acknowledging?
LMCW – yes we need a way to do this to ensure equality of access not just for red flag as some benign conditions are more time critical – working through with Departmental colleagues

BC majority of gynae are category 2C so therefore, they understand their share will be less – 20 consultants across both sites and they have got 0.5 lists per week! Gyane consultants are watching to see how the BT consultants did in SWAH. Our consultants keen to get capacity as worried about de-skilling. They will consider other sites.
DMCC – plan was that Paul Doherty would detail SWAH capacity and Trusts to say here our priority patients and given priority to use those theatres. Will be opportunity via Monday meetings.

DMCC PAS technical guidance – Alastair Campbell and Charlotte McArdle – may need to re-examine the categorisation. There is going to be a piece of work to that at that document again to make sure there is a level playing field across all the specialties.

LL where are the discussions around SWAH happening? DMCC ?? between Geraldine McKay and the Department. Highlight our suggestions at the Monday meeting. DMCC identify what specialties and what procedures you would like and identify who would go ie. Surgeon / surgeon & anaesthetist / surgeon, anaesthetist and support staff. SWAH have a laminar theatre and a ward mothballed. ? they could cover the oncall arrangements.

LL need to see what types of kit they have before we talk to our folks. Mel we have had a few conversation with Geraldine – more comfortable with general surgery and gynae. No appetie for orthopaedics or haematology. But potentially elective surgery.

Mel what is our ask; what is acceptable to our consultants; what can they provide. Mel has asked Ronan to gather this. David will alert Paul D about this to make sure he has all the necessary information.

Active 62-day breachers – concern around the volumes – AN some concern from the breast team around screening and the impact – trying to catch up on the backlog and then continuing the screening then they will hit the surgical need and breast will start to breach greater than normal pattern. AN ?? they have a feel that they are getting a higher rate of patients than normal.

Urology patient ITTd to Belfast – what is particular issue – SG was a TP biopsy wait

D85+ LGI UGI and Urology

Karen Lusk – key points – KL met SG on Monday – QFIT; CTC;
One in particular wants to discuss – skin patient – DNAd but not off the pathway – SG noted the patient was in bluestone so given leeway on that – KL to go back to SG with a few other queries

DMCC was there an issue around suspensions – SG yes some queries etc around what we can suspend or not – all met Regionally yesterday – SG anything not covid related we will apply the suspensions – only those that have covid fears will not be adjusted –
SG also issues with patients choosing to not self isolate or participate in the swab testing – DMCC ? raise at cancer cell tomorrow. Personal feeling is then refer back to referring clinician and the consultant ? remove them off the list and invite for face to face review. If they refuse then discharge back to GP. ?? letter used by SET – should you be able to suspend for 3-months and if they then refuse again discharge them.
DMCC will raise at the Cancer Reset Cell to get a generic agreement to roll it out across. SG anything that is not covid related will be returned to IEAP compliance and SG will be tidying up those pathways.

SG keen to get a Regional direction on suspensions for patients not following / returning the QFIT.

DMCC Chris in SET has knack for securing scope capacity – AN noted that we are using the weekends in Ulster for colons and then OGDs in LVH. We are using our Endoscopy monies to cover this.

DMCC enquired about Radiology – is there a place for all of this – LL we are still working through and challenging but trying to work to draw this to a conclusion. LL ? would like to run the funding into next year. BC made a bit of progress – data map set out and with DLS. Chicken and egg – cannot get connection if no contract – cannot get contract without connection – challenging and outwith our control. BC NOUS is our big concern and if we can carry forward. LL know that we cannot carry over – if we give it back to you can you give it back to us as first call. DMCC ? any consumables?? DMCC will ask. DMCC ? any other capacity.

MW was to raise the waits at the MRCN. DMCC going to speak to MW again after this meeting – need to look at the RF and Urgents only and not the totality or planned in the future.

MMCC – have to say it is broader than diagnostics – when we were standing down RF and Urgent for the ICU surge yet other Trusts were standing down routines and activity that we haven't don't for year. DMCC acknowledged and Mark Haynes had raised this to Lisa and David regarding a Regional prioritisation and regional oversight to make sure applied appropriately and also then the capacity acknowledged in his allocated on the basis of need.

LL two amounts of funding at risk and hope to have position by mid-week.

Orthopaedics – DMCC – when will we know?? LL hope to have early decision next week. DMCC has someone who could potentially spend.

DMCC needs definitive answer by next week. DMCC will see if there is any other capacity out there ? SWAH.

FSSA guidance

- Breach reports submitted to Karen Lusk

- Telecon between Sharon Glenny and Karen Lusk on Monday, 23 November 2020 to discuss breach reports. Sharon reported:
  - Very light touch undertaken by Karen as it was acknowledged that not much change from previous discussions;
  - Pressures felt in the system were acknowledged;
  - Karen noted that all Trusts noted were in a similar position; and
  - All other Trusts have decided stood down their cancer performance meeting.

- Referral patterns are back to pre-Covid levels.

- Currently tracking circa 1100 patients on the 31-day pathway (albeit only a small volume are formally on the pathway); and circa 2900 patients on the 62-day pathway. Top 7 tumour site volumes on pathway as follows:

  - LGI 38%;
  - UGI 18%;
  - Skin 14%;
  - Urology 10%;

- Breast 7%;
- Gynae 6%;
- Head and Neck 4%

- 1861 awaiting first appointment, with 416 having appointments in the future. Lower GI tumour site has the largest volumes of unappointed patients.

- Some concerns around confirmed cancer rates – reference Northern Ireland Cancer Registry information where ST appears to have a lower rate than the other Trusts.

- Tumour site pressures:

  - Lower GI – delay in first appointments; QFIT; and CTC pressures – challenges with patients not returning their QFIT and no adjustments permitted on CAPPS due to 'Covid fears' – Matthew McAlinden is following up on QFIT non-responders – of note there appears to be a low level of discharge of patients with a low QFIT score as Consultants appear keen to still scope the patients.

    Action: Need to raise the issue of suspensions; failure to return QFIT etc with HSCB – also wider impact on all steps on the pathway for non-covid reasons

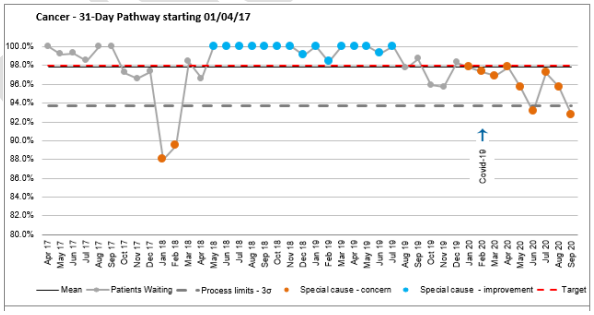
    Of note SET have sent a letter to patients re: 'Covid fears' – Barry to talk to Mark Haynes re: Covid fears; non-responders; refusal to attend for swab / refusal to self-isolate.

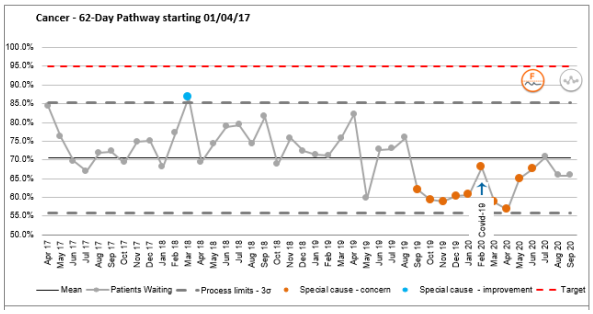
  - Urology – delays with TP biopsies – machine has been moved to STH and an all-day list will be undertaken in lieu of flexi sessions – when Thorndale is reinstated (? wc: 23rd November) the machine will be moved back to CAH and capacity will be sufficient.

  - Upper GI – delay in first appointment; scopes; diagnostics.

  - Skin – challenges with excisions due to Covid fear / refusal to self-isolate.

- Whilst performance appears to be holding in comparison to previous year need to consider that this is only the patients completed and if the high volumes on the PTL complete then performance is likely to take a sharp and significant decrease.





- PET – 2nd scanner up and running in BCH and therefore, not using Blackrock – wait time circa 3-weeks – BT are risk stratifying confirmed cancers first and diagnostics second.

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

- Escalation process still on-going, although now doing in a 'batch' manner. Tracking not up to date – peak for UGI and LGI.

- Urology review – separate MDT being established to discuss patients from the Orthoderm reviews.

- Cancer reset cell have agreed to wording from radiology requests, as drafted by Maria Wright – all Trusts to apply – Barry to share at internal cancer meeting.

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

62-Day Cancer PTL @ 18 November 2020

Tumour Site	Active Volume	% of Total	Suspect	Confirmed
Acute Leukemia	3	0%	3	0
Brain	2	0%	2	0
Breast	206	7%	195	11
Children's	1	0%	1	0
Gynaecology	167	6%	165	2
Haematology	56	2%	55	1
Head and Neck	115	4%	112	3
Hepatobiliary/Pancreatic	1	0%	1	0
Lower GI	1067	38%	1061	6
Lung	26	1%	26	0
Other	11	0%	11	0
Sarcoma	4	0%	4	0
Skin	393	14%	389	4
Testicular	7	0%	7	0
Thyroid	2	0%	2	0
Upper GI	508	18%	506	2
Urology	275	10%	267	8
Total	**2844**		**2807**	**37**

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST CANCER PERFORMANCE MEETING
WEDNESDAY, 13 JANUARY 2021 AT 2.00PM
VIDEOCONFERENCE

Meeting cancelled

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST CANCER PERFORMANCE MEETING
FRIDAY, 7 MAY 2021 @ 10AM
VIDEOCONFERENCE

LNL; Barry; Sharon; Melanie; Ronan; Clair
David; Jill

- David noted that Sharon and Karen Lusk have already gone through the breach reports
- David happy that this meeting is lead by the Trust
- David noted that he has agreed with Lesley that HSCB will recurrently fund the Nurse Endoscopist post, that the Trust put in at risk - Caroline Cullen is developing the IPT for this
- David also noted the new guidance issued in respect of adjustments to be made due to Covid fears ie. reinstatement of IEAP

Breast Review

- David advised that Paul Cavanagh has written to Ryan Wilson in the Department in respect of bringing forward some of the outcomes of the Breast Service Review
- Stephen Boyd BT is to release one date for ST patients - likely to be only 15 patients
- Need a longer-term solution
- David noted the % of patients discharged following first appointment in SET - Lynn noted the pattern of referrals from Primary Care, in to the Symptomatic Breast service, without having seen a GP or having had a physical examination - with the pressures on the service it is vital that Primary Care play their part - Barry also noted this pattern across all tumour sites
- Melanie suggested that this also be re-enforced down NMS lines and ask Margaret O'Brien to push down to Primary Care - Melanie advised of our DOS which has gone live - David asked if this could be shared with him - **Action: Lynn to send DOS link to David/Jill**
- Melanie asked Ronan to also raise at the Surgical Ambulatory Working Group to re-enforce the need for Primary Care to 'do their bit'
- David noted that on e of the key recommendations from the Breast Review was a centralised waiting list - David has asked to expedite this
- Melanie advised that at RMB this was agreed in principle - however, the logistics of central booking to be considered and also critical to have clinician engagement at the start of the process - David noted that on this basis this will help the transfer of patients to BT

Pressures on Tracking

- Barry raised the current pressures on the Tracking Team
- Sharon advised that based on Cara Anderson's previous analysis, based on 2017 figures, the ST required 8.6 WTE trackers - we only had 3.9 WTE plus 1.00 WTE recurrently funded recently - the remaining posts, which the Trust have at risk, are covered off non-recurrently
- Sharon noted that given the current volumes that we are tracking, we have a need for a further 1.50 WTE on top of the gap of 4.6 WTE - total funding required for 6.1 WTE
- Barry confirmed that we needed this recurrently - David advised that no recurrent funding at this time
- Melanie noted that on the context of recent SAIs, which is moving to Independent Inquiry, there are a number of recommendations which will require Commissioner funding to fill the gaps identified via the SAIs
- David to talk to Caroline / Cara regarding the funding for the 6.1 WTE

Quarter 2

- Barry enquired about Q2 bids
- Lynn advised that she had sent an email out this week seeking the Q2 bids
- David asked Lynn to 'tag' the Q2 bids on to the Q1 bid
  Action: Lynn to join Q2 bid onto Q1 bid

Theatre Capacity

- David enquired about the Trust's ability to increase theatre capacity
- Ronan noted that the Trust had 75 staff nurse absences

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

- Ronan advised that currently:
  - CAH - 2 urgent bookable lists - for all surgical specialties including Trauma and Orthopaedics
  - DSU - doing endoscopy, some Orthopaedics, and some Pain
  - DHH - hope to have 1 half day UBL from June
- Ronan noted the concerns of the surgeons in respect of the low volume of surgeries that they are able to do
- The surgeons would like to know what the elective activity is like in the other Trust's by specialty for IP/DC/Scopes
- David advised that he will share the information previously given to RPOG - Lynn asked that Method of Admission / Urgency code be included - David to ask Cathy Gillan to amend and re-run - David to also routinely share the RPOG meeting minutes to Lynn - Lynn will share internally
- Lynn raised the issue of P3 and P4 categories being included in the technical guidance now - David to check with John McKeown as he was unsure if there were sufficient fields/codes
- Ronan advised that they have 9 International Nurses starting and some S/Ns coming back - Melanie noted that a number of internal actions are also being undertaken to try and address the theatre nursing situation
- On the basis of the pressures on the Trust and that BT are hoping to switch on 70% of their pre-covid theatre capacity - David is going to speak to Lisa McWilliams to discuss the re-balancing of the IS capacity towards ST given that BT lists are increasing significantly

Cancer Reset Cell

- Barry noted the linkages between the Cancer Recovery Cell and the Elective Recovery Cell
- David advised that he had just reviewed the Elective plan which was at a strategic level - rather than a practical/operational level - the backlog gap is costed at £700 million with an annual gap of £115 million

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
5 JULY 2021
VIDEOCONFERENCE

Meeting cancelled by HSCB

HSCB / TRUST CANCER PERFORMANCE – PERFORMANCE TEAM INFORMAL (INTERNAL USE ONLY) MEETING NOTES

HSCB / TRUST SERVICE ISSUES AND PERFORMANCE MEETING
8 SEPTEMBER 2021
VIDEOCONFERENCE

Meeting cancelled by HSCB

Southern Trust Cancer Performance Meeting 25/11/20

Meeting Format

* Overall Cancer Performance
* 31 day Cancer performance
* 62 day Cancer Performance
* Breaches against 31 & 62 day Waiting List
* Late ITTs
* PTL
* Longest Waits on PTL

Overall ST Cancer Performance

	18/19	19/20	20/21
Breast 14 Day	99%	100%	96% (Apr-Sep)
31 Day	99%	98%	95% (Apr-Sep)
			65% (Apr-Sep)

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Overall ST 31 day Cancer Performance 2020/21 (Apr-Sep)

Tumour Site	Total Breaches of 31 day	Total Treated	Tumour Site Performance
Brain/Central Tumour	0.0	1.0	100%
Breast Cancer	6.0	112.0	95%
Gynae Cancers	3.0	22.0	86%
	0.0		
Head/Neck Cancer	0.0	12.0	100%
Lower Gastrointestinal Cancer	0.0	66.0	100%
Lung Cancer	0.0	38.0	100%
Other	0.0	17.0	100%
Sarcomas	0.0	1.0	100%
Skin Cancer	10.0	107.0	91%
Upper Gastrointestinal Cancer	0.0	37.0	100%

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Overall ST 62 day Cancer Performance 2020/21 (Apr-Sep)

Tumour Site	Total Breaches of 62 day	Total Treated	Tumour Site Performance
Breast Cancer	3.5	76.5	95%
	8.0		
	6.0	16.5	64%
	17.5	25.5	31%
	3.0	5.5	45%
	8.5	16.0	47%
			65%

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Active 31 day Breaches as per WL taken on 04/11/20

Tumour Site	31 Day Breaches	
	4th Nov 20	2nd Sep 20
	2	0

Active 62 Days Breaches as per WL taken on 04/11/20

Tumour Site	62 Day Breaches	
	4th Nov 20	2nd Sep 20
Haematological Cancers	22	6
Hepatobiliary/Pancreatic	1	
Lung Cancer	2	
Skin Cancer	42	21
Upper GI Cancer	152	91
Grand Total	**856**	**719**

Active Patients on a 62 day pathway ITT>Day 28 as of 04/11/20

Tumour Site	Number ITT'd over 28 days	Number ITT'd over 62 days	Longest ITT day	Receiving Trust
	3	1	65	Belfast
	1	0	51	Belfast
	1	0	42	Belfast
	3	1	98	Belfast
Urological Cancer	5	4	226	Belfast
	13	**6**	**226**	
Trust rec'd	**1**	**0**	**42**	

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

85 Day Waiters as per PTL taken on 04/11/20

	Southern Trust		REGION	
Tumour Site	**No. Waiting 85+ days**	**Max Wait (days)**	**No. Waiting 85+ days**	**Max Wait (days)**
Breast Cancer	0	*0*	3	*248*
Gynae Cancers	1	*100*	18	*199*
Haematological Cancers	12	*134*	15	*134*
Head/Neck Cancer	0	*0*	23	*168*
Hepatobiliary/Pancreatic	1	*152*	3	*152*
Lower GI Cancer	401	*430*	1471	*430*
Lung Cancer	0	*0*	4	*300*
Other Cancer	0	*0*	1	*120*
Sarcomas	0	*0*	1	*90*
Skin Cancer	22	*288*	196	*288*
Testicular Cancer	0	*0*	1	*140*
Upper GI Cancer	96	*296*	446	*320*
Urological Cancer	76	*371*	317	*448*
Thyroid Cancer	0	*0*	1	*91*
Total Waiting 85+ days / Longest Waiting time (days)	**609**	***430***	**2500**	***448***

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Longest Waiters
as per PTL taken on 04/11/20 (62 day pathway)

Days Waiting	Casenote No.	Tumour Site	Day Of ITT	ITT Trust
430	Personal Information redacted by the USI	Lower GI Cancer		
343		Lower GI Cancer		
335		Lower GI Cancer		
317		Lower GI Cancer		
371		Urological Cancer		
370		Urological Cancer		
317		Urological Cancer		
317		Urological Cancer		
296		Upper GI Cancer		
278		Upper GI Cancer		
273		Upper GI Cancer		
268		Upper GI Cancer		
288		Skin Cancer		
216		Skin Cancer		
190		Skin Cancer		
112		Skin Cancer		

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 18th March 2021 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Ms E Mullan, Trust Chair
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director (item 10 only)
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Leeman, Assistant Director Performance Improvement
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

None

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and no apologies were noted. She particularly welcomed Ms Eileen Mullan, Trust Chair and Mr Eoin McAnuff, Boardroom Apprentice to his first Performance

Committee meeting. At this point she advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 3RD DECEMBER 2020

The Minutes of the meeting held on 3rd December 2020 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Cancer Services was agreed as the themed area for the next meeting.

The Chair requested that item 10 be discussed at this point

10. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

Dr O'Kane presented the Infection, Prevention and Control, Antimicrobial Stewardship report for assurance purposes. The paper provides data from 1st April 2019 to 31st January 2021 for PFA target. She advised that the deferred December report is included in members' papers.

Dr O'Kane reported that following the increase in Clostridium Difficile in 2019/20 with a significant rise in October 2019 she provided assurance that the team continues to work with Directorates to reduce Clostridium Difficile and the rates have reduced in 2020/2021.

The IPC team and Microbiologist between Covid-19 surges while continuing to support the management of Covid-19 in Trust and with Independent Sector providers are refocusing attention on C difficile, AMR and Gram negative bacteraemia with the current resources.

A discussion ensued on the long term use of antibiotics and Dr O'Kane explained that antibiotics have been used to treat patients with Covid-19 infection and this has increased the use of antibiotics throughout the Trust. She added that Dentists who were restricted in who they could treat during the pandemic also saw an increase in the use of antibiotics. Ms Donaghy referred to the monthly target monitoring report from PHA on secondary care antimicrobial prescribing data and asked if the Trust routinely receives feedback or a comparison to other Trusts from the PHA. The Chief Executive commented that feedback has been requested on a number of occasions. Dr O'Kane agreed to contact the PHA on this matter and feedback at the next meeting.

Action: Dr O'Kane

In regards to MRSA, Dr O'Kane reported that there have been three preventable MRSA bacteraemia from April 2020 to March 2021 and post infection views have been carried out to identify learning.

Antimicrobial Stewardship Activities were discussed. Dr O'Kane stated that due to Covid-19 pandemic, there was less availability of microbiology time to become involved in antimicrobial stewardship activities. However, pharmacist led antimicrobial stewardship rounds continued with monthly feedback on prescribing to the DHH and CAH Medical M&M. In addition, monthly antimicrobial stewardship reports were sent to all clinical, lead nursing and pharmacy staff within all directorates.

Mr Wilkinson commented that Infection Control will continue to be paramount for the safety of patients and enquired if the staffing levels within the IPC team were adequate. Dr O'Kane acknowledged that the IPC team is relatively small for the amount of work that they undertake throughout the Trust and community and explained that training a registered nurse to become an Infection Control nurse takes two years. Dr O'Kane added that recruitment for microbiologist

and band 7 IPC nurse, and band 6 ICPNs is in progress. She advised that an IPT (Investment Proposal Template) has been submitted to the HSCB. The Chief Executive added that he has written to the Permanent Secretary requesting additional support to enhance the IPC team.

Dr O'Kane left the meeting at this point

6. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented two reports for this section: Performance Report for assurance and Corporate Performance Scorecard for approval purposes.

Mrs Magwood began by updating the committee on regional planning and the development of a new Future Planning Model. Directors of Planning /Performance are the Trust representatives on the regional group led by the DOH/HSCB. This will see a new outcomes driven model, building on local relationships with primary care particularly advanced through the system response to the covid-19 pandemic towards a NI Integrated Care System (ICS) with prototypes to be established in each Trust geographic area. It is anticipated a new performance monitoring regime aligned to an integrated care system will be introduced based on a range of outcomes, indicators and targets (where appropriate). Updates on progress will continue to be provided to the Performance Committee. Mrs Magwood stated that during the transition period to this new planning regime the Trust continues to monitor performance through the monthly Performance Scorecard, Rebuilding Plans and Performance report to Committee.

Ms Donaghy asked how the integration and collaboration in building local relationships with Primary Care will be achieved. Mrs Magwood spoke of the relationships already in place with the LNC, GP Federation Leads and Associate Medical Director within OPPC. She advised that there is a great willingness to work together and she provided examples of achievements through the Covid-19 pandemic; emergency department phone first service, Paediatric Consultant providing a Paediatric Advice Line (PAL) to support GPs and to help reduce hospital admissions.

Mrs Magwood stated that the initial plan is to build up the relationship between Primary and Secondary care and the integrated care system will build on after and include for example other parties through our community planning relationships and inclusive of other statutory agencies and services users. She emphasised the importance of building relationships in the first instance.

Rebuild Plans were discussed. As previously reported, the recent wave of the pandemic significantly impacted the rebuild in the period January – March 2021. The Trust is currently developing plans for Quarter 1 of 2021/2022. This will identify planned actions aligned to the de-escalation of intensive care and critical acute services balanced with the necessity for staff to take annual leave / rest periods before resuming and/or scaling up core activities.

The Chair referred to the joint Covid-19 Contingency Framework for the delivery of services to vulnerable children that was developed by the Departments of Health and Education and asked if changes can be made in this area from this framework. Mr Morgan commented that there are opportunities from this framework for better working across education and health for vulnerable children but noted his concern in fully achieving this with the increase in referrals re-building services and overall capacity in the system.

Mr Wilkinson asked if a potential fourth wave occurs does the Trust have plans in place to secure performance. Mrs Magwood stated that the solution would be the ongoing collaborative work at a regional level to ensure that services are available throughout the region for all patients.

Annual Care Reviews in the Older People and Primary Care Directorate were discussed. Mr Wilkinson noted that the level of reviews undertaken on an annual basis has significantly decreased due to workforce challenges, Covid-19 outbreaks in homes and restrictions to reduce footfall. He asked how the Trust is addressing this. Mr Morgan commented that Mr Beattie has been proactive in securing additional social workers to undertake care reviews and utilise remaining staff to work differently to undertake these reviews.

Mr Wilkinson referred to the home treatment crisis response service. He commented on the importance of this service and how it helps to prevents hospital admissions. Mr Wilkinson noted the increase in admissions to this pathway and asked has an evaluation of the service been carried out recently. Mrs Magwood advised when the service was first introduced through the tiered model an evaluation was carried out by the MHLD Directorate. She referred to the Mental Health Benchmarking report which will be presented under item 11 and agreed to source if there is an updated evaluation on the home treatment crisis response service. She advised she will link in with Mr McNeany and feedback at the next meeting.

Action: Mrs Magwood

Mrs Magwood guided members through the corporate performance scorecard which includes an assessment performance against established targets on a Red, Amber and Green (RAG) basis and associated analysis of trends and periods of variation. A summary of key risks in relation to the Trust's broader performance across a range of other areas considered by SMT were also included in the report.

Members approved the Corporate Performance Scorecard

7. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. **Integrated Performance Report:** *Diagnostic Imaging – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mr Barry Conway, Assistant Director, Cancer and Clinical Services / Integrated Maternity & Women's Health to the meeting. Members were provided with a comprehensive presentation in advance of the meeting which focuses on Endoscopy, Cardiac Catheterisation and Physiological Measurement Imaging.

Mrs Leeman presented information on the Endoscopy and Cardiac Catheterisation service on behalf of Mrs McClements. She began by providing background to the Endoscopy service and reported that currently there are 4700 patients on the active waiting list. Mrs

Leeman spoke of the recurrent capacity gap challenges with delivery of core services as currently the Trust is funded for 10,490 scopes; however only delivered 70% of capacity in 2019/20 due to Operator issues. She added that due to the Covid-19 pandemic and restrictions there was reduced capacity in sessions due to Aerosol generation. Ongoing Nurse endoscopy turnover and vacancy also has an impact on core services. Mrs Leeman reported on the demands for the service including significant demand for red flag and urgent scopes, routine wait times increasing and planned / repeat patients waiting beyond clinical timescales. In regional context, Mrs Leeman reported that the Southern Trust has the largest volume of Red Flag and Urgent endoscopy waits, however this data was used to inform the split of additional non-recurrent funding to Trusts for Q1 of 2021/2022 with SHSCT receiving the largest share of allocated funding. In comparison to the Red Flag and Urgent waits the Southern Trust's volume of Routine & Bowel Screening waits is the lowest, with 13% out of the Regional total. Mrs Leeman reported on the actions to manage capacity and demand as outlined in the presentation.

Mrs Leeman reported on Cardiac Catheterisation Service. She informed members that the service has a well established medical & multi-disciplinary workforce which is attractive to recruitment. There are regional links via PCI rota and BHSCT sessions. The service has a well-regarded and accredited catheterisation laboratory serving inpatients and elective day cases and there is a Research and Innovation focus throughout cardiology. Mrs Leeman spoke of the challenges within the service; capacity is below demand for the Southern Trust population which impacts on access for inpatients, lengthening wait times for urgent and routine cases, vulnerability with singular lab on Acute site – risk to in-patient provision with downtime and lack of Regional contingency plan, infrastructure challenges, lack of capacity within Independent Sector with options only for outsourced modular capacity provision and patients not accessing the Cath lab within clinical timeframes.

Physiological Measurement (Cardiac non-invasive investigations) was discussed. Mrs Leeman spoke of the challenges in recruiting trained Clinical Physiologists trained to report echocardiograms, limited capacity to undertake in-house additionality, limited Independent Sector capacity option, no recurrent funding for capacity

gaps except for TTEs, TOEs now classified as Aerosol Generating Procedure (AGP) impacting capacity per session. Mrs Leeman drew members' attention to the actions to address these issues in the presentation which highlight that recruitment for band 7's is underway, the Trust is working collaboratively with the South Eastern Trust who have provided core capacity monthly to address an element of the long waiting TTEs and in-house additionality secured for TOEs. She added that 2 Cardiac Consultants have recently been appointed who are undertaking a data cleanse of the waiting list and a Quality Improvement project has commenced within the Echo Team.

Mr Conway presented information on Imaging. He guided members through the presentation reporting data on: imaging waits, elective access, activity and regional context. He informed members of the issues that the service is facing: demand and capacity challenges - recurrent gaps for some years, high level of urgent demand for imaging when compared regionally, working within new IPC environment - Covid guidance - reduced sessional capacity, challenging capital funding environment and on-going requirement for capital investment; on-going reliance of mobile / modular kit, new Regional Imaging Board established and the challenges within the workforce. Mr Conway spoke of the rebuild in services and noted that the waits are slowly decreasing.

Mr Conway informed members that the new CT services are now available on either side of catchment area DHH and STH and the Southern Trust is the only Trust in NI to provide Low Dose CT scanning. He spoke of the future developments; twin CT suite CAH (October 2022), DHH CT/MRI suite, DHH hybrid interventional Radiology suite, reporting and training facilities on CAH site and Radiology MDT room.

The Chair thanked Mrs Leeman and Mr Conway for the detailed presentation and welcomed the actions to address the issues highlighted.

Ms Mullan stated that it was evident that using the Independent Sector for short term use was the way forward in relation to Endoscopy waiting lists and asked if there is sufficient capacity within

the Independent Sector to carry this work out and what are the risks the Independent Sector using Trust facilities. Mrs Leeman explained that a number of Independent Sectors providers have approached the Trust who can offer their own staff to carry out these procedures, therefore capacity is not an issue, however the key risk is that the Independent Sector providers are not RQIA registered, therefore to use Trust facilities the Trust will be responsible for the governance arrangements and necessary checks will be undertaken. She advised that other Trusts have used this approach and learning from them has been identified and shared and she felt that this was an opportunity to address the waiting lists. In response to a question asked by Mr Wilkinson on the cost of utilising the Independent Sector, Ms O'Neill advised that it is more expensive that using Trust staff. She also confirmed that the cost of using the Independent Sector is funded separately.

Ms Mullan asked if there was a regional plan for a dedicated elective centre. Mrs Magwood advised that regional discussions are ongoing for this topic, for example, it has been suggested that Lagan Valley would continue to be the best fit for a dedicated elective care centre and the Trust working in collaboration with this service. She spoke of the opportunities and benefits of working collaboratively with other Trusts to provide treatment and care throughout the region to work differently and maximise sites and these opportunities to improve access for our population.

Mr Wilkinson noted his concern on the routine waiting lists and asked how those patients are managed. Mr Conway advised in the first instance the Radiologist ensures that from the information on the referral they are placed on the correct waiting list and correct diagnostic test. He added that work is ongoing to validate the waiting list to ensure that patient's circumstances have not changed or they no longer require a test. Mrs Leeman commented that Primary Care will inform the Trust if a patient is deteriorating and requires urgent diagnostic testing.

Ms Donaghy asked for assurance that once a diagnostic test is carried out that the patient receives treatment in a timely manner. Mrs Leeman spoke of the developed regional process for clinical oversight prioritisation of elective cases to ensure equity. For those

patients who require surgery there is a particular timeframe in when those patients are operated on. Each week the Trust provides the list with the most urgent cases requiring surgery with the region to ensure they are given priority for surgery. She noted that the cancer recovery plan and elective plan will address this.

The Chief Executive thanked Mr Imran Yousaf and Mr Conway for their excellent leadership in driving this service forward.

Mr Conway left the meeting at this point.

8. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan presented the above named report and noted that as at 29th January 2021 there were in total 93 unallocated cases. There are no unallocated Child Protection or Looked After Children (LAC) cases. He commented on the challenges faced with maintaining a full complement of staff in the context of social work vacancies, maternity/sick leave across the service and COVID-19 contingency arrangements. Mr Morgan provided assurance that management are liaising with Human Resources to address these gaps and to undertake regular recruitment. The Chair asked on the likelihood of securing additional staff. Mr Morgan stated with the rolling recruitment programme for the Family Intervention Team and Gateway teams he was optimistic that additional staff would be secured. He added that during the Covid-19 pandemic the Trust provided a wraparound service to placement students and he was positive that a healthy number of those students once graduated would return to the Trust.

Mr Morgan spoke of the benchmarking exercise undertaken by Mr Tommy Doherty in the HSCB which looked at the previous ten years data. The data showed that there has been a 67% increase in the number of children on the Child Protection register since 2012 and has been consistently rising from 2014. He added that the Looked After Children population has had a 42% increase from 2011. Mr Morgan stated that these increases across the system adds pressure to staff and has an impact on the number of unallocated cases.

The Chair asked since the pandemic, has there been a change to the severity of cases now presenting to the service. Mr Morgan commented that the data does demonstrate that the number of complex cases is increasing which is adding to the number of cases on the Child Protection Register. He spoke of challenges and pressures young people face and how the staff manage these circumstances.

In responding to a question asked by Ms Mullan, Mr Morgan explained that there has been an increase in referrals from the BAME and other communities into the system and he felt this was a reflection of the breakdown percentage in the population across the Southern Trust region. He added that the Trust is proactively working with these communities through the Southern Outcomes to ensure that they have access to all health and social care services. Mr Morgan spoke of the translation hub which provides a range of information to communities in their own language. The community volunteer sector also works proactively with these families to help and support them.

9. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice. This report is reflective of the Covid-19 surge impacts and largely covers the period November 2020 to February 2021. Mental Health and Disability Nursing Workforce Information presentation was included in members' papers.

Mrs Trouton guided members through the report and highlighted specific areas for noting. She referred to the information on supervision and stated that the average compliance with meeting the AHPs Supervision Standards for period ending 31st December 2020 was 65%. There was a small reduction in performance by 4% when compared with September 2020 and she attributed this to service

pressures linked to the second Covid-19 pandemic surge. Mrs Trouton commented that supervision within nursing and midwifery is an area of focus to ensure that nursing staff have the opportunity within their formal supervision to discuss their career progression and training. She felt that this proactive approach would help determine those staff wishing to undertake additional training and encourage them in planning career progression within the Trust; Mrs Trouton also advised that performance data will be used to highlight particular areas where there are vacancy gaps for specialised staff e.g. advanced AHP practitioners, advanced nurse practitioner, endoscopy nurses etc.

Nursing Quality Indicators were discussed. Mrs Trouton drew members' attention to the audit results by ward over the last 3 months. She stated that the team has reviewed widening out the indicators to new areas which now include ICU, Emergency Department, Maternity, CYP and OPPC. Mrs Trouton spoke of the challenges in the commencement of indicators for these areas however she reported that results are improving.

Ms Donaghy noted her concern on the midwifery formal supervision figures. Mrs Trouton reported that this is an area for ongoing improvements and high importance. It was noted in the figures presented that there was a 75% nil response as to whether formal supervision had occurred or not. She explained that the report can only include the actual number of formal supervision that took place as reported but work is ongoing on the recording of same.

Ms Mullan queried if supervision is on the Nursing, Midwifery and AHP Directorate Risk Register to which Mrs Trouton reported that it was.

11. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) Mental Health Benchmarking Report

The Chair welcomed Mr Barney McNeany, Director of Mental Health and Learning Disability, Ms Jan McGall, Assistant Director Mental Health Services and Mrs Lynn Woolsey, Assistant Director Inpatient Services to the meeting to present the above named item.

Mr McNeany stated that the information is from the 2020-21 data from the NHS Mental Health Benchmarking dataset. Whilst the full report has not been provided to the Committee the presentation includes the areas that the Trust is closely aligned from a benchmarking perspective. He explained that for more than seven consecutive years, the NHS Benchmarking Network has been successful in providing Mental Health Trusts in England, Wales and Northern Ireland quality and performance data that inform future research, national policies and service transformation.

Ms McGall and Mrs Woolsey presented information for the following areas - Acute Adult; beds, occupancy rates, admissions, length of stay, restraint, workforce and vacancies, delayed transfers and re-admissions; Older Adult; beds, occupancy rates, admissions, length of stay, delayed transfers and re-admissions; and community mental health domains.

The Chair welcomed the informative presentation and stated that this report is an excellent tool to interrogate the Trust's performance and noted the challenges faced for the Directorate throughout the Covid-19 pandemic.

Mrs Magwood spoke of the importance of quality indicators and raised the issue of registered nursing vacancies. Mrs Trouton spoke of the recent success in reducing vacancies in this area and the effort to increase morale and attitude throughout this workforce.

In response to a question asked by Mr Wilkinson, Ms McGall explained that the dataset does provide some information as to quality of care provided to patients (e.g. caseload contacts) however the experience of the service user and analysis of their outcome is also important and captured via other means to ensure quality of care. The feedback from the peer support workers and the focus on the patient's life changes following their interaction with the service can also demonstrate how well services are performing. Mr McNeany added that the data on the readmission rate, use of seclusion and hands on intervention are important factors which demonstrate if unit is high performing. Mr Morgan added that the report shows a low number of patients detained under the Mental Health Act which is

also a good indication of the quality of community service provided. Mr McNeany informed members that discussions are underway with Trade Unions on the use of body worn cameras in the Bluestone inpatient unit and he felt that this would add another level of assurance to safeguarding measures for both patients and staff.

Mrs Woolsey spoke of the Nursing Quality Indicators already in place. She advised that work is underway to develop and introduce an additional set of specific nursing quality indicators into the unit. Such NQI's are also in place in Dementia Inpatients.

In regards to the readmission rate, follow up with patients after their discharged aims to be decreased from 7 days to 3 days in the year ahead, in line with best practice from the National Confidential Enquiry into Suicide. Ms Donaghy noted her concern that the length of stay rate could be viewed as both positive and negative. Mr McNeany agreed and explained that a balance is required between the length of stay and readmission rate. He advised that the length of stay varies depending on the diagnosis and in some cases there is a reasonable cause for readmission. Mrs Woolsey advised that going forward a piece of work will be undertaken to correlate the length of stay and readmission rate to understand if there are particular issues or an acceptable rationale and respond appropriately to the findings.

The Chief Executive welcomed the level of detail in the presentation and spoke of his concern is moving forward with a single Mental Health service for NI as the benchmarking data highlights the difference in service provided by other regional Trusts. He welcomed the focus on correlation of the length of stay and readmission rate. The Chief Executive thanked Mrs Woolsey and Ms McGall and their team for their hard work and dedication and in particular to Mr McNeany for the work that has been accomplished since joining the Trust. Mr McNeany added that it was important to note that from an assurance perspective, Mrs Woolsey and Ms McGall are taking forward work in regards to the Royal College of Psychiatrists Quality Improvement Standards for community and inpatients and this will provide a level of external assurance from peers.

12. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.30 p.m.

Signed _____ ***Dated _____***

Southern Health and Social Care Trust

Performance Committee

Agenda Focus: Diagnostic Services
(Endoscopy – Cardiac Investigations – Imaging)

Acute Services Directorate

18 March 2021 – Performance Committee

Contents: Diagnostic Services - Acute Services Directorate	Slide	Presenter
➢ Endoscopy	3	Lesley Leeman
➢ Cardiac Catheterisation	10	
➢ Physiological Measurement	14	
➢ Imaging	19	Barry Conway
➢ Professional Issues	39	Executive Directors
➢ Questions?		

- Endoscopy -

Endoscopy

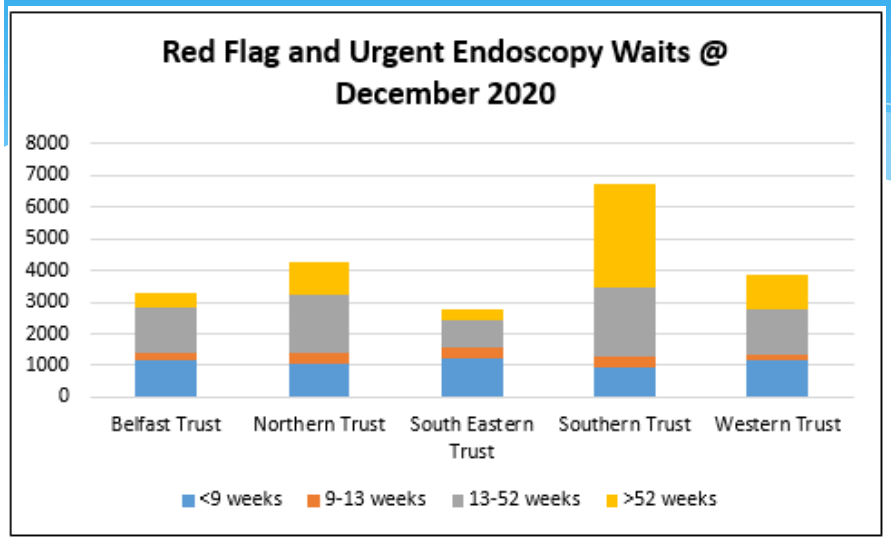
Capacity Issues

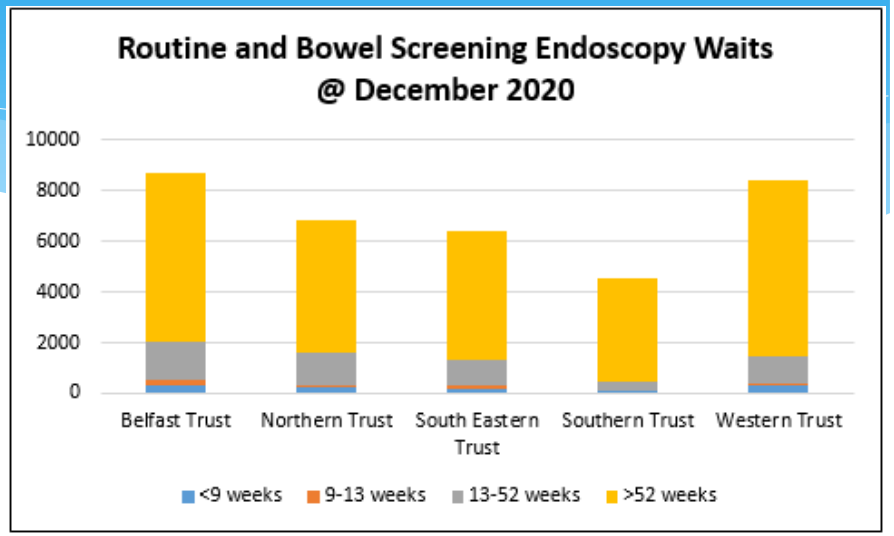
* Recurrent capacity gap Challenges with delivery of core services : currently funded for 10,490 scopes; however only delivered 70% of capacity in 19/20 due to Operator issues
* Operator capacity (40/60 split medical staff: nurse endoscopist)
* Reduced capacity in sessions due to Aerosol generation
* Ongoing Nurse endoscopy turnover/vacancy; lead in time for training (Team of 5, 2 vacancies – 1 replaced in training)

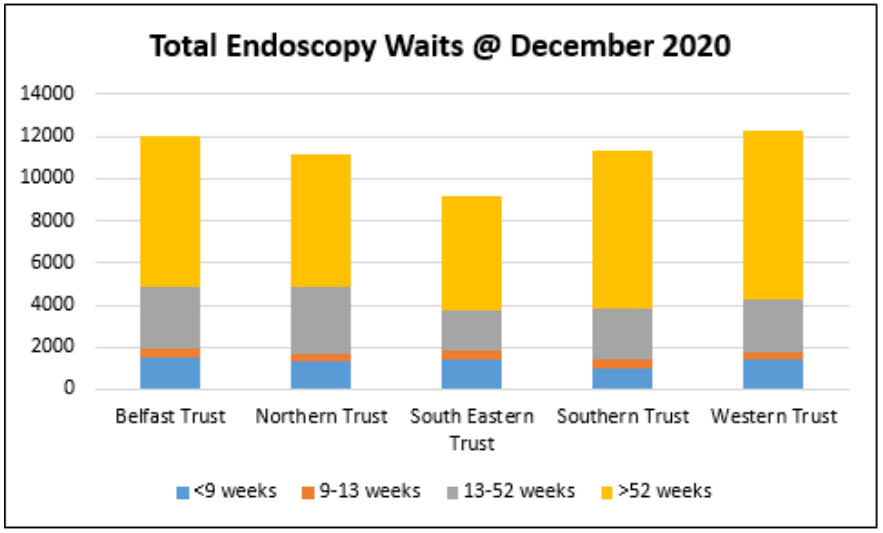
Demand

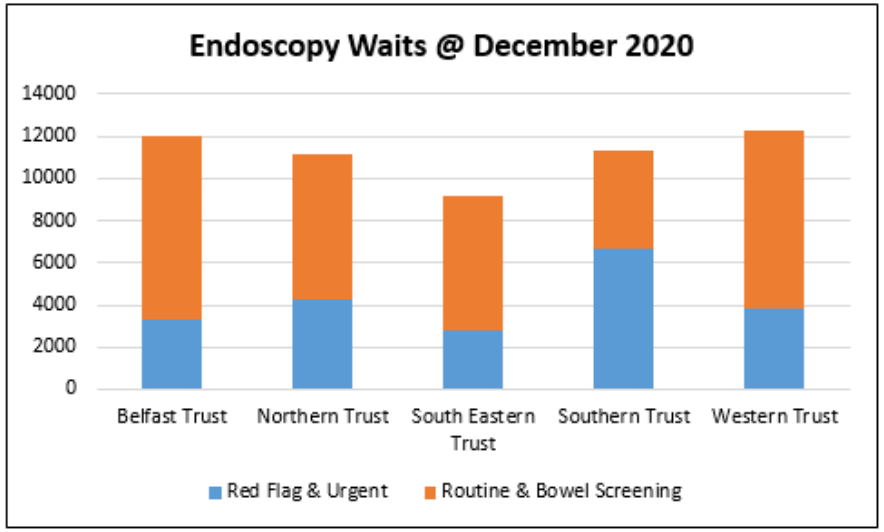
* Significant demand for red flag and urgent scopes
* Routine wait times increasing
* Planned /repeat patients waiting beyond clinical timescales

Endoscopy Regional Context

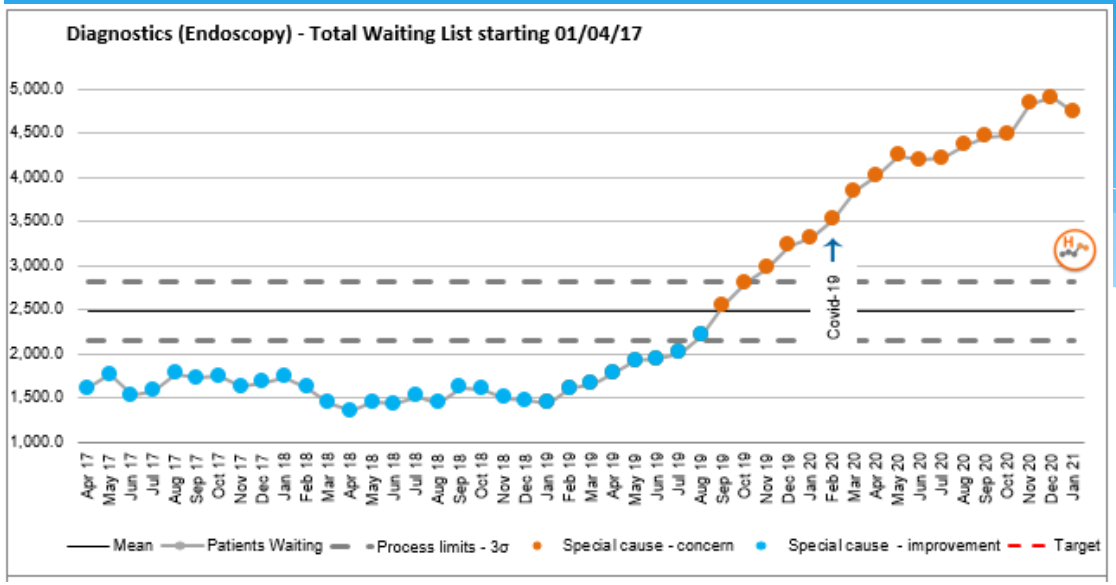






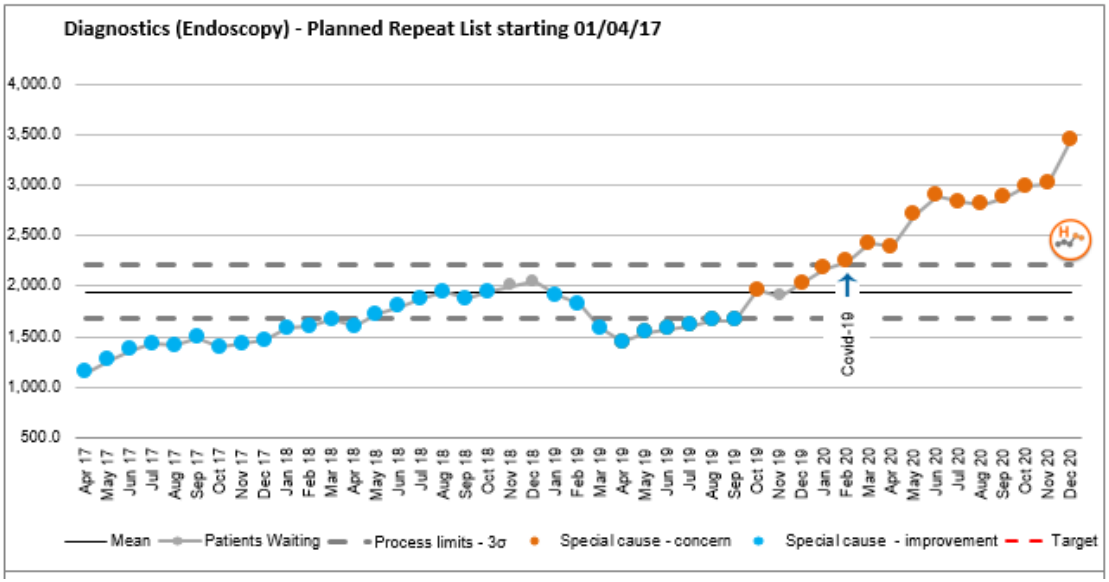


Endoscopy Waits



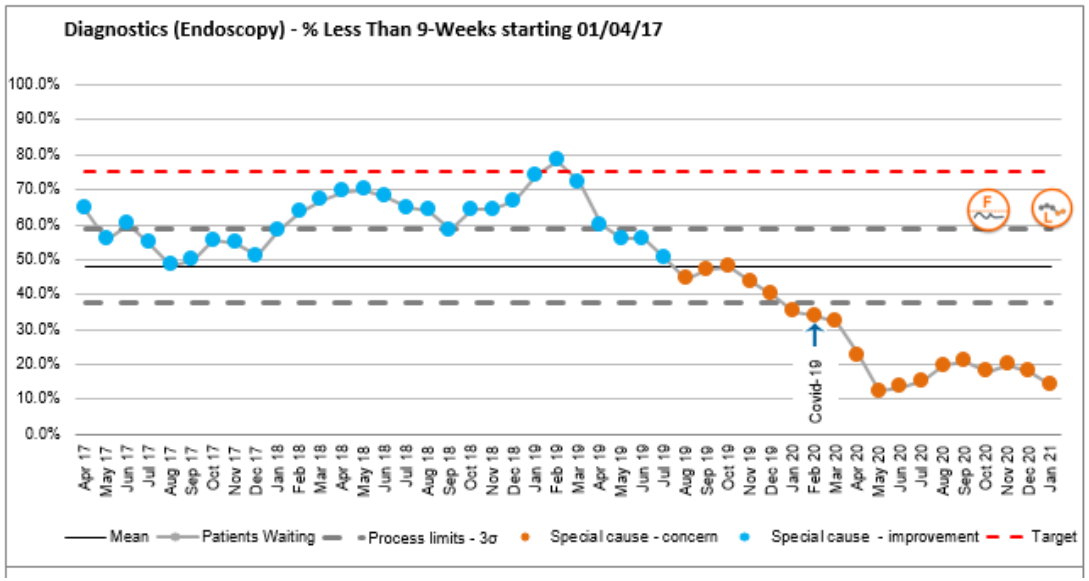
Increase in total waits by 3131

Increase in planned repeats by 2306



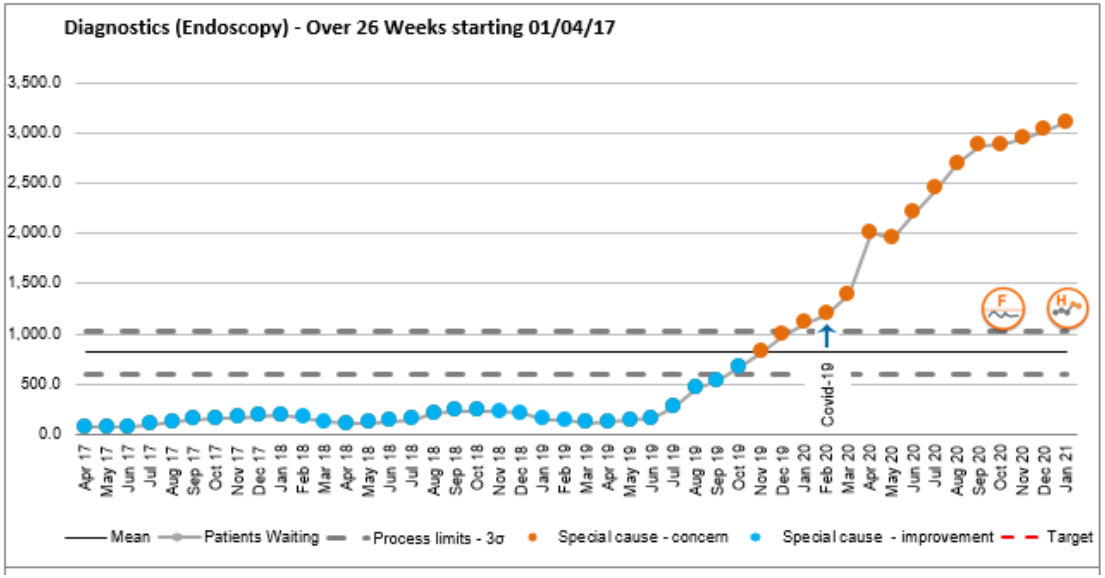
Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Endoscopy Elective Access OGI

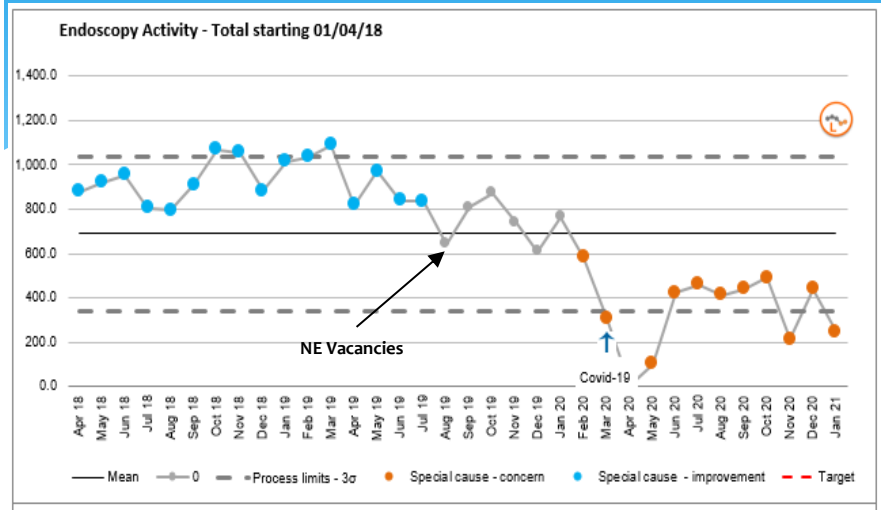


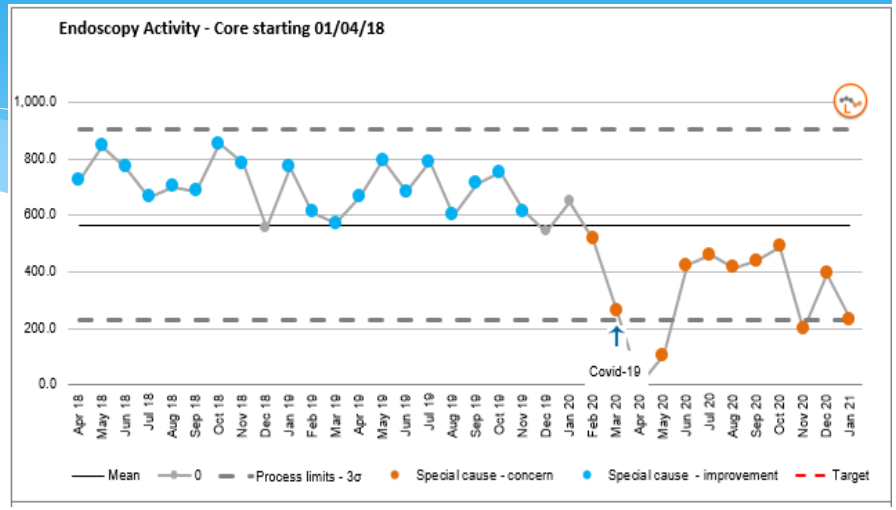
<9-weeks Decrease in performance by 50.5%

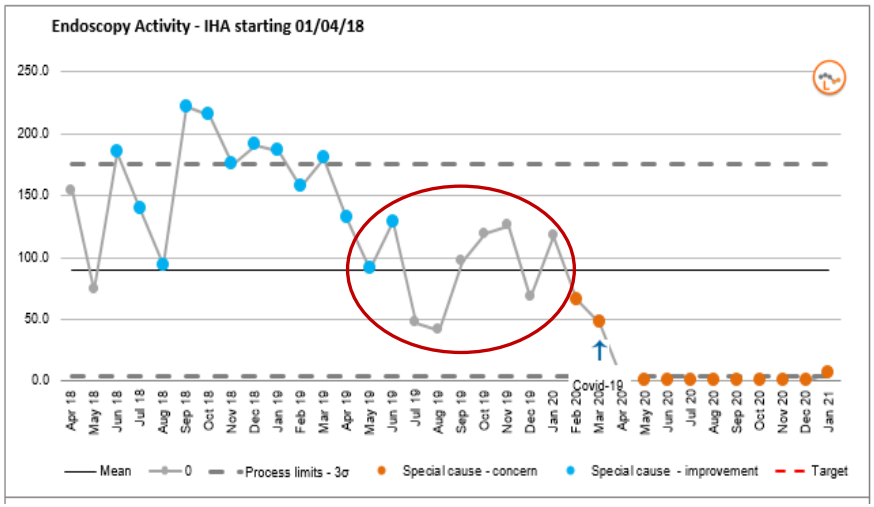
>26-weeks Increase in waits by 3035

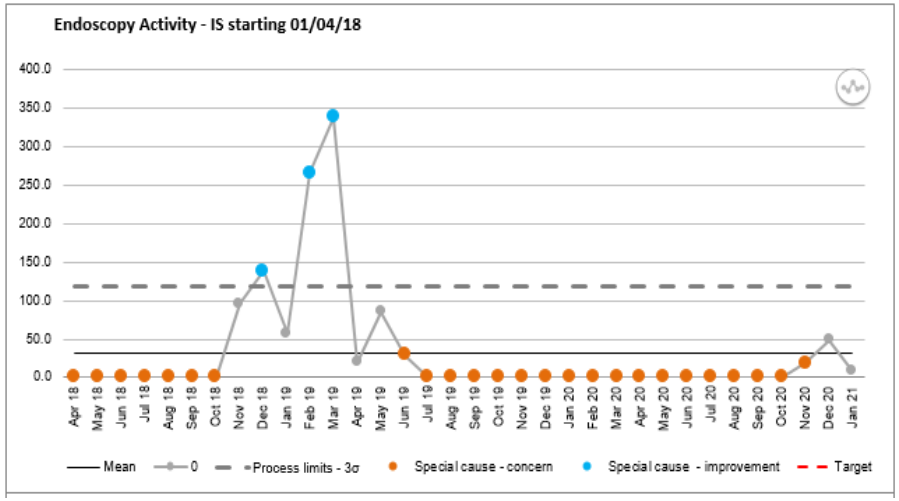


Endoscopy Activity









Endoscopy Actions

To Manage Capacity

* The Trust recruited, at financial risk, Nurse Endoscopists to increase capacity. Lead-in time for training and has new banding structure with pay progression from Band 7 to Band 8A on achievement of agreed competencies and tasks
* **Additional capacity** secured in Quarter 4 2020/2021 funded regionally on a non recurrent basis. This includes extra In-house scopes provided sessions; IS provision provided on site at South Eastern Trust, and regional at Lagan Valley Hospital
* Trust has secured largest share of regional non recurrent monies for scopes in Quarter 1 2021/2022 in line with share of urgent/red flag waits and will continue with a mixed provision of additionality & IS provision in SET in Q1 2021/2022
* Trust is developing **proposal for IS use of Trust facilities** to further increase capacity
* Additional Endoscopy sessions are coming back on line in line with de-escalation plans. Currently still less than 50% of sessions in place of pre Covid average of 40-45 sessions per week. Q1 rebuild plan will detail the pace of future increases.

To Manage Demand

* Introduction of Q-fit testing to risk stratify demand / clinical risk and On-going validation of waiting lists, including planned lists
* Internal clinically lead endoscopy users Group and Trust participating on Regional Endoscopy Reform and Modernisation Group, led by HSCB
* Regional Equalisation Programme for Elective Services

- Cardiac Catheterisation -

Cardiac Invasive Diagnostics

* Well established medical & MD workforce; attractive to recruitment
* Regional links via PCI rota and BHSCT sessions
* Well regarded and accredited catheterisation laboratory serving inpatients and elective daycases
* Research and Innovation focus throughout cardiology

* Cardio vascular disease remains the main cause of death an disability in NI
* Capacity below demand for the ST population
* Impacting on access for inpatients/meeting standards for Non-ST elevation cardiac infarcts
* Lengthening wait times for urgent and routine cases
* Laboratory age/downtime/risk

Cardiac Cath Issues / Actions

Issues:

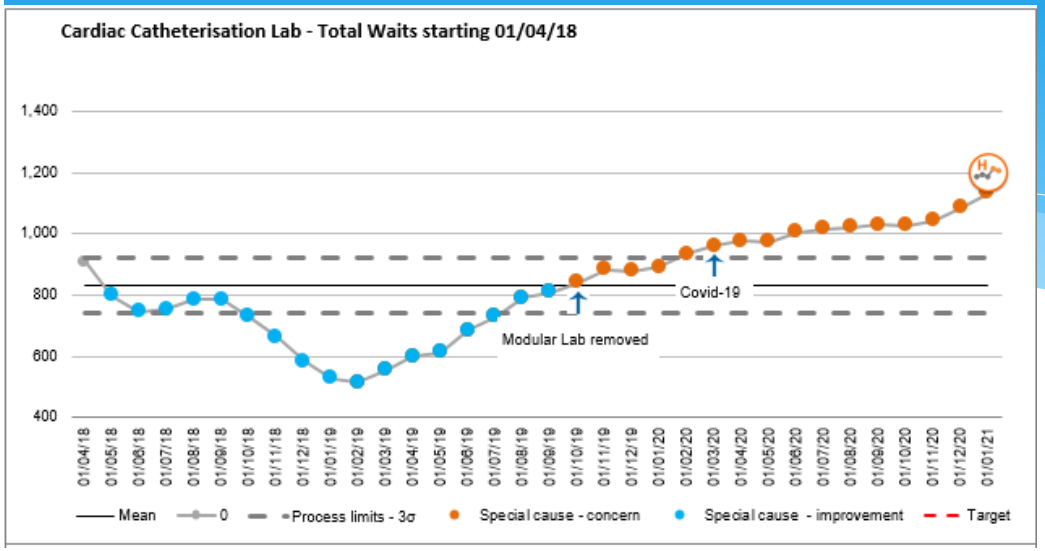
* Vulnerability with singular lab on Acute site – risk to in-patient provision with downtime/ lack of Regional contingency plan
* Inability to provide required levels of in-house additionality due to infrastructure challenges eg. beds for recovery; impact on C-Arm
* No current capacity in the extant Northern Ireland Independent Sector with options only for outsourced modular capacity provision
* NSTEMI patients not getting access to Cath Lab within the 72-hour target – Southern Trust only achieving 33% - Western Trust achieving 98%
* High risk AVS not getting angiography within clinical timeframe of 4 weeks

Actions:

* Southern Trust escalated the absence of a Cardiac Catheterisation strategy to HSCB – meeting with commissioner to be followed up
* Ongoing development of cardiology services, cross sites, and range of supporting cardiology pathways/developments
* Member of cardiac network.
* Bid for additional in-house capacity in Quarter 1 2021/22 (limited volumes)

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

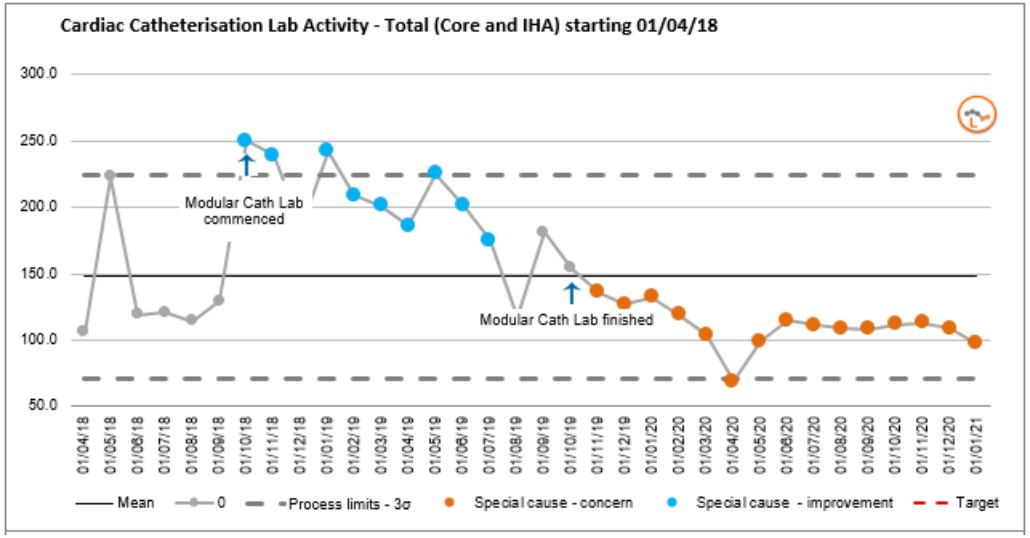
Cath Lab Elective Access



2018 to 2021
+177 waits

2019 to 2021
+579 waits

Cath Lab Activity



Activity = elective access and unscheduled care

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

- Physiological Measurement -

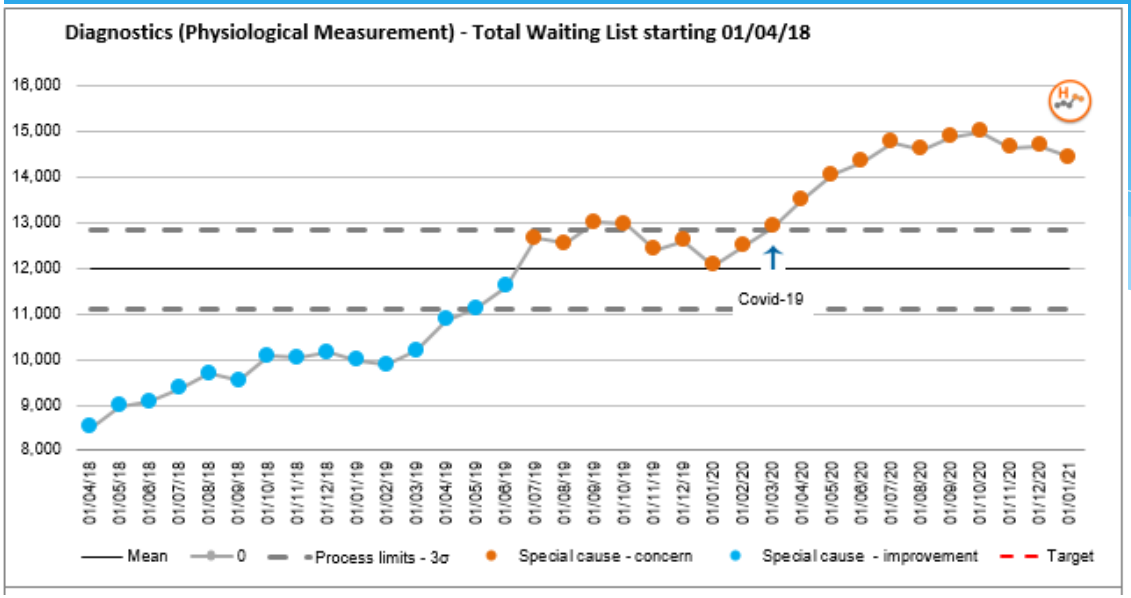
Physiological Measurement (Cardiac non invasive investigations)

Issues:

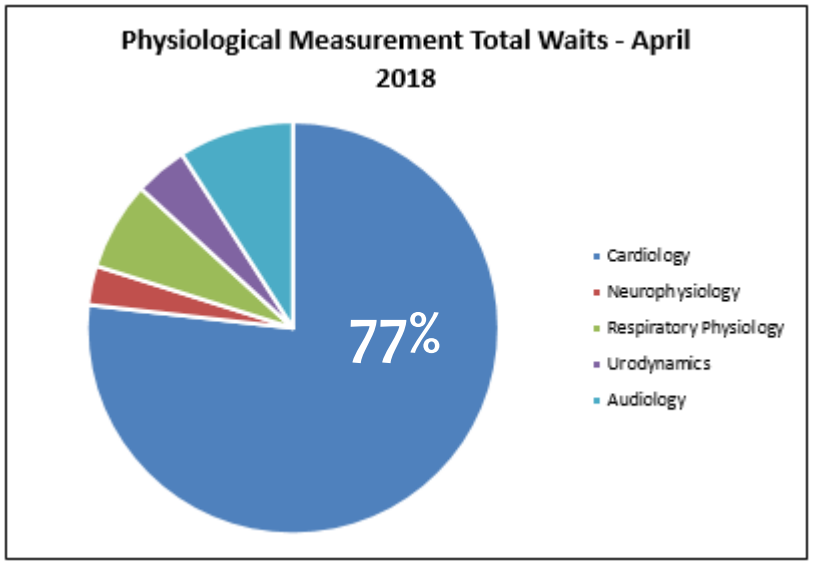
* Challenges to recruiting trained Clinical Physiologists trained to report echocardiograms
* Limited capacity to undertake in-house additionality
* Limited Independent Sector capacity option
* No recurrent funding for capacity gaps except for TTEs
* TOEs now classified as Aerosol Generating Procedure (AGP) impacting capacity per session

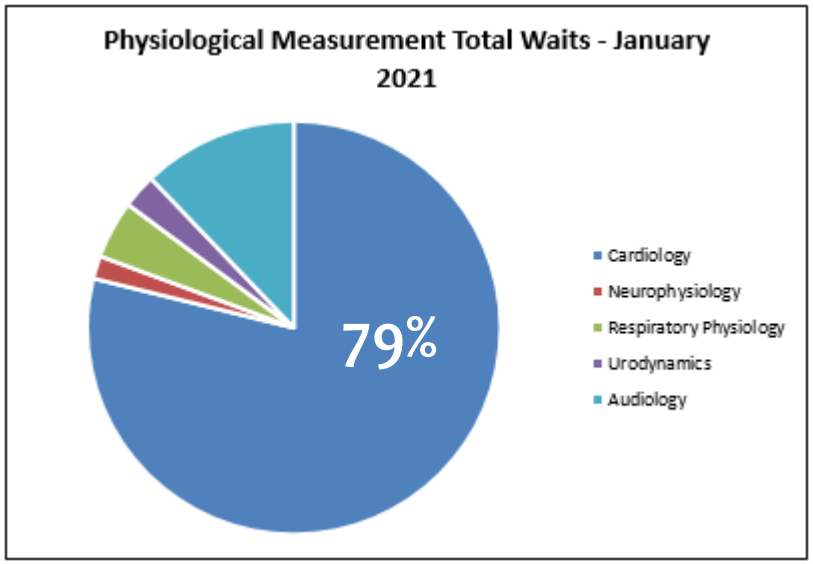
* **Actions:**
* Recruitment for Band 7s has been undertaken three times – Agency placement now secured
* Band 6 training ongoing for reporting with competency workbook awaiting sign off
* The Southern Trust is working collaboratively with the South Eastern Trust who have provided core capacity monthly to address an element of our long waiting TTEs
* In-house additionality secured for TOEs
* Validation undertaken for DSEs and TTE waiting list as high volume of referrals for Direct Access
* Quality Improvement project commenced with the Echo Team

Physiological Measurement Waits



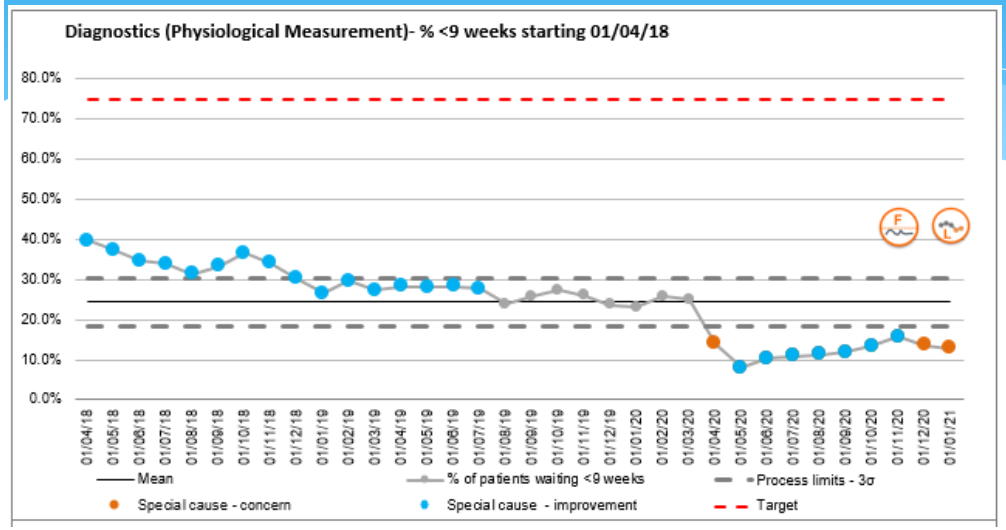
Increase in total waits by 5,929





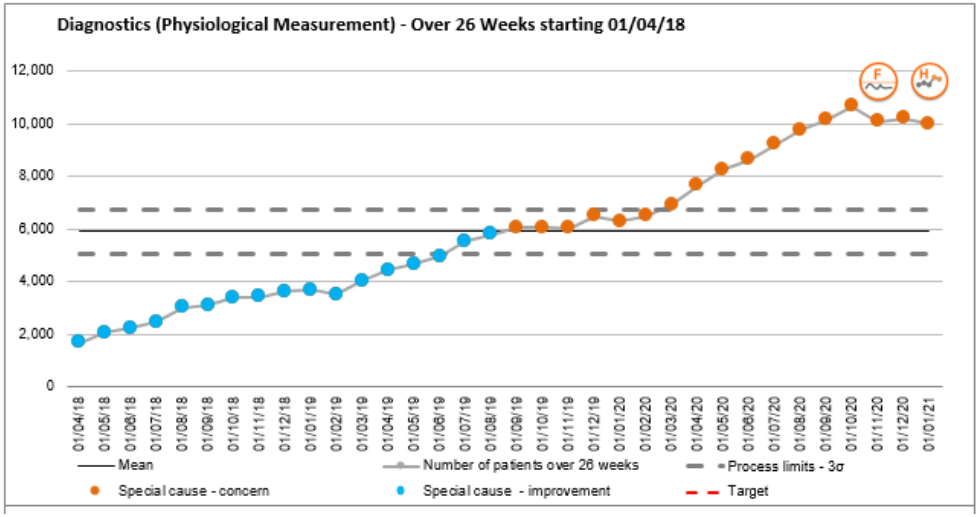
Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

Physiological Measurement Elective Access OGI



<9-weeks Decrease in performance by 26.8%

>26-weeks Increase in waits by 8,314



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Physiological Measurement Regional Context

	Physiological Measurement - Total Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	17257	5916	7437	12598	5161	48369
December 2020	16209	7605	4945	14710	5918	49387
Growth	-1048	1689	-2492	2112	757	1018
% Growth	-6%	29%	-34%	17%	15%	2%

	Physiological Measurement - Over 9 Week Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	13035	2726	4302	9630	2612	32305
December 2020	13200	4813	3132	12731	3646	37522
Growth	165	2087	-1170	3101	1034	5217
% Growth	1%	16%	-9%	24%	8%	40%

	Physiological Measurement - Over 26 Week Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	8720	1283	1464	6508	756	18731
December 2020	10093	1904	1854	10212	1388	25451
Growth	1373	621	390	3704	632	6720
% Growth	11%	5%	3%	28%	5%	52%

- Imaging –

Barry Conway AD Cancer and Clinical Services & Integrated Maternity and Women's Health

Imaging Issues / Actions

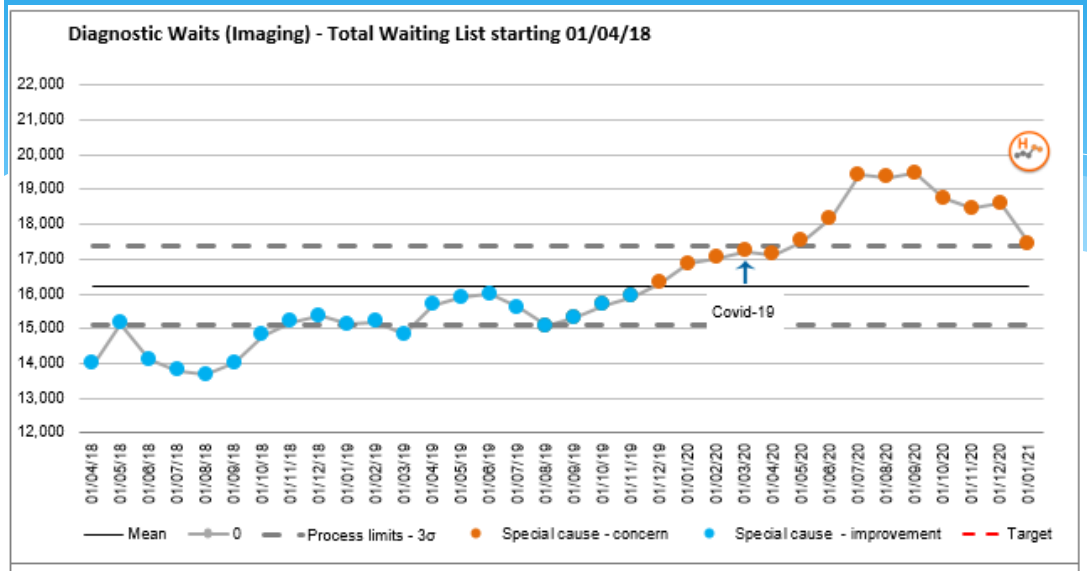
* **Issues:**

* Demand and capacity challenges - recurrent gaps for some years
* High level of urgent demand for imaging when compared Regionally
* Working within new IPC environment - Covid guidance - reduced sessional capacity
* Challenging capital funding environment and on-going requirement for capital investment; on-going reliance of mobile/modular kit
* Regional Imaging Review – recommendations – new Regional Imaging Board established
* Workforce challenges – Radiographers and Radiologists

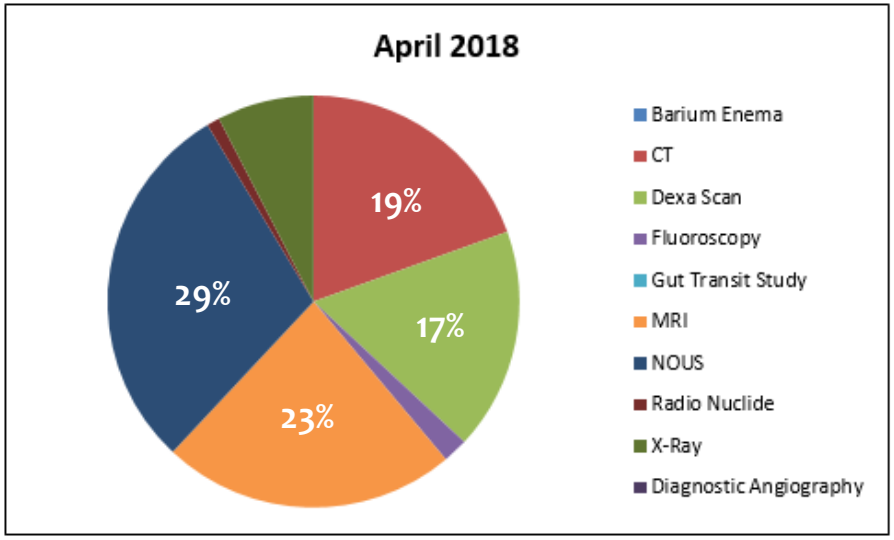
* **Actions:**

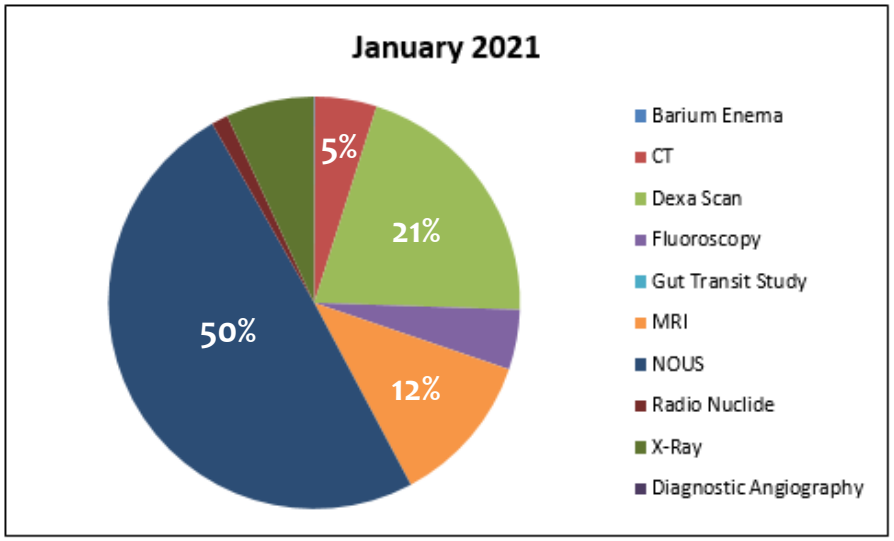
* Regional collaborative working to ensure fair equity to Independent Sector capacity
* Collaborative working with Northern Trust for the provision of NOUS examinations
* Permission and support sought to complete business cases for major service developments
* Short term funding to replace critical equipment
* Agreed plan to deliver the 10 year equipment replacement strategy
* Task and Finish Group established to address 'hard to fill' Radiographer posts
* Flexible pool available for Radiographer vacancies / absences

Imaging Waits



Increase in total waits by 3,438





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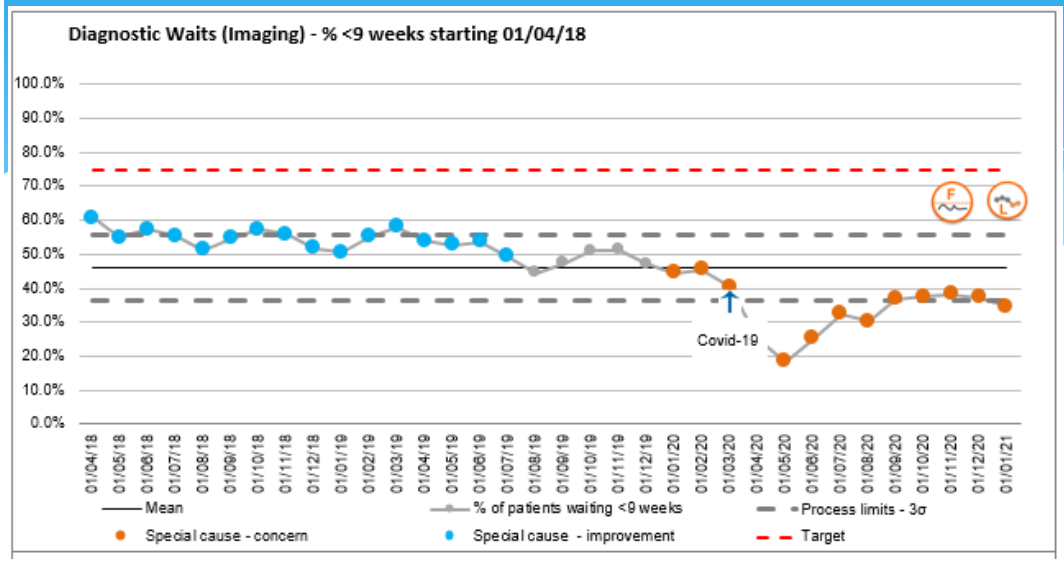
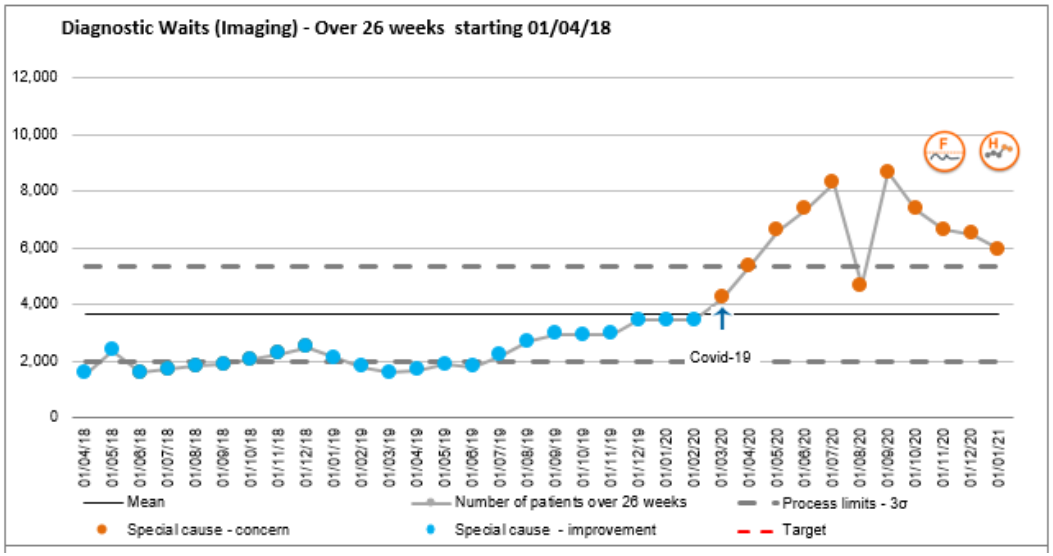
Imaging Elective Access OGI



<9-weeks Decrease in performance by -26%

>26-weeks Increase in waits by 4,395



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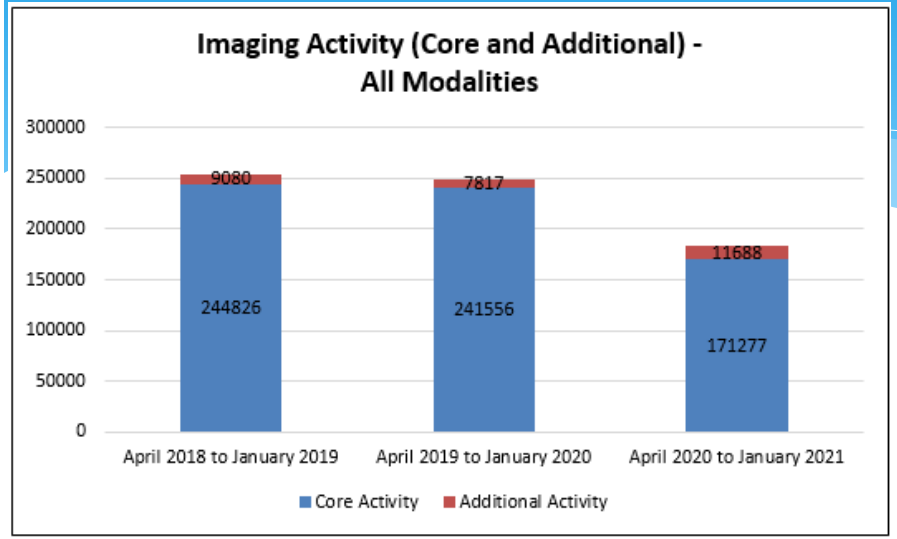
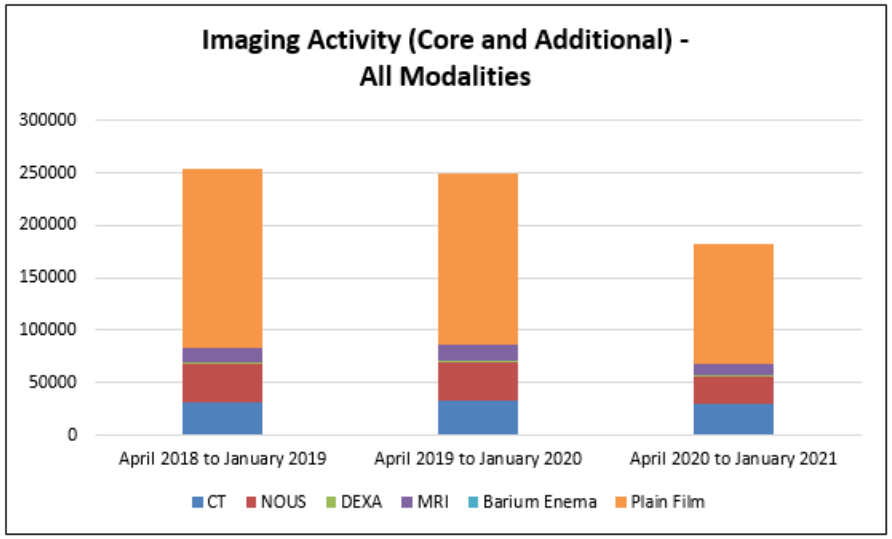
Imaging Activity

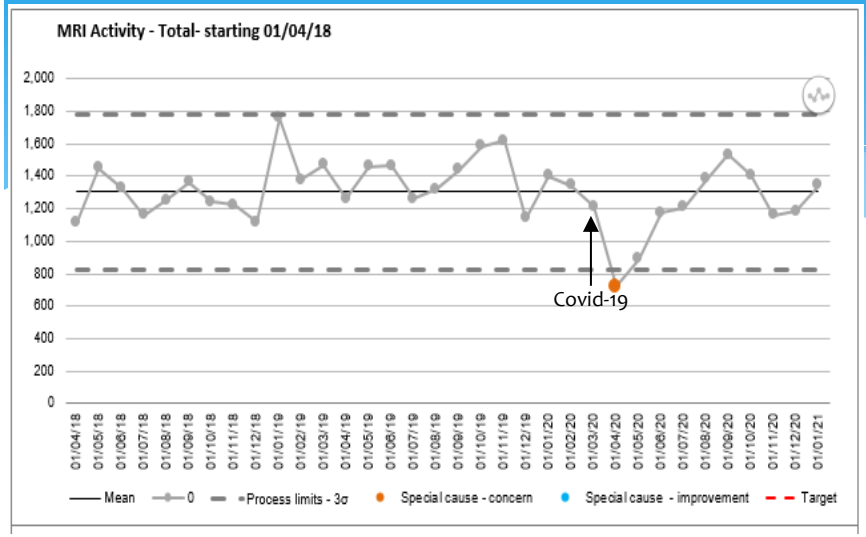


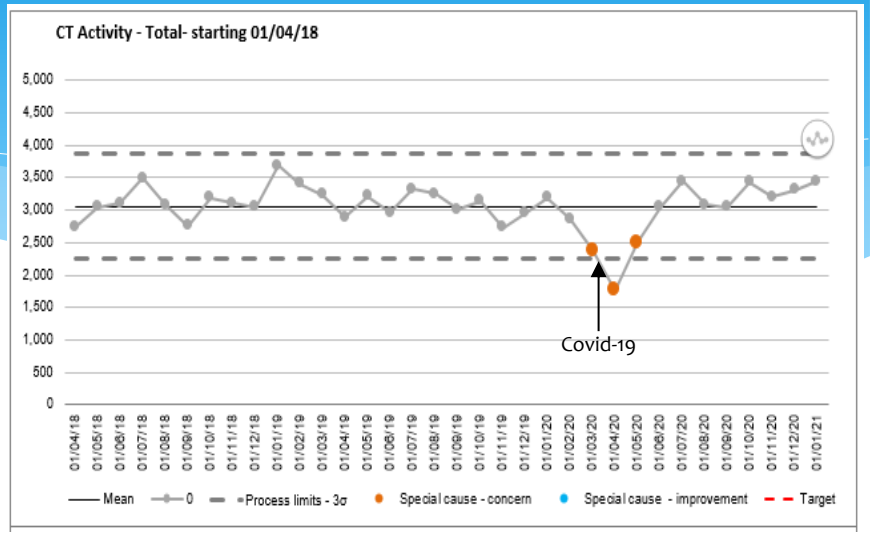
Decrease in total activity (all modalities) by 70,941

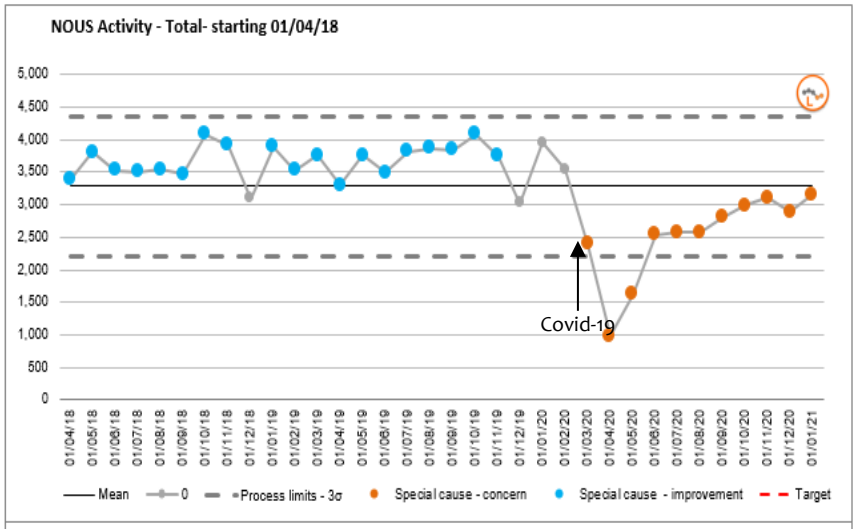
Financial Year	Core Activity	Additional Activity	Total Activity
April 2018 to January 2019	244826	9080	**253906**
April 2019 to January 2020	241556	7817	**249373**
April 2020 to January 2021	171277	11688	**182965**

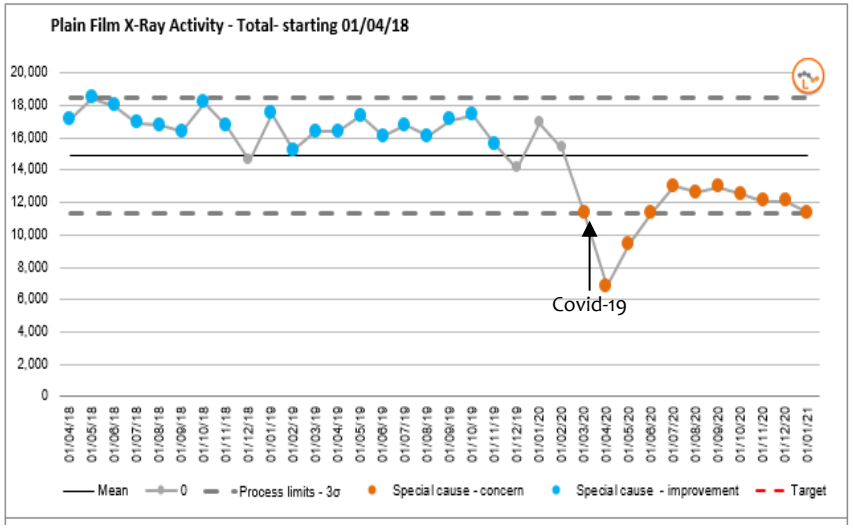


Imaging Activity – Main Modalities









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Imaging Regional Context

	Imaging - Total Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	18010	23619	9871	16262	6195	73957
December 2020	14428	11980	14464	18709	6086	65667
Growth	-3582	-11639	4593	2447	-109	8290
% Growth	-20%	-49%	47%	15%	-2%	-11%

	Imaging - Over 9 Weeks Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	8181	15120	4241	8711	1062	37315
December 2020	7265	4309	7290	11766	1559	32189
Growth	-916	-10811	3049	3055	497	-5126
% Growth	-11%	-72%	72%	35%	47%	-14%

	Imaging - Over 26 Weeks Waits					
	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Regional
December 2019	2651	10092	1628	3465	6	17842
December 2020	3479	1701	4185	6492	128	15985
Growth	828	-8391	2557	3027	122	-1857
% Growth	31%	-83%	157%	87%	2033%	-10%

What do we really do?

- Unscheduled care pathways
- ED
- Inpatient

- Cancer pathways
- Screening

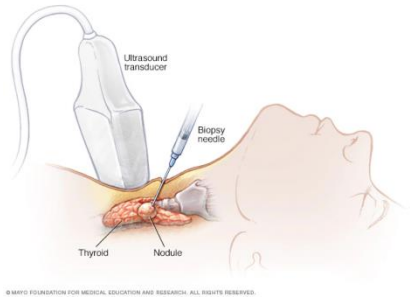
Diagnosis
Assurance
Interventional

Detection
Prevention
Monitoring
Interventional

RADIOLOGY

Diagnosis
Triage
Screening
Monitoring

Diagnosis
Prognosis
Treatments



- GP services
- Elective pathways

- Prevention
- Pain management

WE reduce diagnostic uncertainty and streamline patient care

Why are we so important?

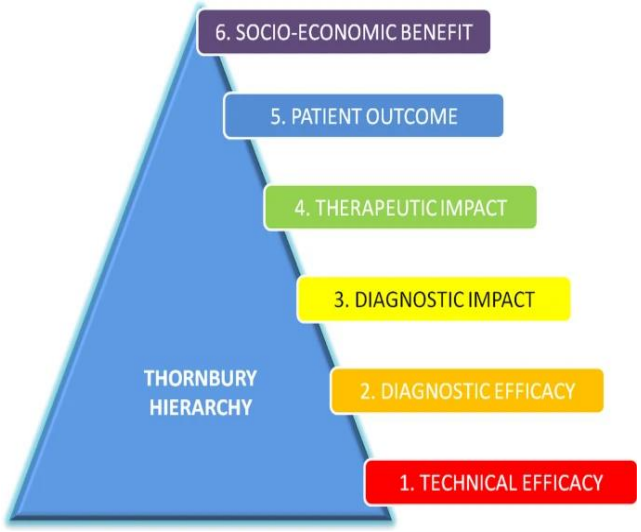
Diagnosis delayed is Diagnosis denied – Cancer pathway

Time is Brain (Stroke) – 20 million brain cells lost per minute

Time is Life (Trauma) – Golden Hour

Time is money (ED) – Radiology Bottleneck!

Solution→ THINK BIG – THINK LEAN!



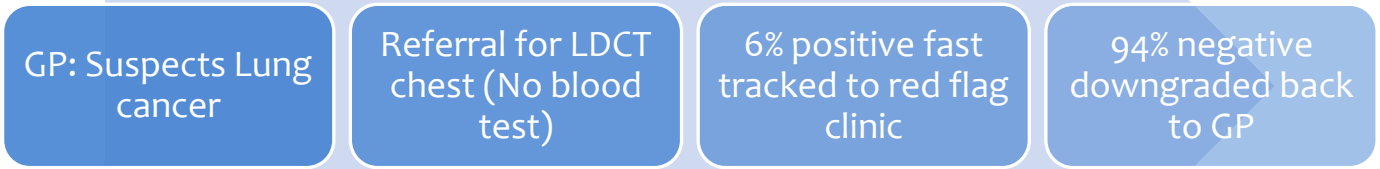
Mission: Value based healthcare model

https://insightsimaging.springeropen.com/articles/10.1186/s13244-020-00941-z

Lean Thinking– In Practice

Old (1900AD)→ Suspected lung cancer GP referral

New Pathway → Low Dose CT Chest



Lean Thinking

LDCT: why now and not earlier?

* Answer→ Maximised replacement of DHH CT in Feb 2020 despite LV supply limitations.
* Replacement– no new investment.
* We negotiated to upgrade STH CT at the same time
* Team work: Ground staff , Clinical Input, Receptive management, BSO, IT , PALS, Planning and Estates departments.
* No stone was left unturned!

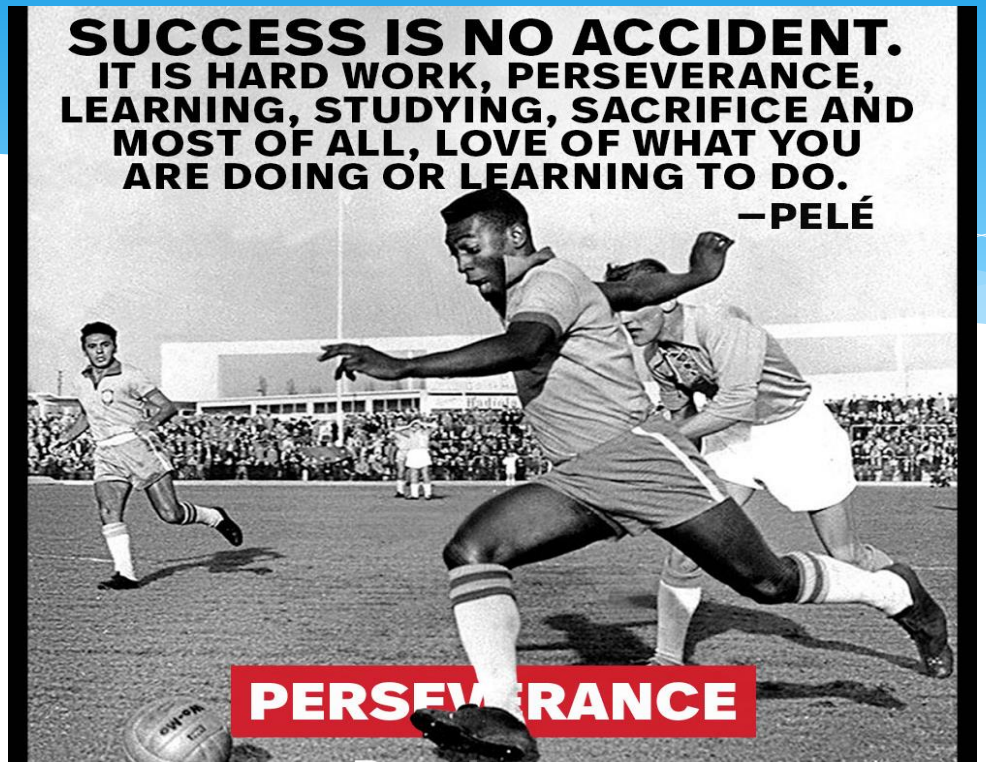
Lean Thinking – Results so far ..

LDCT – Started November 2020

Equality of access: New CT services are now available on either side of catchment area (DHH and STH)

Only Trust in NI to provide Low Dose CT scanning

* 76 scans→ 3 early cancers → 73 patients diverted from red flag clinics!
* Improved 31 day and 62 day targets
* Reduced bottlenecks, and wastages
* Reduced staff stress
* Secure CT service for Newry area
* Improved patient safety
* More Lean Thinking– Introduce new services!



…….but we have to keep going!

Future Developments

* Twin CT suite CAH (October 2022)
  - Spectral CT
  - Cardiac Imaging
  - Advanced Stroke and Trauma imaging
  - Streamline GP, ED and OP imaging pathways
  - Diagnostic efficacy
  - Cost Neutral within 5 years
* DHH CT/MRI suite (3rd MRI – interim solution)
  - Enable equality of MRI access
  - Reduce inter-hospital patient transfers for MRI (20/week)
  - Service resilience and safety
* DHH Hybrid Interventional Radiology suite
* Reporting and Training facilities on CAH site
* Radiology MDT room

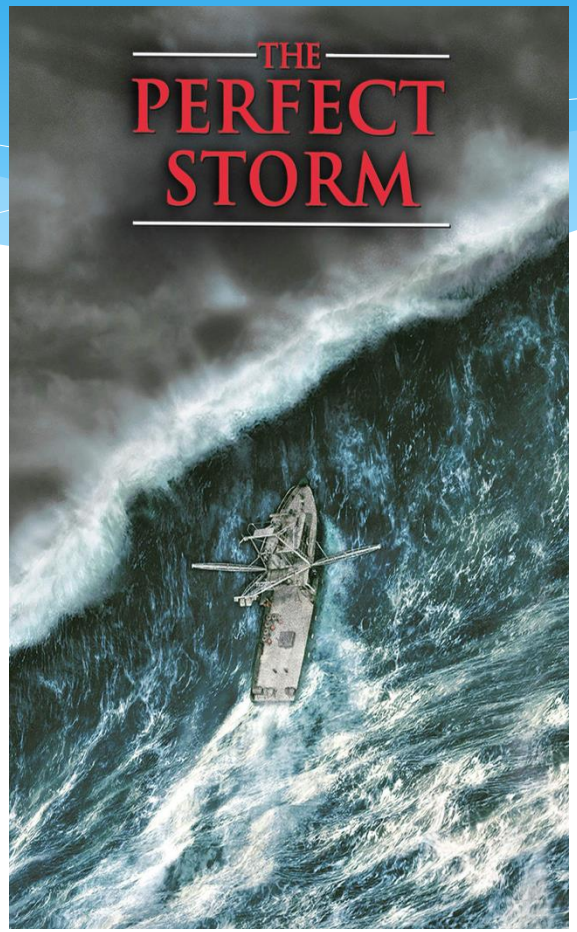
Critical Replacement Equipment Requirements - Next 3 years

* Mammography - CAH – 2 x units, £500,000 and 2 mobile screening units, £400,000
* MRI scanners - 2x units £2,000,000
* CT scanner - CAH and STH £1,000,000
* Fluoroscopy - 2 CAH and 1 DHH £906,000
* Ultrasound – 11 units £715,000
* General X-ray – 10 rooms includes Dexa and dental £1,250,000
* Image Intensifier (theatre) – 5 CAH, 1 DHH and 1 STH £560,000
* Nuclear Medicine – CAH £400,000

* **TOTAL REQUIREMENT: £7,731,000 in 3 years!**

The Perfect Storm

* Over £7 million replacement equipment required in 3 years to sustain services.
* Additional funds to keep up with the demand.
* Investment in accommodation and training facilities to keep the service safe and compliant
* Radiology department was built in 1972!



The Good News!

* We are already spending most of the funding

Interim Solution	Monthly rental cost	Yearly cost
CT modular CAH	£65,000	£780,000
CT modular DHH	£31,500	£378,000
Outsourced scanning	£125,887	£1,510,651
		2,668,651

What if we do nothing?

* Loss of staff moral and recruitment.

(Breast cancer patients are still using equipment expired in May 2019)

* High risk to clinical services (>4000 patients use the breast service)
* High risk of ED step down due to equipment breakdown.
* Increase maintenance costs
* Reduced capacity
* Short-term options are much more expensive
* Increase in waiting lists and times
* Lack of developing service in line with advances in technology

Proposals

* Permission and support to complete business cases for major service developments
* Short term funding to replace critical equipment
* Agreed plan to deliver the 10 year equipment replacement strategy.

Will we ever board an air plane past its service contract?

Should ST patients be reliant on old CT and MRI scanners for life saving imaging?

Are ST patients entitled to access the same imaging technologies compared to other citizens of NI?

Time is Money, Time is Life, Time is Brain

Diagnosis delayed is Diagnosis denied!

Thank You for Listening

Now is the time to choose our path!

Professional Issues

Nursing/AHP(Radiographers)

Nurse Endoscopists

- Lead in time for training /scare resource. Previous turnover of trained staff losing trained staff to other Trusts.
- Previous Regional inequity in banding – issue now resolved with Nurse Endoscopists pay progression from Band 7 to Band 8A on achievement of agreed competencies/tasks
- Ongoing challenges with leave/absences and lack of backfill opportunities

Radiographers

- Workforce of just less than 200 staff; Vacancy rate of 9.2%; challenges with supply.
- Task and Finish Group established to take forward wider recruitment, including identified European countries where there is a potential oversupply Radiographer
- Advanced practice framework in place and locally the Trust will seek to implement this via a workplan to set out the extended roles for radiography to support the rebuild of services
- On-going innovation in this area with the expansion of Radiographer skill mix with Reporting Radiographers now in place and in training for Plain Film; NOUS; and CT

Professional Issues

Technical Staff

- Previous challenges to get trained Senior Clinical Physiologists who could undertake reporting (Band 7), now resolved.

Medical Staff

- Ongoing Consultant Radiologist vacancies – reduced now to 2.00 WTE vacant posts. Additional reporting sessions in private sector contracted to support gaps
- Ongoing challenges in securing Radiologists with sub specialty interests to support some of our Cancer MDMs

Any Questions?

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: Thursday, 18th March 2021
TIME: 9.30 a.m. – 12.30 p.m.

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies:	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 3rd December 2020	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.10 a.m.	6.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.10 – 10.40 a.m.	7.	Integrated Performance Report PRESENTATION: Diagnostic Imaging	Mr. B Conway	Assurance
COFFEE BREAK				
11.00 – 11.15 a.m.	8.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
11.15 – 11.30 a.m.	9.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
11.30 – 11.45 a.m.	10.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
Performance Reporting - External Assurance				
11.45 – 12.15 p.m.	11.	Mental Health Benchmarking Report PRESENTATION	Mr B. McNeany	Assurance
12.15 – 12.30 p.m.	12.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 20th May 2021 at 9.30 a.m.

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

Minutes of a Virtual Meeting of the Performance Committee held on Thursday, 20th May 2021 at 9.30 a.m.

PRESENT:

Mrs P Leeson, Non-Executive Director (Chair)
Ms G Donaghy, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director

IN ATTENDANCE:

Mr S Devlin, Chief Executive *(Items 9, 10 & 11 only)*
Mrs A Magwood, Director of Performance & Reform
Mr P Morgan, Director of Children and Young People's Services / Executive Director of Social Work
Dr M O'Kane, Medical Director
Ms H O'Neill, Director of Finance, Procurement and Estates
Mrs V. Toal, Director of Human Resources and Organisational Development
Mrs H Trouton, Executive Director of Nursing, Midwifery and Allied Health Professionals
Mrs L Leeman, Assistant Director Performance Improvement
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager
Mrs L Gribben, Committee Secretary *(Minutes)*

APOLOGIES:

Mrs H McCartan, Non-Executive Director

1. WELCOME AND APOLOGIES

Mrs Leeson welcomed everyone to the meeting and noted Mrs McCartan's apologies. She particularly welcomed Mr McAnuff, Boardroom Apprentice 2020 and Mr Martin McDonald to his first Performance Committee. Mrs Leeson advised that Mr McDonald and

Mrs McCartan are now members of the Performance Committee and the Terms of Reference will be amended to reflect this change and presented for approval at the next meeting.

At this point, Mrs Leeson advised members on some aspects of virtual meeting etiquette.

2. DECLARATION OF INTERESTS

Mrs Leeson asked members to declare any potential conflict of interests in relation to items on the agenda. There were none noted.

3. CHAIR'S BUSINESS

None noted.

4. MINUTES OF PREVIOUS MEETING HELD ON 18th MARCH 2021

The Minutes of the meeting held on 18th March 2021 were agreed as an accurate record and will be duly signed by the Chair.

5. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

Maternity Services was agreed as the themed area for the next meeting.

6. PERFORMANCE REPORT

Mrs Magwood presented the Performance Report for approval. She advised that this report focuses on a broad range of issues and spoke of the areas of improvement / achievement. Included in the report was the Trusts' rebuild plans for restarting services after the pandemic. Mrs Magwood stated that it is anticipated longer term regional service reform is required to effect significant longer term achievement across a number of key areas and improvements to Trust infrastructure is needed in respect of hospital based services to support a safe return to services post-pandemic.

Mrs Magwood guided members through the report which provided updates in the following areas: Cancer Service Performance, CAH elective capacity, hospital infrastructure issues, unallocated cases, medical workforce pressures impacting core services, demand for elective services within CYP, access to services (Adult Mental Health Services), mental health inpatient demands, carers supports, Allied Health Professionals, ongoing performance of statutory functions (carers assessment, annual reviews), unscheduled care - care homes fragility of sector and GP Out of Hours.

Mrs Magwood reported that following the outworking's of the Covid related SAI and report recommendations by the Department's Nosocomial Support Cell, the Trust has successfully secured £8.7m of capital investment for expenditure in the 2021/2022 year across a range of areas to address some of the most critical clinical improvements required primarily at Craigavon Area Hospital. Ms O'Neill welcomed this investment and stated that discussions will take place with Mrs Magwood and Mrs McClements to produce a programme on where and how this funding is spent for maximum impact

The Mental Capacity Act was discussed. Mrs Magwood stated that the associated compliance with this legislation is impacting on all operational Directorates. The outstanding volume of legacy Deprivation of Liberty (DoL) cases in the community, the impact of new cases, review cases and returns from the Attorney General's office are significant. The volume of work in this area is resulting in significant and competing demands as staff working in these areas are impacted by pressure of backlogs and associated targets and the conflict between this work and increasing pressures in core services. Mrs Magwood advised that the Trust continues to seek to increase the workforce to undertake Deprivation of Liberty applications.

The Chair welcomed the detailed report and noted the importance for staff to take their annual leave and rest periods before resuming and / or scaling up core activities and asked if this was feasible. Mrs Magwood advised that a detailed Re-build Plan will be discussed at the next Trust Board meeting; however she commented that managers and teams are required to facilitate the need for staff to use their leave. Mr Morgan agreed that staff have worked tirelessly

through the pandemic and it is important for management to seek a solution to ensure that staff receive their annual leave.

Mr McAnuff referred to page 8 of the report on access to services within Mental Health and noted that as at the end of February 2021 the Trust accounted for 74% of the total excess waits regionally for Adult Mental Health and asked what other Trusts are doing differently. Mrs Leeman explained that different models are used across Trusts and Dr O'Kane explained the Southern Trust model. Mrs Magwood also spoke of the staffing gaps across Mental Health and the demands following Covid-19 which impacts on the waiting lists.

Dr O'Kane commented on the waiting lists within the Mental Health Directorate. She advised that resources are required to support the routine appointments and measures are in place to support those on a waiting list for routine appointments. Dr O'Kane advised that Ms Jan McCall is reviewing the system and they are having conversations nationally. Mrs Magwood spoke of the development of the Multi-Disciplinary Teams (MDTs) in primary care, one of which provides mental health support.

Mr McDonald commented on the challenge of obtaining a face to face appointment with GPs and felt that this has may have an impact on early diagnosis / treatment. Dr O'Kane stated that a meeting was held recently with the GPs for the way forward on easing out of the pandemic and noted that the GPs are keen to increase additional face to face appointments. She spoke of the positive impact that telephone and virtual appointments have been for some service users but agreed on the importance of face to face communication.

The Chair noted her concern that the waiting times for Speech and Language Therapy review appointments within the Children and Young People's Directorate has increased from 36 weeks to 60 weeks. She commented that this is beyond the clinically indicated timescale for review and asked for further clarity. Mr Morgan explained that Paediatric AHP services have been impacted significantly over the last year due to staff redeployment, vacancies sickness, and PARIS implementation. He explained that the increase can be attributed to demand and capacity issues and work is

underway to reduce the backlog of review appointments. Mr Morgan commented that the re-opening of special schools has seen the demand for AHP services rise by 15% and the team are working creatively and collaboratively to ensure that this need is met.

Members approved the Performance Report

7. CORPORATE PERFORMANCE SCORECARD

Mrs Magwood presented the Corporate Performance Scorecard (March 2021 performance) for approval. The report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework. It includes an assessment performance against established targets on a Red, Amber and Green (RAG) basis and associated analysis of trends and periods of variation.

Mrs Magwood guided members through the report highlighting areas of improvement, for example, breastfeeding at discharge is above target for 2021/21; CAMHS, as at March 2021, demonstrated that 94.7% waiting less than 9 weeks than at April 2020 which is a considerable improvement. Areas of concerns were highlighted as outlined in the report. Mrs Magwood provided assurance that services and teams are reviewing available options and way forward to reduce waiting lists.

Ms Donaghy asked about the uptake of the flu vaccine. Mrs Toal stated that whilst the uptake was a significant improvement on the previous year, the Trust has not met the 75% target. The Trust continues to promote a range of initiatives such as the peer vaccine model. Ms Donaghy raised the increasing staff sickness absences to which Mrs Toal advised that Covid related sickness had an impact on absence levels. Mr Wilkinson referred to the data on Dementia and noted the number of patients waiting in excess of 9 weeks and asked what steps have been taken to improve this. Dr O'Kane contributed this increase as a direct consequence of the management response to Covid-19 during which time only urgent referrals were seen. Capacity for routine referrals is now being re-instated and an improvement in the volumes of waits in excess of 9-weeks is expected. The service is reviewing options to reduce the waiting list

and have approved weekend clinics and additional screening clinics. Dementia in patients under 65 was discussed. Dr O'Kane advised that the Head of Community Dementia is liaising with GPs to improve the waiting list for this cohort of patients by September 2021. Mrs Magwood added that there is no commissioned service for patients under 65 diagnosed with dementia. In response to a question asked by the Chair, Dr O'Kane commented that the numbers of patients under 65 with dementia may be small but still significantly important to ensure they receive the correct treatment within clinically indicated timeframe. The Chair stated the importance of the Chief Executive continuing to feed into regional discussions with regard to Dementia patients under 65.

There was discussion on the Regional Management Board and the new HSC framework for Northern Ireland. In response to question asked by Mr McDonald on the level of autonomy at a local level, Mrs Magwood advised that there a number of areas that still need clarified such as scope and control. She noted that the Elective Care Framework is about to be published. Mr Morgan spoke of the various forums on which the Trust is represented to try and influence the shape of the framework with a more focused community approach.

In regards to regionalisation, Ms Donaghy asked if plans are in place to communicate the way forward to the public. Mrs Magwood advised that this is a piece of work that needs careful consideration and work is underway regionally to address this. Mrs Leeman reiterated the importance of engaging publicly on regionalisation of services.

Members approved the Corporate Performance Scorecard

The Chair requested item 12 be discussed at this point

12. PERFORMANCE REPORTING - EXTERNAL ASSURANCE

i) Health Quality Improvement Partnership (HQIP) Hip Fractures Database Annual Report

The Chair welcomed Mrs McClements, Director of Acute Services to the meeting to present the above named item. She reported on the National Hip Fracture Database (NHFD) which is a national clinical

audit undertaken by the Royal College of Physicians on behalf of the NHS. Data is collected on all aspects of the care given to hip fracture patients in England, Wales and Northern Ireland aged 60 and over. The report provides information to give assurance that a range of mechanisms are in place to review the outcomes of the data and consider improvement opportunities identified in respect of arrangements to the care and outcomes of those presenting with hip fractures.

Mrs McClements guided members through the report highlighting the key areas of variation that are below national average: 1 - prompt Orthogeriatric Review: SHSCT 68% vs 86% nationally. Mrs McClements explained that the decrease represents the loss and non-replacement of 0.6 WTE Orthogeriatrican Consultant and has been negatively affected by the ongoing lack of weekend and bank holiday Orthogeriatric cover which guarantees a failure to meet this target for patients admitted at these times. Mrs McClements reported that the present Orthogeriatric team have shown notable flexibility regarding their job plan to facilitate the service which has improved the position; however the figure shows an ongoing under met need which can directly bring further improvements in patient care. 2 - prompt surgery: SHSCT 27% vs 69% nationally. Mrs McClements added that this is a clear representation of the capacity vs demand discrepancy that has been acknowledged for several years but without any notable increase in capacity created either in ward or theatre space.

Mrs McClements spoke of the areas that are above the national average: 30 day Mortality (recognised as among the best in the UK), NICE compliant surgery, post-op delirium, prompt mobilisation, return of patients to original residence. All of these targets show markers of high levels of quality care across the whole MDT which combines to ensure patients are receiving optimal standards across their operative journey and resulting in the high percentage able to return to their original residence.

Mrs McClements reported that to meet trauma demand the use of commissioned orthopaedic theatre time is required on a daily basis which has a significant impact on the orthopaedic waiting times. She added that a recent DoH capacity and demand report on the

orthopaedic service was deemed to be very significantly short in terms of capacity to deal with demand. She felt that to lose further capacity on the orthopaedic side to make up for a shortfall in trauma capacity should not be acceptable.

Mr McDonald asked if support is available regionally to which Mrs McClements spoke of the Regional Trauma Network which aims to work collaboratively with HSC Trusts in order to co-ordinate the delivery of trauma services across Northern Ireland, however she noted that there are known capacity issues across all Trusts.

Dr O'Kane left the meeting at this point

8. PERFORMANCE REPORTING - INTERNAL ASSURANCE

i. Integrated Performance Report: *Cancer Services – performance issues and actions to include Executive Director Professional issues.*

The Chair welcomed Mrs McClements, Director of Acute Services, Mr Barry Conway, Assistant Director Cancer and Clinical Services and Dr David McCaul, Clinical Director for Cancer Services to the meeting to present the above named item.

Mrs McClements began by presenting performance information in the following areas; breast cancer 14 day, 31 day performance and 62 day performance. Data was also included on targets pre and post covid. She presented data on regional performance and from the NI Cancer Registry.

In regards to the issues affecting cancer performance, Mr Conway reported that referrals during the pandemic have decreased; therefore there is a concern that patients may be missed. He spoke of the capacity gaps prior to the pandemic. Mr Conway highlighted the actions to address the local and regional issues as outlined in the presentation and spoke of the Regional Recovery Plan Workstreams.

Mr Conway stated that the need to comply with social distancing has had an impact on capacity issues and patient flow, however teams are working differently and an in innovative way to address this. He

spoke of the good news stories and in particular the lung cancer pilot that diagnoses early detection of lung cancer. Mr Conway advised that the Cancer Reset Cell plan is currently with the Minister for Health and positive feedback has been received to date. Following discussions with the Executive and once the plan is published; teams will then be able to begin to re-build the service. Members asked for the Cancer Reset Cell plan to be shared to which Mrs McClements agreed to undertake.

Action: Mrs McClements

In concluding the presentation, Mrs McClements spoke of the professional issues impacting cancer services; medical staffing – workforce issues for oncology & haematology, theatre nursing challenges, regional challenges and recent approval for non-recurrent funding to maintain required resources.

Dr McCaul thanked the committee for the opportunity to present information on cancer services and stated a significant issue from his perspective is resourcing the service and spoke of the current capacity gaps within Urology, GI, Haematology, Oncology and theatre nursing staff. He noted that this has major impact on theatre utilisation and welcomed the ongoing work to review the staffing issues to attract and retain staff. In responding to a question by Mr McDonald, Dr McCaul advised that there is a natural draw to the Belfast Trust and spoke of the different incentives provided there. Mr McDonald welcomed the work that is being undertaken by the subgroup that will link with Human Resources which can review the Trust's recruitment. In relation to the nursing capacity gap, Mrs Trouton added that she and Mrs McClements have met with nursing staff from Theatres to gain feedback and a better understanding on staff leaving these posts. She advised that this is a regional issue and Ms Mary Hinds is taking forward a theatre nursing workforce plan to address this.

In response to a question asked by the Chair, Mr Conway advised that all patients are tracked throughout their treatment: all scans, tests, appointments are tracked so the MDT team are always on the progress of each patient. Mrs Leeman noted that during the pandemic a number of patients opted to stop their treatment due to

their own concerns, anxiety and need for shielding with the pandemic. Mr Conway explained that those patients have been contacted to reinstate their treatment from April 2021.

Mr McDonald asked for further information on the Lung Cancer pilot. Mr Conway explained that Dr Gerry Millar set up an early screening pilot that took low dose CT chest scans to pick up early detection of lung cancer. Through updating the scanner and the software on the South Tyrone site this was achievable. He said that GPs can directly refer patients for this scan rather that a referral to a clinic, thus decreasing the wait time. Mr Conway advised that this pilot model has been presented at meetings as an innovated way to manage this cohort of patients and felt that the model could be replicated regionally, however an Investment Proposal Template will need to be progressed for funding to take this pilot forward.

Ms Donaghy enquired on the regionalisation of cancer services. Mr Conway explained that if the service is centralised the workforce will remain significantly limited as it is still the same pool of staff. Dr McCaul advised that centralisation may be successful for particular types of cancer but for others there will be a need for significant investment for infrastructure and workforce. Mr Conway commented that the Trust currently works collaboratively with other Trusts and the Independent Sector for certain services/diagnostics and felt that this was a step in the right direction for regionalisation, which is included in the re-build plans. In responding to a question by Ms Donaghy, Mrs Leeman provided assurance that the Southern Trust population has equity access to these regional services and is well represented. She spoke of the Cancer Re-set Plan and the Elective Plan and the importance of the two working together.

The Chief Executive joined the meeting at this point

9. UNALLOCATED CHILDCARE CASES REPORT

Mr Morgan presented the above named report and noted that as at 31st March 2021 there were in total 120 unallocated cases which is an increase from 93 in the previous quarter. There are no unallocated Child Protection or Looked After Children (LAC) cases. He provided assurance that weekly monitoring is completed by team managers

and monthly monitoring is completed by Head of Service and the Assistant Director. Mr Morgan confirmed that all LAC children and children on the child protection register have an allocated social worker and up to date plans in place.

Vacancies were discussed. Mr Morgan advised that vacancies across the Gateway, Family Intervention and Children with Disabilities Services continue to impact on the level of unallocated cases. He added that his Directorate is proactively liaising with Human Resources in regards to students and reported that five final year social work students that are currently placed in CYPS have been recruited to Gateway and are due to commence in mid July 2021. Mr Morgan spoke of the importance in providing a wrap-a-round service to social work students in supporting them for potential future employment with the Trust.

Mr Morgan informed members that a regional recruitment pilot of social workers is taking place during May 2021.

10. EXECUTIVE DIRECTOR OF NURSING, MIDWIFERY AND AHPS REPORT

Mrs Trouton presented the Executive Director of Nursing, Midwifery and AHPs report which largely covers the period from February 2021 to April 2021 and provides assurance on the standards of professional practice of Nurses, Midwives and Allied Health Professionals (AHPs) working in the Trust. The indicators are taken from SHSCT Nursing and AHP Assurance and Accountability Framework and include areas regarding workforce, education training, and quality of practice.

Mrs Trouton guided members through the report and highlighted specific areas for noting. She was pleased to report that the NMC's New Future Nurse standards have been fully implemented and the referred members to the training numbers included in the report.

International recruitment was discussed and Mrs Trouton advised that since activity has been recommenced in September 2020, 56 International Nurses have commenced post in Southern Trust,

however due to the Covid-19 situation in India; the International Nurse recruitment has been paused.

Mrs Trouton highlighted that as part of the regional response to workforce challenges during Covid-19, the initiative whereby final placement nursing students would work as a Band 4 whilst awaiting registration the Trust was successful in securing 26 (90%) students who commenced as Band 5 when registration was completed.

Nursing Quality Indicators (NQI) was discussed. Mrs Trouton informed members that a 'stocktake' of NQIs was carried out in April 2021. She reported that there are currently 46 clinical areas completing NQIs across the organisation and approximately 88 additional clinical areas that are not monitoring NQIs.

Mrs Trouton highlighted her concern on the lack of corporate governance resources within the AHP structure. She stated that this has a significant impact on the level of information in regards to quality indicators, workforce, initiatives and practice placement. The Chief Executive added that work is underway with Mrs Trouton and the Assistant Director AHP Governance, Workforce Development and Training to discuss the issues highlighted and the way forward to secure additional resources.

Mrs Trouton referred to the information on supervision and stated that the average compliance with meeting the AHPs Supervision Standards for period ending 31st March 2021 was 74%, which is an increase from 65% in the previous quarter. She added that those services who have embraced a virtual approach have positively impacted the compliance rates. She did note her concern on the lack of assurance of formal professional Nursing & Midwifery supervision. Mrs Trouton attributed this to the surge 3 of Covid-19 and reported that the Corporate Nursing team are currently engaging with directorates to understand their current processes around supervision with a view to supporting directorates and teams to improve overall compliance. Mrs Trouton spoke of the importance of undertaking formal supervision as this supports the retention of staff.

In response to a number of questions on supervision, Mrs Trouton commented that she is keen to ensure that formal supervision is more robust as this contributes to improved culture and behaviours for staff

which positively impacts on the experience of service users. She confirmed that managers do receive supervision training and advised of a pilot on restorative supervision within ICU which is based on a regional model. Mrs Toal added that there is merit to review the induction for those staff stepping into sister and ward manager roles and work is underway to achieve this.

Mr Wilkinson asked for further clarity on the issue of consistency on maintaining green level compliance with designated Nursing and Midwifery quality indicators. Mrs Trouton explained that there are a number of reasons for this; high level of agency usage, high turnover of staff or sick leave. She added that her team are liaising with IT to introduce Qlikview' onto the wards which provides staff with live up to date information on NQI. Mrs Trouton felt that this would have a positive impact to rectify any issues in a timely manner.

Dr O'Kane returned to the meeting at this point

11. INFECTION, PREVENTION AND CONTROL, ANTIMICROBIAL STEWARDSHIP REPORT

The Chair welcomed Mrs Trudy Reid, Interim Assistant Director Infection Prevention & Control to present the above named report. The paper provides data from 1st April 2019 to 31st March 2021 on infection data and antimicrobial stewardship data for PFA targets.

Mrs Reid presented information on C. Difficile monitoring which meets the requirement of the British Infection Association. She added that a Gastroenterologist is now a member of the C difficile team who have developed links with Acute Care at Home team to improve the management of C difficile and identify learning.

In regards to MRSA, Mrs Reid reported that there have been three preventable MRSA bacteraemia from April 2020 to March 2021 and post infection views have been carried out to identify learning.

Mrs Reid spoke of the outbreaks that occurred in 2020 and stated that there have been no outbreaks to date. She advised that Multi-disciplinary teams meet on a daily basis to ensure proactive measures are taken to prevent further outbreaks.

Antimicrobial Stewardship Activities were discussed. Mrs Reid reported that the current reduction in Covid-19 is allowing the IPC team and Microbiologists to review the Infection Prevention and Control / Antimicrobial Stewardship strategy with a short term work plan focusing on reconnect – refocus -reskill. This will focus on relationships, audit and upskilling of the workforces using a back to basics approach. Mrs Reid reminded members that the Antimicrobial Stewardship rounds were continued by the pharmacists in the SHSCT with SHSCT Stewardship work presented to the PHE at ESPAUR. She further added that Acute Medical Antimicrobial Stewardships rounds are commencing.

Mrs Reid noted that the IPC / Microbiology team are concerned about new variants of Covid-19, the risk of increased community transmission, vaccine escape, and virulence are likely to impact on hospital admissions and possible nosocomial transmission. Seasonal winter pressures, the impact of Covid-19, and potentially influenza, RSV and other respiratory viruses will impact on health services this winter. Therefore the requirement of additional isolation facilities with the current environmental constraints will be a significant challenge for the Trust.

Mr Wilkinson asked if the Trust is still supporting Care Homes. Mrs Reid confirmed that the IPC team continue to liaise with Care Homes to provide support and advice. She added that the IPC nursing staff continues to monitor the data and intervene early, if required. Mrs Reid said that a wraparound support service for care homes is in place while working closely with the Acute Care at Home team and District Nursing.

In responding to a question asked by Mr McDonald, Mrs Reid commented that if visiting is re-introduced at present, there is no plan for visitors to take a prior Covid test. She added that these rules may be subject to change if positive cases increase and the possibility of introducing lateral flow tests.

The Chief Executive recorded his thanks to Mrs Reid and her team for continuing to keep everyone safe.

13. ANY OTHER BUSINESS

None noted.

The meeting concluded at 12.45 p.m.

Signed _____ ***Dated _____***

Southern Health and Social Care Trust

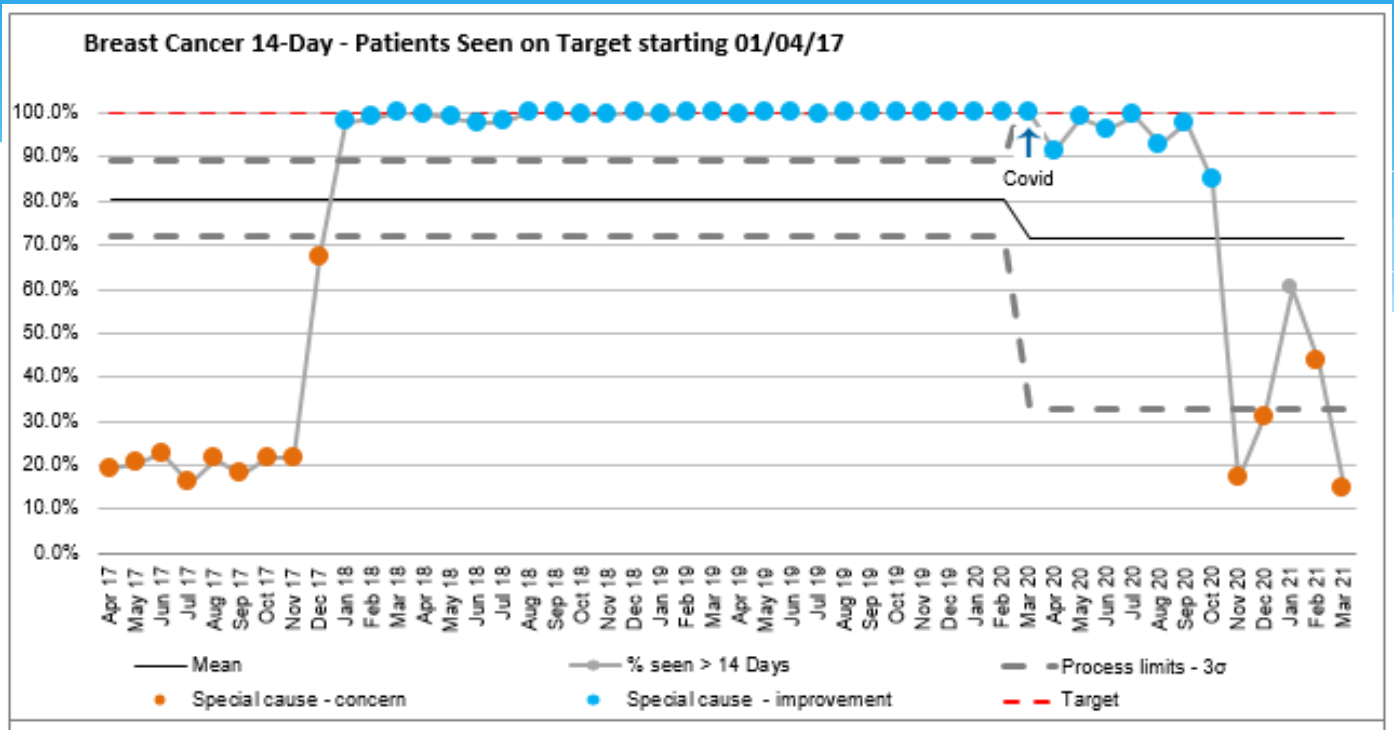
Performance Committee

Agenda Focus: Cancer Services

Acute Services Directorate

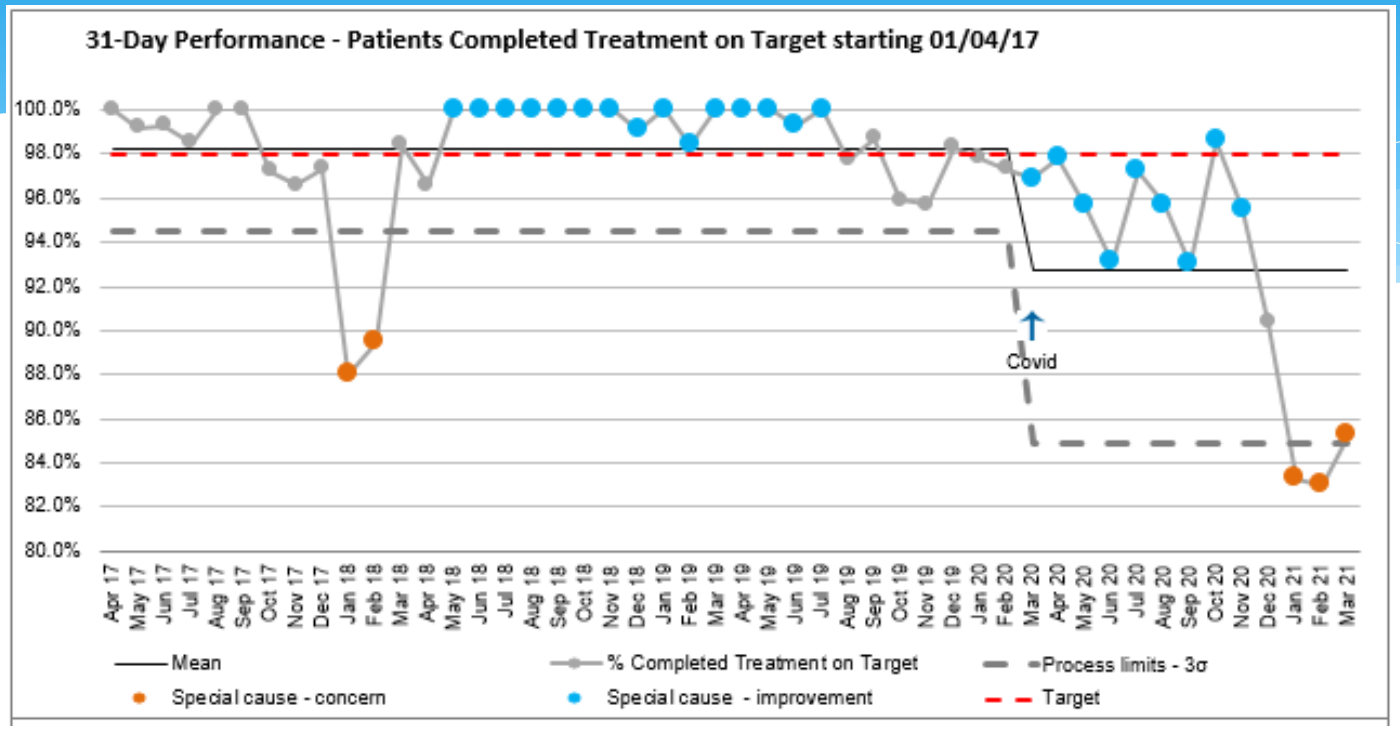
20 May 2021 – Performance Committee

Elective Access OGI



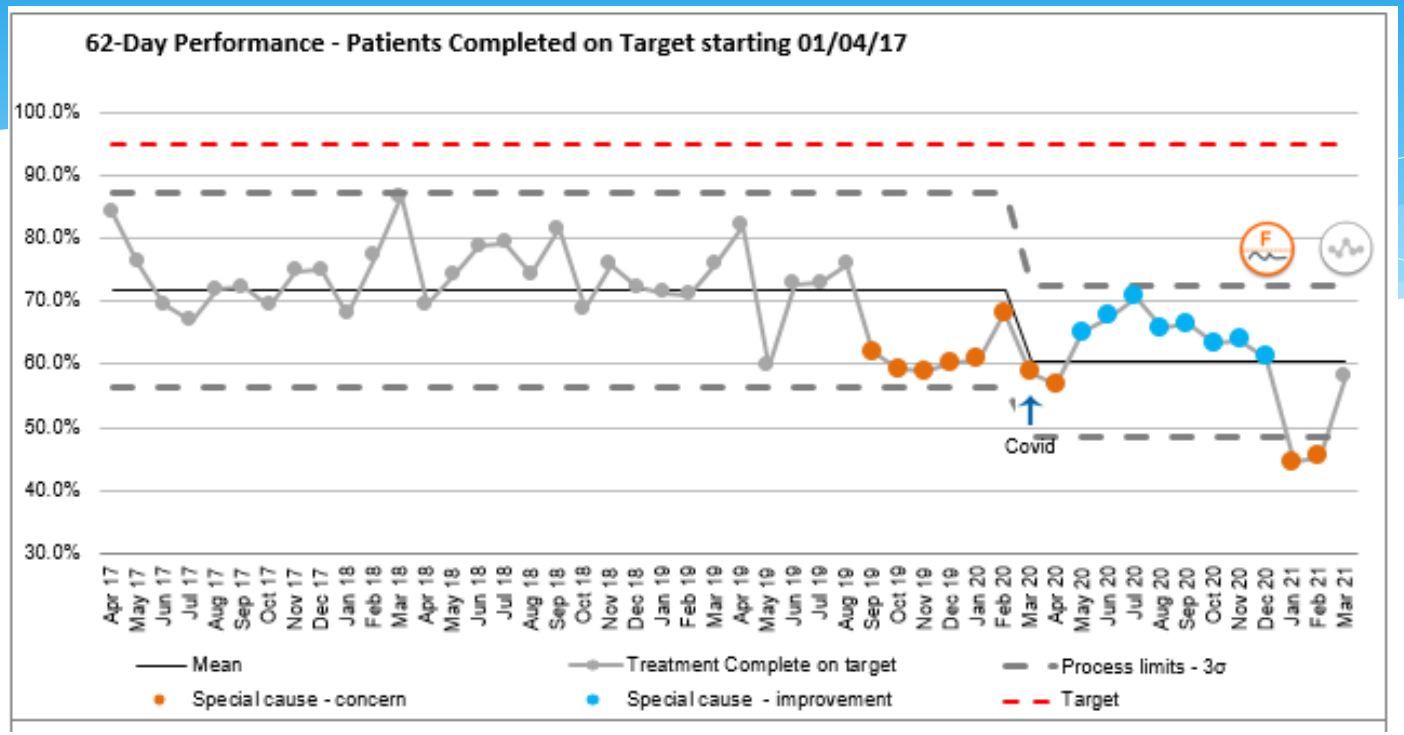
Target	January 2019	January 2020 (Pre-Covid)	January 2021 (Covid Surge 3)
14-Day	99% (268 out of 270)	100% (252 out of 252)	60.2% (154 out of 256)

Elective Access OGI



Target	January 2019	January 2020 (Pre-Covid)	January 2021 (Covid Surge 3)
31-Day	100%	98%	83%

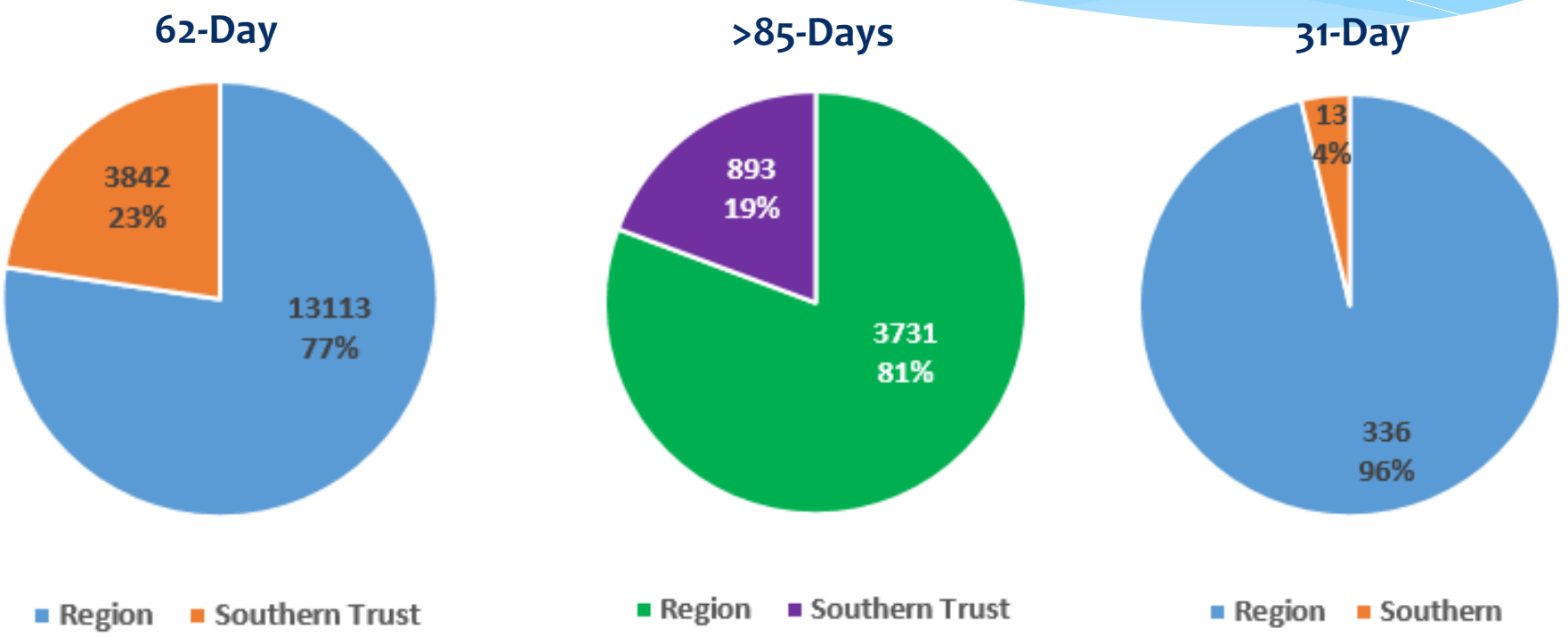
Elective Access OGI



Target	January 2019	January 2020 (Pre-Covid)	January 2021 (Covid Surge 3)
62-Day	71% Longest wait 356-days	61% Longest wait 213-days	44% Longest wait 456-days

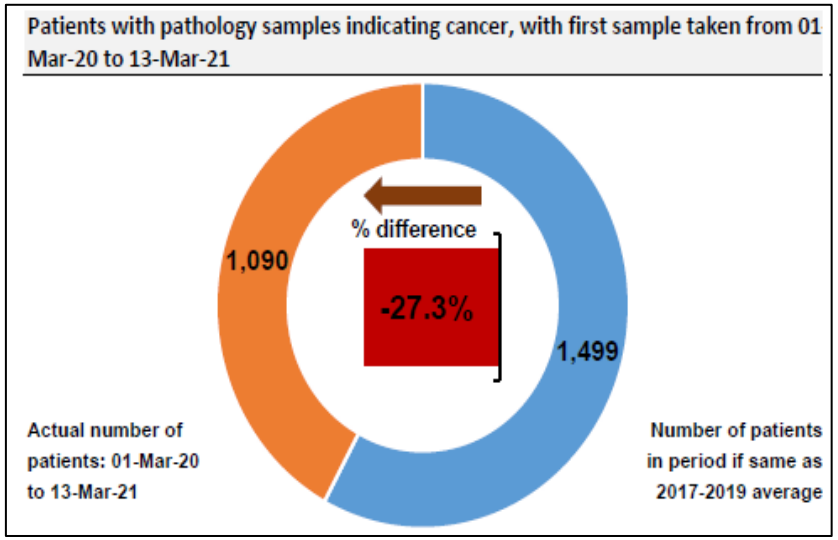
Regional Performance

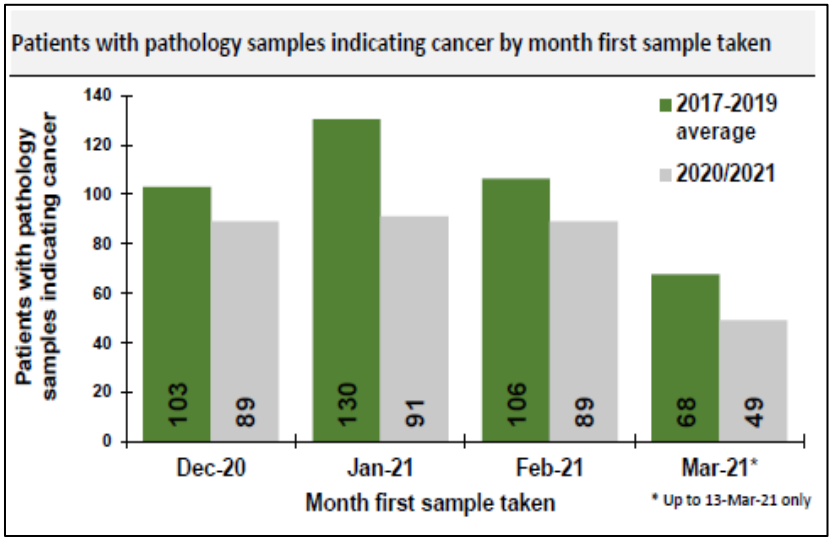
Southern Trust Actively Tracking 5,170 patients on Cancer Pathways
(3,840 62-Day and 1,330 31-Day Pathway)



62-Day Longest Wait Southern @ 469-Days / Regional @ 532-Days

NI Cancer Registry





Cancer Services Issues / Actions

* **Issues:**
  - Decrease in referrals during Pandemic
  - 'Missing' patients
  - Backlogs and increased volumes patients waiting longer
  - Capacity gaps pre-Covid – scopes; CT; out-patients
  - Service vulnerability pre-Covid – oncology and haematology
  - Theatre nursing constraining surgical developments
  - Changing profile of patients

Cancer Services Issues / Actions

* **Actions: Local –**
  - Fortnightly Cancer Checkpoint Meetings with multidisciplinary team representative from tumour sites, assessing pressures and actions
  - Weekly clinically led Theatre Priority Group
  - Balance between virtual and face-to-face consultations
  - Straight to test for certain patient groups
  - Radiology investigations expedited, eg, patients waiting CT guided biopsy
  - Q-Fit implemented for risk stratification on LGI & LGI pathways
  - Clinic templates adjusted to see more red flag patients
  - Close links with Regional Cancer Reset Cell
* **Actions: Regional -**
  - 3-year costed plan covers entire pathway except surgical
  - Aligned to draft recommendations in cancer strategy
  - Significant programme of modernisations focusing on improving patient outcomes and experience
  - 11 key work streams
  - Aims to create a smoother and more efficient pathway; and ensuring patients have equitable access to diagnostics; care; treatment; and support

Regional Recovery Plan Workstreams

1. Supporting People
2. Screening
3. Awareness and Early Detection
4. Safety Netting and Patient Flow
5. Diagnostic - Imaging
6. Diagnostics – Colposcopy
7. Diagnostics – Endoscopy
8. Diagnostics – Pathology
9. Prehabilitation and Rehabilitation
10. Oncology and Haematology
11. Palliative Care

Cost

- Recurrent cost 3 years £82.53m
- Non-recurrent cost £20.23m
- Capital investments £11.31m

Challenges

- Workforce
- Infrastructure
- Broader context

Next Steps

- RMB for ratification
- Subject to RMB support – to be presented to the NI Executive

Professional Issues

* Medical Staffing – Workforce Issues for oncology & haematology

* Nursing – Major theatre nursing challenges

* Technical – Tracking Resource Pressures – recognition Regionally of challenges and recent approval for non-recurrent funding to maintain required resources

Any Questions?

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

VIRTUAL PERFORMANCE COMMITTEE MEETING

DATE: **Thursday, 20th May 2021**
TIME: **9.30 a.m. – 1.00 p.m.**

AGENDA

TIME		ITEM	DIRECTOR	Purpose
9.30 – 9.40 a.m.	1.	Welcome and apologies: • *Mrs H. McCartan, Non-Executive Director*	Mrs P. Leeson	
	2.	Declaration of Interests	Mrs P. Leeson	
	3.	Chair's Business	Mrs P. Leeson	
	4.	Minutes of previous meeting held on 18th March 2021	Mrs P. Leeson	Approval
	5.	Matters Arising from previous meeting	Mrs P. Leeson	Information
Performance Reporting - Internal Assurance				
9.40 – 10.10 a.m.	6.	Performance Report	Mrs A. Magwood	Approval
10.10 – 10.30 a.m.	7.	Corporate Performance Scorecard	Mrs A. Magwood	Approval
10.30 – 11.10 a.m.	8.	Integrated Performance Report PRESENTATION: Cancer Services	Mrs M. McClements	Assurance
COFFEE BREAK				
11.30 – 11.50 a.m.	9.	Unallocated Childcare Cases Report	Mr P. Morgan	Assurance
11.50 – 12.10 p.m.	10.	Executive Director of Nursing, Midwifery and AHPs Report	Mrs H. Trouton	Assurance
12.10 – 12.30 p.m.	11.	Infection Prevention and Control and Antimicrobial Stewardship Report	Dr. M O'Kane	Assurance
Performance Reporting - External Assurance				
12.30– 12.50 p.m.	12.	Health Quality Improvement Partnership (HQIP) Hip Fractures Database Annual Report	Mrs M. McClements	Assurance
12.50 – 1.00 p.m.	13.	Any other Business	Mrs P. Leeson	

The next Virtual meeting of the Performance Committee will take place on Thursday, 2nd September 2021 at 9.30 a.m.

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting

Date of Meeting: Tuesday, 27 November 2018 @ 2pm

Venue: Meeting Room, Admin Floor

Attendees: Esther Gishkori **(Chair),** Ronan Carroll, Barry Conway, Anne McVey, Anita Carroll, Lynn Lappin, Ciara Rafferty

Apologies: Lesley Leeman

Agenda Item	Discussion	Action
Strategic Information Forum Update	Siobhan Hanna requested Lynn to raise some key issues identified in the Corporate Data Quality Report at the meeting. **Recording of Disposals after Clinic Attendances on PAS** Lynn asked all to ensure the data quality of information on PAS and ensure disposals are recorded for each attendance. Midwifery is reporting a significantly high number of disposals followed by Cardiology and Dermatology. Anita and Barry advised that the Midwifery figures may be due to the new antenatal pathway and/or the issue that clinical outcome sheets are not being completed. **UDDA Diagnosis Coding** This is undertaken by Nursing Staff within STH Minor Injuries Unit. Anne and Mary have previously raised this with staff. **Outpatients with Procedures** Rheumatology is currently showing a low level of procedures. Louise Devlin felt this did not reflect the correct position and is to review this.	Anita and Barry to review Midwifery figures to determine reasons. Lynn to determine last year's position and share. Item to be added to ASD Cross Divisional meeting agenda. Anne to follow up on this. Louise to follow up on this.
Trust Board Report Update	Lynn provided an update on the Trust Board Performance Dashboard at October 2018 Report Summary.	

Agenda Item	Discussion	Action
	Cancer Care Lynn highlighted the increase in the number of referrals across all pathways with a particular increase during October in Breast Cancer referrals which is anticipated to be due to Breast Cancer Awareness Month. Within Breast Cancer Services, the team has already flexed up out-patient capacity to maintain the 14-day objective, however, they are unable to increase this theatre capacity for subsequent surgical requirements due to unscheduled care pressures and capping. Cumulatively 99% of patients with suspected breast cancer have been assessed within 14-days. The longest wait for routine assessment is 87-weeks (associated with the 'lost' patients returned from NHSCT) however, this will reduce to 39-weeks by the end of November. In comparison to the increase in out-patient referrals there has been no comparable rise in the conversion to confirmed cancer. Lynn highlighted that SHSCT is, Regionally, one of the best performing Trusts on the 62-day pathway. Also it was noted that the referral peak will have an anticipated impact on the 31 and 62-day pathways in the coming months. **Elective Care** Lynn reported New Out-Patients and In-Patient and Day Cases are performing well against trajectories. Lynn noted further funding has been allocated for additional in-house capacity and the provision of independent sector activity. This totals the amount of non-recurrent spend to £9.7 million to be used by the end of March 2019. Lynn reported that she has been advised of risk with ATICS & SEC Division, however, there was an anticipated solution to this. To date no other risks have been. Barry advised that after discussions this week there may be a risk within Outpatients for Gynaecology, Colposcopy and Haematology.	Sharon Glenny to confirm risk for CCS & IMWH Division.

Agenda Item	Discussion	Action
	Diagnostics including Endoscopy Lynn reported that SEHSCT have procured a Medinet mobile endoscopy suite which has capacity that the SHSCT is able to avail of. Lynn and Wendy are meeting with Chris Allam from SEHSCT next week to discuss additionality for scopes. Within diagnostics it was reported that 47% are waiting less than 9-weeks. Additionality is in place for DEXA and MRI. Within Endoscopy 230 patients are waiting over 26-weeks. Funding for in- house and independent sector additionality has been allocated with at least 500 patients to be seen within SEHSCT. It was also reported that one of the Nurse Endoscopists has undertaken validation work. **Imaging/Non Imaging** The mobile CT scanner is currently being funded by second CT recurrent case and capacity gap funding. Alliance are also undertaking additionality at weekends. Funding has been received for CT Colonography and CT Cardiac Angiography which will be undertaken in the Independent Sector. Additionality is on-going for originally allocated funding within Cardiac Investigations and Urodynamics. **DRTT (Plain Film)** Lynn highlighted that this has been included in the Trust Board report to highlight the improved performance. **In-Patients and Day Cases** Lynn noted that 8 specialties are currently waiting in excess of 52-weeks. The longest wait is 248-weeks, however, she highlighted that the average waiting time is 35-weeks with the longest wait within the 95th percentile being 111-weeks. This results in only 5% of patients waiting between 111-248-weeks. Lynn also reported that SHSCT is performing slightly better than the Region.	Lynn and Wendy to meet with Chris Allam in SEHSCT to confirm capacity.

Agenda Item	Discussion	Action
	Anne noted that the Modular Cath Lab was down last week due to repair work. Lynn requested details of the number of sessions/patients impacted as this will impact on the PTL / additionality plan. Lynn noted Orthopaedic additionality is to be undertaken in the Sports Surgery Clinic, Dublin and North West Independent Hospital, Ballykelly. **Outpatients** Lynn noted over 8,000 patients are waiting in excess of 52-weeks. The longest wait is in the Ortho-Geriatrics specialty at 146-weeks. Within Out-Patients the average waiting time is 31-weeks with the 95th percentile wait at 91-weeks, therefore only 5% of patients are waiting between 91 - 146-weeks. Anne noted that it would be of benefit to establish where the Ortho-Geriatric demand was coming from and how other Trusts were operating this service. It was reported that additionality is in place for urgents, red flags and a small volume of longest waits. **Hospital Out-Patient Cancellations** Anita advised she had looked at this report and there was no specific specialty impacted by this and 61% of the cancellations are due to late notice of consultant leave. Lynn noted that 5,500 appointments were cancelled during 2017/2018, which detrimentally impacted on the patient. Cumulatively, at September 2018, 3.1% of appointments have been cancelled, which detrimentally impacted on the patient. It was noted that this is likely to increase over the winter period. **HCAI** Lynn noted that we are now reporting on gram-negative bloodstream infections and antibiotic prescribing and consumption within the Corporate Dashboard.	Anne to share the number of sessions/patients impacted. Lynn to review information available on waiting lists and referrals within Ortho-Geriatrics and share. Lynn to confirm what specialties are included in the hospital cancelled out-patients information return.

Agenda Item	Discussion	Action
	Stroke Lynn highlighted the additional analysis extracted from the report prepared by Colum Robinson regarding those patients eligible for thrombolysis noting that 100% were assessed within 30-minutes of arrival, received their CT scans within 45-minutes and first bolus of thrombolysis within 60-minutes. Lynn noted that this wider performance agenda sets the current Commissioning Plan objective into perspective. **Unscheduled Care** Lynn noted that cumulatively as at October 2018, 71% of ED patients were treated, discharged or admitted within 4-hours. 55% of patients in CAH were within the 4-hour standard. Anne advised that a senior staff member is now assisting with triage in ED. Lynn advised that the 12-hour waits performance in SHSCT ED is in line with the Regional position. She also reported that non-elective admissions have increased compared to last year. Lynn advised that the Performance Team had met with Anne; Mary and Lisa to review the ED Trajectory. Work is still on-going to understand the variance in performance, however, Anne confirmed that she did not want to reduce the trajectory performance any further and would rather spend the time analysing what is impacting on performance. Lynn also noted that waits between 6-10 hours continue to be high.	
ASD Cross Divisional Meeting – 8 November 2018	Lynn advised the minutes from the last meeting are to be distributed shortly. Lynn highlighted an action point from the meeting in relation to Risk Registers and felt it would be useful to get guidance from Esther on how and where Acute risks are to be recorded. It was discussed that risks should sit on the risk register for the level at which it can be managed and escalated as required. Also if a risk is on the Corporate Risk Register, it is still required to be looked at, at a lower level.	Esther to confirm process for recording and escalating risks and the communication process.

Agenda Item	Discussion	Action
Trajectories	Lynn advised that the Performance Improvement Trajectories Update as at October 2018 was sent to SMT this week and on the whole performance against trajectories is going well however the following are assessed as Red: • Diagnostics including MRI and Non-Obstetric Ultrasound; • Delivery of Core IP/DC at specialty level (Dermatology, ENT, Paediatrics and Orthopaedics); • Delivery of Core OP at specialty level (General Medicine, Gynaecology and Urodynamics); • Emergency Department. Lynn noted that a number of revised trajectories are currently with her for review and once completed they will be sent to Esther for final approval. Lynn noted that the Emergency Department is currently off trajectory and it has been agreed not to revise this. Anne highlighted the present difficulties with the discharging of Physical and Learning Disability patients under 65, of which there are 8 - 10 per day. This is impacting on longer discharges times and the ED trajectory. Ongoing work is being undertaken by Lynn and Elaine Murphy to assist Catriona McGoldrick in the presentation of her Control Room Dashboard.	Further discussions are required with colleagues in the Disability Services Division to look at this.
Recurrent Spend	Agenda item was previously discussed.	
Acute Services Performance Action Register	It was agreed to follow up on this outside of the meeting.	Performance Team to follow up on outstanding actions.

Southern Health and Social Care Trust

DRAFT

Name of Meeting: Acute Services SMT Performance Meeting

Date of Meeting: Tuesday, 26th March 2019 @ 2pm

Venue: Meeting Room, Admin Floor

Attendees: Esther Gishkori, Anne McVey, Wendy Clarke, Brigeen Kelly, Helen Forde, Lesley Leeman, Elaine Murphy and Ciara Rafferty

1.0 Apologies: Lynn Lappin, Ronan Carroll, Barry Conway and Anita Carroll

Agenda Item	Discussion	Action
2.0 Trust Board Performance Dashboard Update	An update was provided on the Trust Board Performance Report and Dashboard in advance of the Trust Board meeting on 28 March 2019. **SBA – Elective In-patients** Elective in-patients was reported as underperforming by -35% cumulatively as at January 2019 against its SBA. The top 3 specialties contributing to underperformance were ENT, General Surgery and Gynaecology. It was noted that changes in practice within Gynae, loss of consultants in ENT and the allocation of additional sessions allocated to Urology were contributing factors. It was discussed that the impact of the additional sessions for Urology needs to be determined. **Cancer** Lesley reported that cancer rates have not changed drastically however all areas are experiencing an increase in referrals. **Routine Waiting Times** Esther expressed concerns regarding the number of patients waiting on routine waiting lists and the risks associated with this. She requested assurances that those most in need are being seen first. Discussion took place regarding the current processes in place for triaging of red flag and urgent referrals to ensure care goes to the most urgent.	Acute to determine impact of additional sessions allocated for Urology.

Agenda Item	Discussion	Action
	It was noted that Dr O'Kane has requested for the GP access referrals to be stood down as the staff member who previously reviewed these has now retired. Also urology referrals to WHSCT have ceased but the impact of this is yet to be determined. Esther suggested adding details of symptoms to the letters issued to patients on waiting lists. Discussion also took place regarding the process for DNAs at Outpatient appointments. Helen confirmed if a patient does not turn up for an appointment they have 4 weeks to rebook before they are discharged from the waiting list. Lesley suggested having a discussion with Rose and Mary to look at a mechanism for escalating routine waits to urgent due to a change in the patient's condition. There is a need to manage this locally due to the increased referrals against a limited capacity.	Acute to arrange a meeting with Rose and Mary to look at mechanism for escalating routine waits to urgent.
3.0 Trust Board - Performance Dashboard Summary Report	**Cancer Care** Lesley noted Graph 1 in the report outlines monthly referrals are above the average from May 2018, with the exception of December 2018. Additionality is being utilised for red flags and urgent referrals. It was noted that if there is an increase in demand for surgery there is no additional capacity for this. Lesley advised additional breast assessment clinics have been set up but the Trust has been unable to flex up capacity for treatments as surgical capacity cannot be increased unless bed capacity is also increased. The report lists the following improvement actions: • Reestablishment of the Trust Cancer Steering Group • Cessation of urology referrals from WHSCT • Participation in a number of tumour site specific improvement workshops Lesley suggested raising the increase in cancer referrals at the Trust Board meeting.	

Agenda Item	Discussion	Action
	Elective Care Endoscopy Lesley highlighted the number waiting for planned repeat endoscopy procedures and diagnostic tests in Section 2 of the report. **Unscheduled Care** Lesley highlighted that the Trust has experienced an increase in waits for admission over 12 hours in ED which has exceeded the regional pattern from July this year. Anne outlined that the number of ambulances received from NHSCT and SEHSCT, waits for EMI, under 65 discharges and repatriations to other Trusts have impacted on performance. Lesley noted the challenges with bed capacity and the need for a refresh of the formal bed requirements via a bed demand and utilisation exercise. **Safety & Quality** Lesley highlighted Graph 10 in the report which highlights the Trust compares favourably against the Hospital peer group in relation to emergency re-admission rates within 28 days. Anne advised that they have ceased putting additional patients onto wards and noted that once 4-hour performance falls at the beginning of the day, you are always working to catch up on this. Anne advised they intend to look at what BHSCT are doing in relation to their drugs and alcohol policies. Lesley highlighted the 10,000 Voices presentation, given at the last locality network, and the key messages from service users as outlined in Section 4.3 of the report. It was also noted that Anita is currently looking at including a reference, on letters issued, noting or signposting patients to waiting times. Lesley advised she suggested for Anita to speak to Communications regarding including additional	

Agenda Item	Discussion	Action
	narrative to the existing GP Access Times report regarding what the report is detailing and means.	
4.0 Elective Additionality - Q1 2019/20	Lesley had shared the paper issued to SMT on 19 March 2019. Lesley advised that it has been highlighted to the Board that the Trust is undertaking additionality at risk. Anne advised that a paper is currently with Finance to extend the contract for the Mobile Cath Lab. It was noted that SMT have approved the extension at risk as the Trust is now beyond what was originally funded.	
5.0 Trajectories	Lesley advised that trajectories are available on sharepoint and highlighted to all that some areas are currently underperforming.	
6.0 Corporate Risk Register	Lesley noted that the Corporate Risk Register was issued to SMT for review by 9th April 2019. Risk 10 i.e. Clinical risk associated with inability to manage patient care within clinically indicated timescales was reviewed by all at the meeting. Lesley agreed to update the details on the Corporate Risk Register discussed and issue to all for final review and comment.	Lesley to issue updated Corporate Risk Register to all for review and final sign off by Esther. Esther to forward to Sandra Judt once finalised.
7.0 2018/19 Quarter 2-4 Additionality	Lesley noted at the last update the 2018/19 Confidence and Supply funding has been underspent. Lesley advised that she, Elaine and Gary Donaghy had previously met to review the Confidence and Supply spend and had identified areas of underspend. However she reported the February position is now highlighting additional areas of underspend which are too late to be declared. Lesley advised that the Trust cannot incur any additional slippage in 2018/19 and reiterated the importance of ensuring all Quarter 1 funding is spent. All agreed for a new monitoring database to be created up and uploaded to sharepoint for monitoring spend on a monthly basis.	

Agenda Item	Discussion	Action
	Lesley requested all to ensure all additionality is recorded and coded appropriately in advance of 19th April to enable HSCB to accurately report on this.	
8.0 AOB	There was discussion regarding the admin validation posts which had been discussed at SMT and Investment Board.	
12.0 Date of Next Meeting	Tuesday 28 April 2019 at 2pm	

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting

Date of Meeting: Tuesday, 25 June 2019 @ 2pm

Venue: Meeting Room, Admin Floor

Attendees: Ronan Carroll (Chair), Anita Carroll, Lynn Lappin, Sharon Glenny, Wendy Clayton, Fiona Reddick, Catriona McGoldrick, Ciara Rafferty

1.0 Apologies: Esther Gishkori, Melanie McClements, Barry Conway, Anne McVey

Agenda Item	Discussion	Action
3.0 Matters Arising	**3.1 Elective Inpatients** Wendy agreed to forward details of the impact of reduced elective theatre capacity and theatre staffing issues on trajectories to Elaine Murphy. It was noted this was discussed at the Surgery & Elective Division meeting held today. **3.2 Routine Waiting Times** Anita advised the meeting with Jane McKimm is yet to be arranged. Anita confirmed the proposed format for this information will differ from the current access times report. Ronan felt it would be useful for details regarding red flag waiting times to be included and Lynn suggested the inclusion of DNA rates and communication around this. Ronan suggested holding a provisional meeting with Rose McCullagh and Mary Donnelly to determine what GPs would like to see incorporated. Lynn also outlined the requirement to discuss the frequency of the report. **3.3. Validation/IS Resources** It was reported that Diagnostics, AHP, OP Reg. validation and Mental Health requirements were included in the combined validation and IS resource paper. The paper is currently with the Planning Department. Approval has been granted to appoint a Band 4 from HSCB funding. Lesley had advised the HSCB funded post would assist in validating the waiting lists for DEC specialties. It was noted that this was discussed at the Surgery & Elective division meeting held this morning.	Wendy to share details on the impact of elective capping and theatre staffing issues on trajectories with Elaine Murphy. Anita to arrange meeting with Rose McCullagh and Mary Donnelly to provisionally discuss GP requirements.

Agenda Item	Discussion	Action
	3.4 Endoscopy Ronan noted concerns regarding the current waiting times for Endoscopy. A meeting is to be held on 26 June 2019 to discuss the potential mobile endoscopy unit. Lynn also noted the need to determine the cohort of patients who will be sent to mobile. The Band 8A Nurse Endoscopist job description is to be discussed at the job matching panel on 26 June 2019. **3.5 Cath Lab** Lynn reported that approval for a 6 week extension (9 sessions per week) has been granted. Two core sessions will be displaced to core Cath Lab unit to facilitate SEHSCT Consultants for PCIs. Lynn reported that Kay has advised that SEHSCT are now unable to undertake 2 sessions in July and August and this may impact on the ability to undertake the remaining 7 sessions. It was reported that SHSCT staff have been asked to provide sessions within a BCH Cath Lab, however, the majority of Cardiology Consultants have declined this. **3.6 Non-Recurrent Additionality** Wendy noted that there has been learning taken from the changes/veering made in the early part of Quarter 1. It was noted that Quarter 2-4 bids, excluding admin, have been submitted to the HSCB. At present the Trust is £43,000 under the overall 2019/2020 allocation and this has been queried by the HSCB. Lynn provided approval for services to proceed with booking activity in July. **3.7 2019/2020 Trajectories** All trajectories for 2019/2020 have been received and submitted to the HSCB. **3.8 Review of Governance Arrangements in Independent Sector Hospitals** Ronan advised that a response was sent today. **3.9 Renal Unit Blood Testing Issue** No update on this issue.	

Agenda Item	Discussion	Action
	3.10 Vascular Surgery Pathway Implementation Ronan provided an update on the draft pathway for repatriation of vascular patients which has been agreed by the Associate Medical Directors. The draft pathway is now to be issued to all consultants and patient flow teams. It was noted that the pathway needs to be replicated for trauma repatriation. **3.11 Accountability Meeting with the Chief Executive** Lynn noted that the next meeting is take place on 7 August 2019 and all should revisit any actions from the previous meeting in advance. Lynn advised the Accountability Scorecard measures are still be agreed. She advised the Performance Team will update the scorecards with the information they have available but services will also need to provide qualitative updates yet to be agreed. Lynn outlined the indicators currently being proposed for inclusion in the Acute Accountability Scorecard. In relation to the ward flow indicator, Anita raised the amount of work undertaken by ward clerks each morning to update all flow boards. She raised the need to determine where the information reported in the scorecard is taken from to ensure it is up to date and also the need to ensure flow boards are updated in a timely manner. Catriona outlined that Out of Hours periods are still a weakness. Sharon noted an ongoing issue with the regional 62 and 31 day pathways reports. Currently BOXI reports, used by the Trust, count patients more than once when a change has been made on their pathway. Sharon wished to note that once the BOXI report is amended you will be unable to compare it against previously reported information. Lesley-Anne Reid is to raise this at the Cancer Information meeting this week. Anita advised that details on Laundry Downtime should not be included at this time but it could be reviewed at a later date. Ronan advised that he and Estates have written to the Medical Director and Acute Services Director	

Agenda Item	Discussion	Action
	regarding Capital Equipment. Anita confirmed that she holds details on all requests by Division. Ronan advised they have prepared an update for their division outlining requirements and impact if equipment is not replaced. Wendy agreed to send this to all to enable each division to prepare a similar update. It was agreed that a combination of the information from Anita and Ronan could be used. All present felt that capital equipment should be considered as an indicator. Lynn noted that Shane will get a high level dashboard but a breakdown at divisional level will be available for all.	Wendy to issue Surgery & Elective Capital Equipment update to all.
4.0 Elective Additionality	Lynn noted all Quarter 2- 4 bids have been sent to HSCB and the Trust is awaiting a response. Lynn agreed to follow up on this with Lesley. Lynn confirmed that services can proceed with booking July activity. Lynn highlighted to all that services should not go over their allocations as it cannot be assumed that any slippage will be available to cover this.	Lynn to advise all once HSCB response has been received.
5.0 Performance Improvement Trajectories (2019/2020)	Lynn advised all trajectories have been submitted to the HSCB and no queries have been received to date. Lynn noted that assumptions will be reviewed and submitted to the HSCB at a later date. It was noted trajectories were discussed at the Surgery & Elective Division meeting this morning. Lynn noted that monthly monitoring of the trajectories will continue as per last year and confirmed if any changes are made to Job Plan PAs, then trajectories will be need to be revised.	
6.0 Year End Assessment of Performance against Commissioning Plan Objectives and OGIs	Lynn noted the report has been issued to Trust Board. Lynn outlined that of the 51OGIs assessed as Green/Amber in the TDP, 49 of these achieved a green/amber status at year-end resulting in 2 of these OGIs not been achieved. Lynn highlighted that the Healthcare Acquired Infection OGIs for C Difficile and MRSA were achieved for the first time in 2018/2019.	

Agenda Item	Discussion	Action
	Lynn noted that the Acute Hospital Complex Discharges target was not achieved in light of the change of focus to recording. Catriona noted that recording has now improved but issues with repatriation and nursing homes continue to impact on complex discharges. Lynn also noted that Staff Sickness Absence and Seasonal Flu Vaccine OGIs were not achieved.	
7.0 Accountability Indicators	This was discussed under matters arising.	
8.0 Next steps Risk to Surgical Waiting Times June 19	Ronan advised this was sent to the Director for information and no further action can be taken until the outcome of the pension issues has been agreed. Medicine & Unscheduled Care and Integrated Maternity and Women's Health Divisions have not prepared a similar update however it was noted their commitment would not be the same as Surgery & Elective. Wendy and Ronan agreed to issue template to other divisions.	Wendy and Ronan agreed to issue ATICS/SEC paper to other divisions.
9.0 Action Log (Reference)	All were asked to review and update the action log and return this to the Performance Team. It was noted this will feed into the risk register process.	All to review and update the action log and return to the Performance Team.
10.0 AOB	Sharon noted that the refurbishment of CT in Daisy Hill Hospital is planned to take place in July, however there is no date as yet, and this will take approximately 6-weeks to complete. Any patients requiring a CT will be sent to the mobile CT however patients on stretchers, beds or in wheelchairs will have to go to CAH as they cannot be accommodated in the mobile. Catriona flagged that this is a patient safety issue and noted concerns that NIAS will not be able to accommodate the transportation of patients to CAH. Sharon agreed to escalate this to Barry on his return and to check if NIAS have been informed. Sharon also agreed to determine the number of in-patients currently going to CT on stretchers, beds or in wheelchairs to assess the potential impact.	Sharon to escalate concerns and check if NIAS has been informed with Barry on his return. Sharon to determine number of in-patients potentially to be impacted.

Agenda Item	Discussion	Action
12.0 Date of Next Meeting	Tuesday 23 July 2019 at 2pm	

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting

Date of Meeting: Tuesday 28th January 2020, 2pm

Venue: Meeting Room 1, Admin Floor, CAH

Attendees: M Clements (MC), L Leeman (LL), L Lappin (LNL), A McVey (AM), B Conway (BC), A Muldrew (AM), R Carroll (RC), L McAreavy (LM), J Scott (JS), J Brodison (JB)

1.0 Apologies: Anita Carroll

Agenda Item	Discussion	Action
2.0 Chair's Business	The C&S Transformation Financial Risk Assessment as at 23.01.2020 was discussed. There is potential £1,096,000 slippage. 10,000 Voices is to be replaced with Care Opinion – an online Service User opinion facility. Data will be collated and provided to the Trust. NIPSA are continuing with industrial action on 3rd Feb. B6 Social Workers will not be completing any statistical returns.	**ACTION**: ADs to review and confirm figures are accurate for their areas. **ACTION**: AD's to roll out training to staff which is currently available
3.0 Actions from Previous Meeting	Minutes not available	**ACTION** – performance Team agreed to take action notes for future meetings
4.0 Performance Scorecard	Performance Scorecard was presented for review. The following areas were highlighted for discussion: • Review backlog – up to 29,000 • Complex discharges looking more positive – back up to 70% • Endoscopy – significant sustained increase numbers waiting beyond 26 weeks. RC advised that there has been no IS activity since March 2019. This has been compounded by the reduction in the levels of additionality and Nurse Endoscopist maternity leave.	

Agenda Item	Discussion	Action
5.0 Performance Committee	The format and content of a Cancer Report to be provided to the Performance Committee in March was agreed SMT papers to be issued 6 March. Committee 19th March BC to lead in development.	**Action:** LNL will draft and circulate for population of key information. Paper should be complete for 06.03.2020.
6.0 Chief Executive Accountability Meeting	Action log circulated and updated. Items for inclusion in dashboard discussed	**ACTION**: JB will contact Patricia Kingsnorth to get updated Governance Dashboard information re SEAs, SAIs and Complaints **ACTION**: RC to forward Fracture Hub information for inclusion in place of the Capital Equipment tile **ACTION**: Elective Cancellations - ADs/OSLs to provide the numbers of Red Flags cancelled due to strike action and advise if these have been re-scheduled. Forward to MC by 04.02.2020 **ACTION**: Theatre Utilisation – Jane Scott to send figures to JB **ACTION**: Staff Turnover: RC will provide update on staff turnover
7.0 Confidence and Supply Spend (Elective)	Overview of slippage presented, small amount in Acute and larger in AHPs. Ronan proposed expenditure of slippage on IS capacity; risk were highlighted in delivery within timescales by performance team. Assurances had been provided by IS provider to service Melanie agreed to permit further engagement with IS to utilised AHP slippage. Team to focus on ensuring no further slippage in their areas and that all committed to was realised.	**Action** – ATICs to progress IS capacity for surgical cases to be delivered by March **Action** – All to ensure capacity committed to was confirmed **Action** – All to escalate any risks immediately
8.0 Review Backlog Action Plan	Review backlog increased to 29,000. Discussion re validation of lists and putting actions in place to remove some of the longest waiters.	**ACTION**: Review Backlog Action Plan to be reviewed and updated at speciality level

Agenda Item	Discussion	Action
	Validation is ongoing and OSLs are following up with consultants. Jane confirmed that regional guidance is being followed re removals/IEAP LNL queried if we can quantify how many patients have been taken off the list?	**ACTION**: ADs to discuss with Clinicians and progress as much as possible **ACTION** - ADs to agree internal achievable targets, at specialty level, to improve RVBL
9.0 Inpatient/DC Planned Treatments beyond planned timescales	Planned treatments, particularly non endoscopy continue to increase presenting risk. There was a discussion around validation options, particularly non scopes; are these all valid, etc	**Action:** OSL to validate. ADs to agree internal achievable targets, at specialty level**.**
10 Outpatient Open Registrations	Melanie referred to Anitas paper to be presented at SMT re auto-closure of OP Registrations. It was agreed pre-operative assessment should not be closed	**ACTION:** ADs to review Anitas paper and provide feedback to MC by 04.02.2020.
11 Validation Proposal	Trust-wide Validation Proposal was discussed. The proposal is due to go to the Investment Committee. It is generally felt that Clinicians will support the proposal.	
12 Notification of Elective cancellations (RF / urgent) – Process	HSCB require notifications of cancelled elective urgent/RF; this is process via Performance Team. It was recognised that in times of pressure this might be overlooked. All reminded to ensure notification made to performance team	**Action** – Timely notification of cancelled elective patients to performance time
13 Elective Plan for 2020/21 – Update	LL provided update on elective plan for 2020/21 associated with ministerial commitments provided in New decade New approach document associated with reduction in long waits There was acknowledgement that internal capacity limited and IS provision will be required. Regional discussion ongoing with suggestion that individual Trusts take a lead on IS issues as a regional specialty level. Further information awaited. ST to agree to take a lead in endoscopy if this was required. Acknowledgement of ongoing challenges with WLI guidance re payments and pension issues at Ministerial level	

Agenda Item	Discussion	Action
14 **Endoscopy proposal**	LNL had provided a summary paper to Melanie re options for IS capacity. It was agreed this should be actively pursued again. LL agreed to link with BSO as any procurement would be PaLS lead to identify next steps	**ACTION** – LL to link with BSO
15 **Elective Operational Improvement Group – Proposal**	It was agreed in principle that an elective group be established, similar to the unscheduled care operational improvement Group to provide oversight and co=-ordination of a range of elective care improvement actions.	**Action** – Melanie and Lesley to meet and agreed ToR
16 **EU Mobility Guidance – Update**	Trust has liaised with HSCB who operate this scheme to facilitate treatment of patient son waiting lists in other EC countries to ascertain any issue after EU Exit. Advice at this stage is no change. Guidance will be issued in due course. Patient should continue to be directed to National Contact Point at HSCB	No action
17 **Delayed Transfer of Care – Update from SIF**	LNL provided update from SIF re new guidance on recording for DToC. Anita had updated on this	**Action** – All to ensure guidance implemented
18 **Issues from Cancer Meeting – Day Clinical Centre Capacity**	Number of issues arising re capacity in day clinical centre and opportunities also. Limiting capacity impacting on capacity for blood transfusion with patients being admitted for same and patients attending for specific CT exams.	**Action** – Agreed ADs to meet and consider need for Day Clinical Centre expansion starting with review of services currently provided and appropriateness of same.
19 **ED Letter**	Melanie sought additional information to response to issues arising from ED pressures	**ACTION:** Performance Team to provide numbers behind Bed Occupancy/Length of Stay and 6.45am Occupancy Reports. **ACTION:** AMcV to share Complex Delayed Discharge data collected in control room with Elaine Murphy
20 **Date of Next Meeting**	25th February 2020	

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting **DRAFT NOTES**

Date of Meeting: Tuesday, 23 February 2021 at 11.30am

Venue: Videoconference – Ronan Carroll's Meeting Space

Attendees: Melanie McClements; Mary Burke; Ronan Carroll (**Chair**); Barry Conway; Anne McVey; Tracey Boyce; Anita Carroll; Lynn Lappin; Julie Brodison; Joanne Hughes

Apologies: Lesley Leeman

Agenda Item	Discussion	Action
1. Apologies	• Apologies received from Lesley.	
2. Chair's Business	• Melanie welcomed everyone to the meeting. No Chair's business to be discussed, other than listed on the agenda.	
3. Matters Arising	• Actions notes from the meeting on 26 January 2021 are agreed as an accurate reflection. • Contracts – Lynn advised that Sue-Ann Collins is aiming to have the Band 6 and Band 7 job descriptions with the teams by 16th March.	**Sue-Ann Collins to draft job descriptions**
4. Elective Additionality 2020/21	• Lynn advised that elective additionality was ongoing with no underspend / risk identified by the Teams at this time. • Lynn gave an update to the meeting on Orthopaedics plan with the Hermitage, Dublin. Work is ongoing with Hermitage to get agreement finalised.	
5. Elective Additionality 2021/22	• Ronan suggested that opportunities for IHA would be limited in 2021/2022 as theatre staffing continues to remain an issue. Lynn noted that Q1 bids would be required for red flag / urgents. • Lynn queried with Ronan if the Nurse Endoscopist post, which had been recruited at risk, still required recurrent funding. Ronan to confirm and Lynn to submit to HSCB if required. • Anne raised the vacant Nurse Endoscopist post advising that one of the Consultants had sought the redirection of this funding to consultant sessions. Ronan advised that they would be seeking to	**Ronan to confirm if NE still funded at risk** **Lynn to notify HSCB of cost**

Agenda Item	Discussion	Action
	replace this post with another Nurse Endoscopist and that they believed that this recruitment would be successful. Melanie queried the sessional throughput from a Consultant versus a Nurse Endoscopist. Melanie was advised that a Nurse Endoscopist would have 5 sessions of endoscopy a week versus 1 – 2 for a Consultant.	
6. Regional Elective Prioritisation Process	• Ronan stated that the elective rebuild will be a slow process and that ICU beds are still at 14, therefore, April will not demonstrate a lot more theatre activity. Ronan further indicated that CCANI wished to keep the existing arrangements in place until May. • It was noted that the Regional prioritisation process for IS and elective theatre capacity has worked well. • NOUS being undertaken by the Northern Trust due to extra capacity which is also working well and SET have offered capacity for Echos with Kay working to send patients. • Lynn asked for any issues that needed to be raised at the next HSCB performance meeting: o Anne asked that Cardiology Cath Lab pressures to be raised with Team concerns / frustrations around only have one Lab and lack of back up should the machine break down. o Red Flag waiting time information to be raised at HSCB Cancer Performance Meeting as lack of Regional approach to sharing this information. o Ronan noted daily queries from MLAs regarding waiting times and the time required to answer these queries along with the raised expectations from the patients. Melanie to raise at SMT and Lynn to add to HSCB/Trust Service Issues/Performance meeting agenda.	**Melanie to raise MLA queries regarding elective wait times at SMT** **Lynn to add MLA queries and communication of waiting times to HSCB/Trust meeting agenda**
7. Performance Issues/Update	• Cancer Performance – Barry gave an update from the fortnightly Cancer Performance meeting. The 62 day target is now at 44% reflecting the decline in performance that the Trust has advised would occur as the patients begin to close off their pathway; 14 day target for Breast has shown some improvement. The Cancer Tracking Team continues to track double the normal amount of patients on the cancer pathways. Barry further noted work via the Fortnightly Cancer Checkpoint	

Agenda Item	Discussion	Action
	meetings to start and gather information per tumour site on their pre and post-Covid issues / performance and what their key barriers are now to improve this position. • Review Backlog – approximately 35,000 on list at present. The longest waits are from 2012/13 and if stragglers could be cleared it would make a big difference. Lynn suggested a line by line review of these outlying patients with the patients then being seen or discharged. • Cath Lab – Anne again noted the concern around only having one Cath Lab and the risk involved with this. Melanie asked if we were the only Trust in this situation? Melanie further asked if we had contingency arrangements in place in case of breakdown? • Imaging – Barry suggested that our infrastructure issues need to be flagged up to the new Imaging Board, being managed by Maria Wright. Capital investment and new equipment is needed.	**Lynn to check if any non-recurrent funding available for this** **Lynn to discuss with Regional Performance colleagues** **Anne to advise on contingency arrangements**
8. No More Silos	• Work Stream 2 – Lynn noted that the Interim Directory of Services would be completed by April. Melanie advised that the A/Ds were testing the numbers etc and would feed back to Elaine. Lynn noted the importance of the key Trust numbers being included, kept up to date and not staff's personal numbers as this is a public document. • Ambulatory Developments – Lynn noted the updates that had been submitted to Lesley with the Gynae proposal being finalised and the Surgical proposal still outstanding. Ronan advised that the Surgical Hotline was not being used well. Lynn advised that Lesley queried if space for this service had been requested from the Strategic Accommodation Group? Anita advised that it has not. Anita noted that a list of the vacant spaces has been drawn up which includes the booking centre areas. Anita further advised that there are two other Directorates looking at these spaces. Melanie asked Ronan could the Surgical service be run without current staffing levels if they were allocated accommodation? Ronan confirmed that yes, they could run the service if accommodation was available. Melanie voiced concern that she did not have one compiled document to evidence what space is required for Acute Services and what the justifications / need for it are. A/Ds to urgently meet to complete this and return to Melanie. This document should also include the requirements for the DCC which is currently located in STH theatres	**A/Ds to send any corrections or additions to Vicki this week** **A/Ds to draft detailed proposal and send to Melanie.**

Agenda Item	Discussion	Action
	and should be a 'black & white' solution for the provision of safe medical cover. This will enable Anita to raise at Strategic Accommodation Group. • Urgent Care Centre – Melanie voiced concern that that there are only 2 x 8A's using the allocated area in Ramone and feels that this space could be better utilised. • Work Stream 5 – Lynn provided an update from Elaine Murphy. The Patient Discharge Leaflet has been uploaded onto SharePoint and is out for printing. The Red Cross assisted discharge scheme commenced in January and seems to be working better in DHH than in CAH. In respect of the Dementia & Delirium sub-group Lynn advised that Claire Kelly would be assisting with this. Melanie noted concern and asked that this sub-group does not drag on like the Frailty one did. Anne advised that Patricia Loughran has been appointed as Head of Service for Stroke/Frailty.	
9. AoB	• Mary queried if the Emergency Department 4 hour performance should be added as a standard item to this agenda. Melanie agreed. • Tracey discussed the issue of vaccines for in-patients with the group and the importance of having an up to date list so vaccines are not wasted. It was agreed that a list of patients, that were fit and able to be vaccinated, was needed every morning. Tracey further noted that Edith Doyle was working on a template to send to GP's to inform them that patient has had the vaccine in hospital. • Melanie raised the topic of complaints from in-patients and their relatives that seem to be coming through the Chief Executive's office / other routes and queried where these should be going to / who should be dealing with? It was noted that within the Mental Health Directorate the A/D of the Week is the key link. ? no agreement was reached on how this should proceed.	**ED 4-hour performance to be added to agenda as standing item** **All to consider the appropriate route for complaints from in-patients/relatives**
10. Date of Next Meeting	• **Tuesday, 23 March 2021 @ 10.30am**	

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting - **DRAFT**

Date of Meeting: Monday, 20 September 2021 at 10.30am

Venue: Melanie McClements' Zoom

Attendees: Melanie McClements (Chair); Barry Conway; Wendy Clarke; Anne McVey; Anita Carroll; Tracey Boyce; Mary Burke; Sharon Glenny; Jane Scott; Lisa McAreavey; Lynn Lappin; Joanne Hughes

Apologies: Lesley Leeman; Ronan Carroll

Agenda Item	Discussion	Action
1. Apologies	1.1 As above.	
2. Chair's Business	2.1 Melanie welcomed everyone to the meeting. 2.2 Action notes from last meeting were approved.	
3. Matters Arising	3.1 Cath Lab – No further progress. Regional Clinical Lead remains unappointed. 3.2 Additionality – Melanie noted that there has been some improvement with the forms she has received.	3.1 Lynn to add to HSCB meeting agenda.
4. Contracts Update	4.1 Contracts Manager - No appointment made to the Acute Contracts Manager post. The post will now go out as a permanent post and recruitment process has commenced. 4.2 Sue-Ann will continue to offer light touch support on contract management issues. Sue-Ann's capacity is limited and she is supporting the whole Trust therefore, she will have to focus on the most urgent performance issues and supporting people in their development of the specifications. 4.3 Contract Issues - Letter of concern went to Hermitage on Friday – Lesley had alerted them that the letter would be coming. Hermitage believes they will be	

Agenda Item	Discussion	Action
	able to resolve everything (therefore, not a performance notice at this stage). Melanie enquired as to the reason for the letter. Lynn advised due to invoicing problems/readmission rates. Melanie sought assurance that contract owners checked and validated invoices before sign off. Melanie reiterated that the process for checking invoices needed to be tightened up. Further award of contracts for Ortho / Urology will be deferred until at least the end of September to allow Hermitage time to address the issues. Meeting with Hermitage this week with Brigeen / Sue-Ann and Fiona Jones (Fraud Liaison Officer) 4.4 Pharmacy – still no clear direction of travel. Formal request now to DLS to prepare an 'in sourcing' contract. A Regional approach is needed to take forward the licencing issues. 4.5 Learning from Contract Management Issues – Sue Ann has highlighted issues to relevant HoS. Melanie noted that HoS need to ensure ISP are aware of incident reporting requirements. 4.6 Contract End Dates – DACs need to be completed in a timely manner if extending contracts. Close offs to be done if not extending.	4.3 Contract Owners to ensure processes are in place re invoicing 4.3 Brigeen to update Melanie after the meeting 4.5 Contract owners to ensure ISP are aware of responsibility to report incidents and ensure DATIX is completed 4.6 Contract owners to ensure DACs are completed prior to end date
5. Regional Equalisation	5.1 Requests for Assistance - There have been requests for assistance for RF OP assessments for Dermatology and Gynae. Our Consultants are concerned that other Trusts have not modernised their services to cope and that our staffing pressures are increasing. Lynn advised of direction for Art/Beverley to discuss with NT/SET colleagues. Lynn advised the group of the waiting times in other Trusts. Melanie asked that Clinical leads speak with counterparts this week.	5.1 Clinical Leads/HoS to liaise with colleagues and Lynn to advise David McCormick of this

Agenda Item	Discussion	Action
	5.2 Lynn advised that there has been a lack of uptake of the Urology sessions to UIC. Wendy advised that their best days are Mondays, Wednesdays and Fridays. 5.3 RPOG Actions • Baseline assessment of Green sites. • Trusts should continue to schedule DC lists for priority patients. • Trusts to ensure theatre lists are fully booked / maximised with P3 patients if necessary. • DoH to ensure workforce appeal provides assurance to staff that they would be on covid light sites. • DoH to work with pharmacy leads to agree solution to facilitate in-sourcing.	5.2 Lynn to request Mondays or Wednesdays
6. SharePoint Reports – OP Review Backlog	6.1 Lynn shared the information with the group - 89 patients on OP review backlog report who are waiting from 2016/2017 and earlier.	6.1 OSLs to take forward review of patients
7. Elective Additionality 2021/22	7.1 Lynn informed the group of the current position with additionality funding and stated that if no alternative use could be identified then the funding should be handed back sooner rather than later. 7.2 Lynn advised that IHA approved for Q3/4 but IS only for Q3.	7.1 All to review the Q3/4 bids and advise if any changes 7.1 Lynn to notify HSCB when confirmed
8. Service Delivery Plans	8.1 Q3 projections were submitted last week. Barry noted some early concerns with Dermatology, Haematology and CT due to staffing pressures (Derm/Haem) and case mix (CT). 8.2 Winter Plan submitted on Friday.	8.2 Melanie to circulate
9. Elective Care Framework	9.1 Elective care framework updates on action plan distributed - ATICS & SEC comments received with thanks. 9.2 Virtual OP – Lynn noted target 25% - currently at 23%. 9.3 Text Reminders – Anita noted that some progress has been made to date and Nurse Led clinics have started.	9.1 All to forward comments to Lynn by Friday

Agenda Item	Discussion	Action
	9.4 Staffing - Jane has additional staff starting for Endoscopy IS – 2 Band 3s and 1 Band 4 Supervisor. Melanie enquired if all of the schedulers were fully funded. 9.5 Enhanced Payments – only 1 request for enhanced payment received to date for OP clinics. Lynn seeking clarity if can be approved by HSCB.	9.4 Jane to confirm with Melanie the level of funded vs unfunded
10. Performance Issues/Update	10.1 Performance Scorecard – Lynn noted no new issues of concern, continued performance challenges for Cancer, Endoscopy, Diagnostics, IPDC, OP and Review Backlog. 10.2 Unscheduled Care – Lynn noted ED Performance and Discharge performance. Anne sought clarification on the definition of complex/non-complex discharges. 10.3 Imaging – Barry informed the group that a deep dive had been completed for Imaging in respect of referral trends.	10.2 Lynn to circulate 10.3 Barry to share with Melanie
11. External Assurances	11.1 CHKS Annual Report – Lynn gave a summary of key issues.	11.1 Any comments or requests for training to be sent to Lynn
12. Regional Planning Framework	12.1 SBA working group is ongoing in the development of the new Regional Planning Framework. Lynn to share Janet's presentation on the framework. As a subgroup of the Regional Planning Framework work is ongoing to look at the commissioning/SBA. First meeting has occurred with Region and follow up individual meetings with each Trust. Lesley had suggested a similar approach to the Service Delivery Plans; however, this would replace the current process and not be in addition to it. Key to this will be detailed assumptions.	12.1 Lynn to circulate Janet's presentation
13. Agenda Items for HSCB	13.1 Suggestions were: • Cardiac Cath Lab • CT Modular DHH Funding Risk • DHH Electrical Infrastructure/MRI • Recurrent funding for CT/MRI • Dermatology Staffing Issues	13.1 Any further areas to be forwarded to Lynn

Agenda Item	Discussion	Action
14. Any Other Business	14.1 None.	
15. Date of Next Meeting	**Monday, 18 October 2021 @ 10.30am**.	

Southern Health and Social Care Trust

Service Delivery Plans 2021/2022
SMT EXECUTIVE SUMMARY

SMT Executive Summary provides an overview of the Phase 6 Service Delivery Plans 2021/2022 with:

- 10 service delivery plan areas (contained 48 individual service areas) with collective performance for Phase 6 - July and August 2021 with comparison between actual activity versus projected volumes, based on HSCB monitoring template (Appendix 1); and
- Performance assessed as: 'Green' 0% (and above) to -4.9%; 'Amber' -5% to -9.9%; Red' -10% (and above); and 'White' unable to assess.

70%
Of Plan Areas On Track / Partially on Track

40%
(4 out of 10 Plan Areas)
Out-Patients; In-Patients / Day Cases / Endoscopy; Cancer Services; Community Dental

30%
(3 out of 10 Plan Areas)
Diagnostics; Allied Health Professionals; Community Paediatrics

20%
(2 out of 10 Plan Areas)
Mental Health; Day Centre / Day Opportunities

?
10%
(1 out of 10 Plan Areas)
Health Visiting

** CHALLENGES Highlighted for SMT Consideration **

- Whilst collectively 70% of the plan areas are on track / partially on track ('Green' or 'Amber'), there are 13 (27%) individual service areas (out of 48) demonstrating under performance equal to or in excess of **-10%**.
  - **In-Patients: -26% (-216)**
  - **Orthoptics News -43% (-272)**
  - **Podiatry News -10% (-74)**
  - **Podiatry Reviews -17% (-1,078)**
  - **CAMHS Reviews -17% (-472)**
  - **Psychological Therapies News -18% (-53)**
  - **Psychological Therapies Reviews -33% (-808)**
  - **Dementia News -13% (-74)**
  - **Dementia Reviews -25% (-191)**
  - **Day Care Elderly -24% (-558)**
  - **Day Care Physical Disability -24% (-208)**
  - **Day Opportunities Learning Disability -56% (-2,298)**
  - **Day Opportunities Physical Disability -100% (-24)**
- Services have noted performance impacted by: Vacancies / sick leave / annual leave at higher levels than projected; Absences due to Covid isolation requirements; Day care / opportunities transport challenges and lower attendance levels during the Summer period.
- **Based on the level of underperformance demonstrated in these ten service areas should we:**
  - **Undertake an immediate review of the submitted Phase 7 projections and the assumptions utilised, with a view to re-projecting?**
  - **Seek permission with DoH to amend the submitted Phase 7 projections?**

Southern Health and Social Care Trust

Service Delivery Plans 2021/2022 – Actual Versus Projected

Overview of the Phase 6 Service Delivery Plans, actual versus projected, for July & August 2021 collectively

Out-Patients:

- **New (Face to Face & Virtual):** Actual **8,930** versus **9,703** Projected
  -8% / -773 below projected
- **Review:** Actual **21,855** versus **20,156** Projected
  +8% / +1699 above projected
- **Total:** **30,785** versus **29,859** Projected
  +3% / +926 above projected

Cancer Services:

- **14 Day:** Actual **35%** versus **15%** Projected
  +20% above projected
- **31-Day:** Actual **81%** versus **83%** Projected
  -2% below projected
- **62-Day:** Actual **51%** versus **39%** Projected
  +12% above projected

Phase 6 – July & August 2021

Diagnostics:

- **MRI:** Actual **2,028** versus **1,989** Projected
  +2% / +39 above projected
- **CT:** Actual **5,681** versus **6,744** Projected
  -16% / -1,063 below projected
- **NOUS:** Actual **5,685** versus **5,505** Projected
  +3% / +180 above projected
- **Echo:** Actual **1,582** versus **1,747** Projected
  -9% / -165 below projected
- **Total:** Actual **14,976** versus **15,985** Projected
  -6% / -1,009 below projected

In-Patients and Day Cases & Endoscopy:

- **In-Patients:** Actual **619** versus **835** Projected
  -26% / -216 below projected
- **Day Cases & Endoscopy**:** Actual **4,336** versus **3,963** Projected
  +9% / +373 above projected
- **Total:** Actual **4,955** versus **4,798** Projected
  +3% / +157 above projected

*** Note: Day Cases and Endoscopy must be considered collectively due to the timelag for clinical coding, associated with Endoscopy.*

Southern Health and Social Care Trust

Service Delivery Plans 2021/2022 – Actual Versus Projected

Overview of the Phase 6 Service Delivery Plans, actual versus projected, for July & August 2021 collectively

Allied Health Professionals:

- **New:** Actual **5,491** versus **6,476** Projected
  -15% / -985 below projected
- **Review:** Actual **20,215** versus **20,009** Projected
  +1% / +206 above projected
- **Total:** **25,706** versus **26,485** Projected
  -3% / -779 below projected

Day Care and Day Opportunities:

- **Day Care:** Actual **7,949** versus **9,212** Projected
  -14% / -1,263 below projected
- **Day Opportunities:** Actual **1,788** versus **4,110** Projected
  -56% / -2,322 below projected
- **Total:** Actual **9,737** versus **13,322** Projected
  -27% / -3,585 below projected

Community Dental:

- **New:** Actual **300** versus **165** Projected
  +82% / +135 above projected
- **Review:** Actual **975** versus **790** Projected
  +23% / +185 above projected
- **Total:** **1,275** versus **955** Projected
  +34% / +320 above projected

Phase 6 – July & August 2021

Mental Health:

- **New:** Actual **1,718** versus **1,878** Projected
  -9% / -160 below projected
- **Review:** Actual **17,005** versus **18,858** Projected
  -10% / -1,853 above projected
- **Total:** **18,723** versus **20,736** Projected
  -10% / -2,013 below projected

Community Paediatrics:

- **New:** Actual **165** versus **144** Projected
  +15% / +21 above projected
- **Review:** Actual **513** versus **575** Projected
  -11% / -62 below projected
- **Total:** **678** versus **719** Projected
  -6% / --41 below projected

Health Visiting:

- **Contacts:** Actual activity not available for comparison due to the timeline for reporting

Southern Health and Social Care Trust

Elective Care Non-Recurrent Funding Q1 - Q4 2021/2022
SMT EXECUTIVE SUMMARY

SMT Executive Summary provides an overview of the Elective Care Non-Recurrent Funding allocation for Quarters 1 - 4 with:

- Cumulative spend / activity @ 11th October 2021 (spend as % of allocation / actual activity as % of expected); and
- Operational Team's projected spend / activity @ 30th March 2022 (spend as % of allocation / projected activity as % of expected).

Funding Allocated
Q1 (allocated March 2021);
Q2 (allocated June 2021) & Q3/4 (allocated September 2021)
£7,920,045.33

Expected Activity
52,690 attendances

Actual Spend 41%
Q1 - Q4 @ 11/10/21
£3,217,665.13

Activity Delivered
12,713 attendances 24%

Projected Spend 93%
(As per Operational Teams)
Q1 – Q4 @ 11/10/21
£7,341,802.33

Projected Activity
49,818 attendances 95%

*** Allied Health Professionals: 11,623 * Diagnostics: 28,623 * In-Patients / Day Cases: 406 * Out-Patients / Out-Patient Procedures: 12,038**

** CHALLENGES Highlighted for SMT Consideration **

- **Projected spend for Q1-4 £7,341,802.33 against allocation £7,920,045.33, equating to underspend of £578,243 (veering requests have been received – See Appendix 2).**
- **Mitigations to underspend include redirection of funding to new additionality requests and areas of overspend.**
- **What do we do with the net underspend of £578,243? Do we seek permission, from HSCB, to partly fund the Q4 IS bid, not yet funded? Or, given the impending Winter pressures and further Covid pressures, do we return the underspend to HSCB? Noting the cut off date for return of funding is 31 October 2021.**
- **Detailed specialty specific monitoring, slippage and carry over undertaken at Directorate level and is available on request.**

Southern Health and Social Care Trust

Elective Care Non-Recurrent Funding Q1 & Q4 2021/2022 - Acute Services Directorate

Overview of the Elective Care Non-Recurrent Funding allocation, within the Acute Services Directorate, for Quarters 1 -4 with actual cumulative spend / activity @ 11th October 2021 (1/4/2021 – 11/10/2021)

FUNDING ALLOCATED TO ACUTE SERVICES DIRECTORATE:
* **£6,834,790.09** (86.3% of Southern Trust allocation)

vs

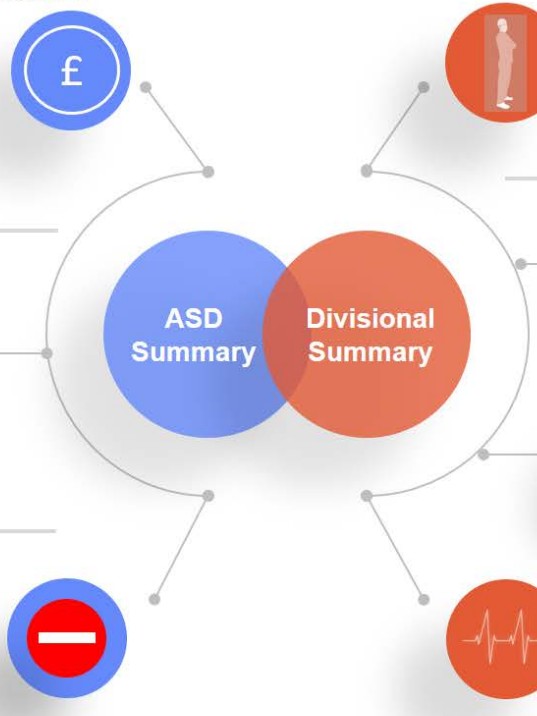
SPEND @ 11/10/21
* **£3,127,518.83** (45.8%)

VARIANCE
* **-£3,707,271.26**

ACTIVITY (Actual out of Expected):
* **11,661** actual out of **39,949** expected attendances (29.2%)
  - AHP – **372** out of **502**
  - Diagnostics – **9,845** out of **28,623**
  - In-Patients / Day Cases – **239** out of **386**
  - Out-Patients / OP Procedures – **1,205** out of **10,438**

RISK:

	£6,834,790.09	allocated Q1- 4
-	£6,293,466.54	projected spend @ 11/10/21
=	£541,323.55	underspend



ATICS & SEC:
- **£1,247,954** spent out of **£2,954,442** (42%)
- **£2,825,978** projected to be spent (96%)
- **1,569** attendances out of **6,815** (5792 projected)
  - Diagnostics – 691 out of 1807
  - In-Patients / Day Cases – 162 out of 214
  - Out-Patients – 716 out of 4794

CCS:
- **£1,601,450** spent out of **£3,087,005** (52%)
- **£2,641,695** projected to be spent (86%)
- **8,564** attendances out of **27,880** (26,708 projected)
  - AHP – 372 out of 312
  - Diagnostics – 8,100 out of 24,760
  - OP – 92 out of 2,808

IMWH:
- **£41,198** spent out of **£125,600** (33%)
- **£113,600** projected to be spent (90%)
- **75** attendances out of **224** (208 projected)
  - Out-Patient Procedures – 75 out of 224

MUSC:
- **£236,915** spent out of **£645,881** (37%)
- **£690,330** projected to be spent (107%)
- **1,453** attendances out of **4,840** (4,879 projected)
  - Day Cases – 77 out of 172
  - Diagnostics – 1054 out of 2,056
  - Out-Patients – 322 out of 2,612

Directorate of Performance & Reform | Elective Care Non-Recurrent Funding | Quarter 1 - Quarter 4 2021/2022

Southern Health and Social Care Trust

Elective Care Non-Recurrent Funding Q1 – Q4 2021/2022 - CYPS / MHD / OPPC Directorates

Overview of the Elective Care Non-Recurrent Funding allocation, within the CYPS / MHD / OPPC Directorates, for Quarters 1 - 4 with actual cumulative spend / activity @ 11th October 2021 (1/4/2021 – 11/10/2021)

FUNDING ALLOCATED TO NON-ACUTE DIRECTORATES:
* **£1,085,255.24** (13.7% of Southern Trust allocation)

vs

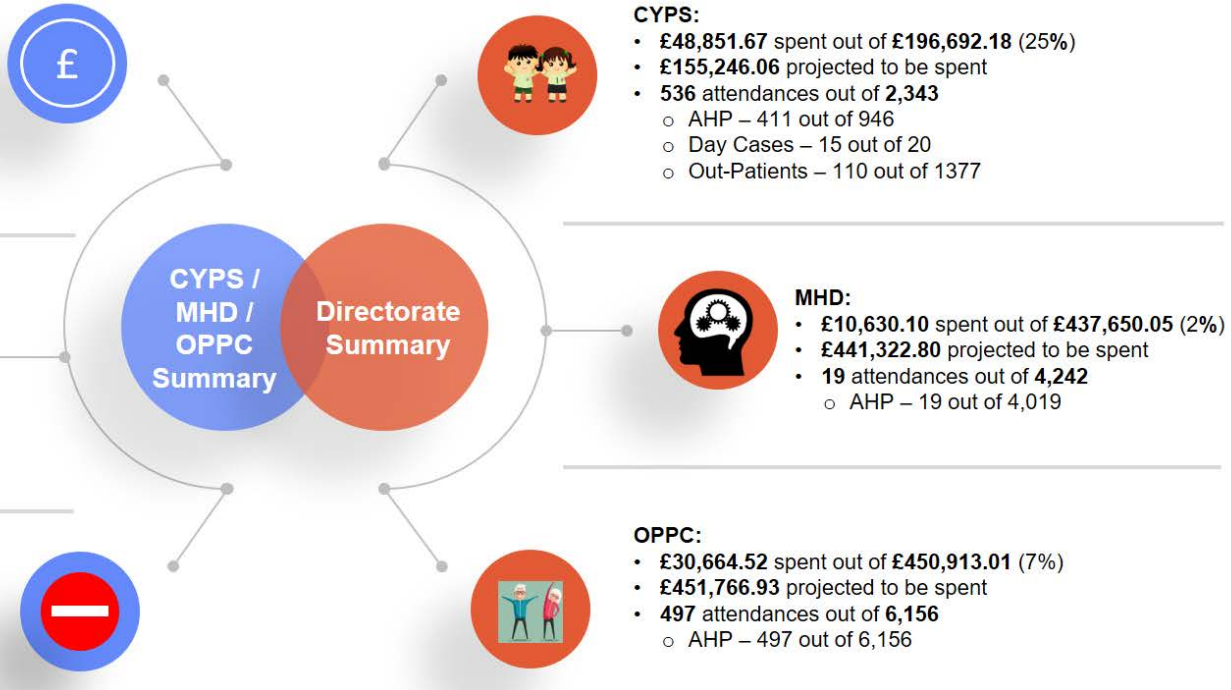
SPEND @ 11/10/21
* **£90,146.30** (8.3%)

VARIANCE
* **-£995,108.94**

ACTIVITY (Actual out of Expected):
* **1,052** actual out of **12,741** expected attendances (8.3%)
  - AHP – **927** out of **11,121**
  - Day Cases – **15** out of **20**
  - Out-Patients – **110** out of **1600**

RISK:

	£1,085,255.24	allocated Q1 - 4
-	**£1,048,335.78**	projected spend @ 11/10/21
=	**£36,919.46**	underspend



CYPS:
- **£48,851.67** spent out of **£196,692.18** (25%)
- **£155,246.06** projected to be spent
- **536** attendances out of **2,343**
  - AHP – 411 out of 946
  - Day Cases – 15 out of 20
  - Out-Patients – 110 out of 1377

MHD:
- **£10,630.10** spent out of **£437,650.05** (2%)
- **£441,322.80** projected to be spent
- **19** attendances out of **4,242**
  - AHP – 19 out of 4,019

OPPC:
- **£30,664.52** spent out of **£450,913.01** (7%)
- **£451,766.93** projected to be spent
- **497** attendances out of **6,156**
  - AHP – 497 out of 6,156

Directorate of Performance & Reform | Elective Care Non-Recurrent Funding | Quarter 1 - Quarter 4 2021/2022

Covid-19: Regional Cancer Reset Cell

Terms of Reference

1.1 Overall Aim

To set out the approach to implementing the reset of cancer services (assessment and treatments), taking into account the potential need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC.

1.2 Objectives for the Cell

- Agree services to be restarted on a regional basis taking into account national guidance and PPE, Social Distancing and Decontamination constraints
- Develop proposals for redistribution of cancer surgery across Trusts to maximise treatment capacity and equalize waiting lists (based on clinical priority) where possible and taking into account innovative practice embedded during the first Covid-19 wave.
- Ensure equitable access for red flag surgery and endoscopy within IS whilst Head of Terms contract is active – ensuring that capacity is fully utilised and all clinically suitable patients are offered the opportunity to be seen there.
- Equalisation of red flag/ urgent imaging waiting lists across the region
- Ensure appropriate safety netting processes are in place to ensure patient pathways restart where they have been paused as a consequence of COVID.
- Information and monitoring

1.3 Co-Chair Arrangements

- Caroline Leonard, Director Cancer and Surgical Services, BHSCT
- Lisa McWilliams, Interim Director of Performance Management and Service Improvement & Emergency Planning, HSCB

1.4 Cell Membership

- Joe Magee - DoH
- Cara Anderson- HSCB, AD Commissioning (Cancer)
- David McCormick - HSCB, AD PMSID.
- Dr Louise Herron - PHA Consultant Cancer
- Dr Kathryn Boyd - NICaN Medical Director
- Loretta Gribben - PHA & NICaN Nurse Consultant
- David Gracey - Consultant Radiologist/CRUK
- Myles Nelson/ Niall MacKenzie*- Consultant Radiologist MRCN
- Tracey McIvor/ Sean O'Conaire* -Radiology Services Managers / Radiography
- Endoscopy Representative- to be identified
- Dr Paula Scullin – Chair SACT CRG
- Prof Alan Hounsell- Chair Radiotherapy CRG
- Mr Mark Haynes/Mr Niall McGonigle - Chair of Regional Cancer Surgical Group
- Dr Mike Mitchell - BHSCT Clinical Representative
- Dr Colin Rodgers - NHSCT Clinical Representative

- Dr David Alderdice - SEHSCT Clinical Representative
- Mr David McCaul - SHSCT Clinical Representative
- Mr Anand Gidwani - WHSCT Clinical Representative
- Debbie Wightman - BHSCT AD Cancer services
- Rebecca Getty - NHSCT AD Cancer services
- Barry Conway - SHSCT AD Cancer services
- Colleen Harkin - WHSCT AD Cancer services
- Margaret Carr - NICaN Cancer Charities Forum Representative
- Teresa Barr - Lived Experience Representative.

**Rotating members*

Other members may be co-opted on as required.

1.5 Interface groups

The work of the cell will be informed by a number of existing cancer structures including:

- NICaN CRGs, and
- Regional Cancer Surgical Group
- Cancer Managers Group
- NICaN Nurse leaders Group
- NICaN Charity Forum.

1.6 Cell Support

Support will be provided to the cell by Naomi McCay/ NICaN Team and HSCB Cancer, Elective and Diagnostic Leads and HSCB information lead.

1.7 Accountability and Reporting Arrangements

The Cell will report to DoH Rebuilding Service Delivery Board within DoH's Covid-19 Emergency Response Structures.

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Health and Social Care Board

Cancer Reset Cell

Friday 15th January 2021

Record of Discussion & Agreed Actions

In attendance	Paul Cavanagh (Chair, HSCB), Cara Anderson (HSCB), Alastair Campbell (DoH NI), Una Cardin (WHSCT), Teresa Barr (Patient experience), Dr Kathryn Boyd (NICaN), Barry Conway(SHSCT), Margaret Carr (NICaN, CCF), Gay Ireland (DoH -Strategy), Maria Wright (HSCB), Mr Mark Haynes (Regional Surgical rep), Heather Monteverde (DoH NI), Debbie Wightman(BHSCT), Margaret O'Hagan (NHSCT), Dr Paula Scullin (BHSCT/SACT CRG), Sean O'Conaire (BHSCT /MRCN), Lorna Nevin (PHA/NICaN), Naomi McCay (NICaN)
Apologies	Caroline Leonard/Stephen Boyd, (BHSCT), Mr David Alderdice(SET), Dr Mike Mitchell(BHSCT), Alan Hounsell (BHSCT/RTCRG) Jenny Keane (DoHNI), Dr Louise Herron(PHA).

Item	Note	Resp
1	**Welcome and introductions**	
	Mr Cavanagh opened the meeting and welcomed members. Attendance and apologies were noted. The group agreed the minutes from the last meeting.	
2	**Actions /Matters arising (from 18th Dec 2020)** **Matters arising** • Population screening: PHA position, Ms Anderson, updated from PHA as follows: operational pause to bowel screening invites (clarified after from week 18th for one week to allow review). Breast screening proceeding. Dr Boyd asked if patients are being made aware that diagnostics tests are delayed. Ms Anderson to follow up. • Proposed change to patient testing protocol prior to surgery (to minimise lost slots): Ms Anderson is waiting feedback from Dr Farrell after the next testing EAG meeting. • Opportunity to amend CMO letter to CEV group: DoH advised that the CMOs letter cannot be amended as it has already gone out via primary care. However caner managers have agreed to issue a cover letter from cancer services to accompany CMO letter and vaccine information. • Vaccine: who identifies eligible patients between caner services and primary care (raised at cancer managers) and Dr McGivern *has written* to Patricia Donnelly at DoH, Dr Margaret O Brien and PHA leads to ask for clarification. **Action: Ms Anderson to get PHA screening update and check screening patients are being informed of delays in their pathway**	
3.	**Trust surge updates**	
	NHSCT (Ms O'Hagan)	

- 212 Covid positive patients across NT.
- Antrim emergency surgery only.
- Endoscopy ceased at Antrim except for emergency and ERCP and small number of high qFIT
- Causeway holing 6 bookable urgent lists per/week to P1 and P2 Ca and endo inpatient and small number of RF.. .
- Whiteabbey endoscopy ceased therefore bowel screening service paused.
- SACT maintained- some CNS redeployed but within unit.
- Outpatients mostly virtual
- Also being asked to provide support to Nightingale.

SHSCT (Mr Conway)

- Extreme pressures. 230 Covid + patients across trust. Significant reduction in outpatient activity, running skeleton service with medical staff as nurses redeployed.
- Needed to redeploy some surgical CNS staff, Onc and Haem CNS protected.
- Surgery -1 urgent bookable list per day- under review.
- Interventional radiology continues,
- SACT very busy, issues with RISOH this week.
- Meetings this pm on staffing issues/support to Nightingale.

BHSCT (Ms Wightman)

- >200 Covid patients across Trust and Nightingale being expanded.
- All cancel all non-emergency surgery (P1) remains cancelled.
- Many staff also off due to Covid.
- Focus on Nightingale: have not avoided redeployment of staff - now being asked to release staff from onc and haem wards.
- Covid outbreak this week in both 1 onc and 1 haem ward.

WHSCT (Ms Cardin)

- Maintaining chemotherapy and radiotherapy.
- A number of nurses self-isolating. Ensuring all CNS ever trained in SACT have competencies assessed to ensure continued SACT delivery.
- Elective and outpatient clinics stood down last week and will continue to stand down RF and Ca surgery for further 2 weeks.
- Radiology services are maintaining and will be kept under review.

SET : (Ms Thompson)

- Cancelled all outpatients and routine. Some RF via virtual consultation Nurses from outpatients now in wards.
- Ca surgery 4 urgent bookable lists per day, some for regional at LV.
- Endoscopy down to 2 urgent bookable lists- to move to one list next week with emergency.
  SACT very busy, No CNS redeployed however helping on non Covid wards / doing additional shifts.

4	**Service updates** **Imaging** (Ms Wright and Mr O'Conaire) • Service managing, RF and urgents continue, some routine still happening where possible. Still supporting breast screening- under review. • Challenging to equalise lists Radiology managers meet weekly to monitor. • Mr O Conaire reported that Interventional radiology and Interventional neurology has put out a call for AHP staff and students. **SACT** (Dr Scullin) • Downturn in surgery for some tumour sites has brought increased referrals. • Some registrars and junior doctors have been redeployed. The service is continuing but probably cannot maintain if further redeployment. Clinics next week to be planned without registrars (consultant only). • Initial concern about pharmacy staff being redeployed in BT but assured will not include SACT service. • RIOSH issues this week. Understand BSO wide issue however RISOH in need of system update and very concerned of further risk to service on top of staff shortage. • Dr Boyd commented that at today's weekly SACT CRG meeting staff were very concerned about the impact of redeployment and the need for SACT treatment to be maintained as once a patient treatment has commenced the timing of treatment is essential to maintain treatment intensity. Dr Boyd acknowledges that support from Gold regarding redeployment has been extremely helpful. Mr Cavanagh assured the group that cancer services are high on the Ministers agenda. Dr Boyd and Ms Nevin will write a letter outlining the groups concerns to Mr Cavanagh to share with Gold. **Action: Ms Anderson to check on current status of RISOH upgrade.** **Radiotherapy** (Prof Hounsell/Ms Cardin) • Currently stable. Still at level 1 of contingency plan. Aware that things may change rapidly. • All radiotherapy patients continue to be treated. • Staffing levels are currently ok with staff off due to Covid issues currently at manageable levels within the different services that make up the radiotherapy process. • There are currently no Covid+ patients on treatment on the Linac treatment units but there are a number of altered airways patients who require additional time and care (ie increased PPE, cleaning etc). Any significant increase in Covid+ or altered airways patients on treatment will impact on the capacity on the Linac's. • NWCC : Risk to RT, risk of 2/4 Medical physics experts self-isolating and The group discussed how to evidence the impact from the downturn in surgery and the added impact on SACT and RT and delayed presentations. Ms Wightman felt that some case studies would be useful to help illustrate the impact and will bring to cancer reset. Ms Monteverde added that NI Hospice	

	rapid access response team may have data that may also be useful. **Surgery** • Progress on regional work is bearing fruit and patients are now moving around the system. Trusts have worked well to maintain as much surgical time as possible. • Regional group are currently planning cases for next week and hoping to keep some surgery going. • A separate challenge is patient support where surgical CNSs may have been redeployed. Mr Haynes asked if it would be possible if patients could be supported by CNS across trusts. • Ms Monteverde responded that CNS may be able to cover for each other across tumour sites and this may be easier than support across trusts. **Action: NMcC to raise with cancer managers CNS support for patients** .	
5	**Elective/Task and finish group update –** Mr Campbell updated as follows: • More capacity has been identified at IS, this is still developing. • Now considering options for coming out of surge, regional planning has improved and IS communication will be ongoing. o Ms O Hagan agreed with equalising surgery and asked about consultant breast surgeon cover for NHSCT. Mr Cavanagh to follow up with Ms McWilliams. o Ms Wright reflected on gaps in infrastructure pre Covid and the need for new long term models of care. o Ms Monteverde questioned if the new regional approach to surgical access will be acceptable to patients, Mr Haynes reported anecdotally that at this stage his patients are satisfied to be getting surgery. Ms Monteverde feels this may need evaluating going forward.	
6	**AOB:** None.	
	Agreed actions: • Ms Anderson to get update on PHA screening communication to patients re delays. • Ms Anderson to follow up with Dr Farrell proposed change to testing protocol prior to surgery to minimise lost slots. • Ms Anderson to check on current status of RISOH upgrade. • Ms McCay to raise with cancer managers CNS support for patients.	
	Next meeting: Fri 22nd January 2021 at 2pm.	

Health and Social Care Board

Cancer Reset Cell

Friday 26th February 2021

Record of Discussion & Agreed Actions

In attendance	Paul Cavanagh (Chair, HSCB), Cara Anderson (HSCB), Teresa Barr (Patient experience), Margaret Carr (NICaN, CCF), Gay Ireland (DoH - Strategy), Heather Monteverde (DoH NI), Dr Paula Scullin (BHSCT/SACT CRG),Sean O Conaire (BHSCT/MRCN), Lorna Nevin (PHA/NICaN), Naomi McCay (NICaN), Pat McClelland (NHSCT), Dr Mike Mitchell (BHSCT), Dr Louise Herron(PHA),Mr Mark Haynes (Regional Surgical rep) Dr Kathryn Boyd (NICaN), Debbie Wightman(BHSCT), Bridget Tourish (WHSCT)
Apologies	,Margaret O'Hagan (NHSCT), Jenny Keane (DoH NI), Mary Jo Thompson (SET) , Dr David Alderdice (SET), Barry Conway (SHSCT) Una Cardin (WHSCT), Loretta Gribben (PHA), Maria Wright (HSCB)

Item	Note	Resp
1	**Welcome and introductions**	
	Mr Cavanagh opened the meeting and welcomed members. Attendance and apologies were noted. The group agreed the minutes from the last meeting.	
2	**Actions and matters arising** **Action 1:** qFIT funding post March 2021 –Mr Cavanagh advised email to Alastair Campbell to request update on qFIT funding post March 2021. **Action: Email Mr A Campbell (DoH NI) re FIT budget past March 2021.** **Action 2:** Cytosponge - discuss potential costings and possibility of inclusion in cancer recovery plan – there have been some discussions with Delta team in Cambridge. NI will be able to join the secondary care arm of the research. There have been initial conversations regarding numbers and costs. NICaN and Dr Mitchell to meet with Delta team and Medtronic (commercial partner) to further explore research logistical issues and potential to expand outside of research sample size. Local Pathology Network also interested. All trusts to be involved. Costings to be estimated for cancer recovery plan. **Action: Cytosponge costings estimate for cancer recovery plan. Keep group updated.** .	
3.	**Trust surge updates**	
	NHSCT (Ms McClelland) • Reduction in COVID cases at causeway and Antrim, ICU busy but reducing slowly. • Returning some staff back to endoscopy from ICU. Anticipating theatres at Antrim may start to open from next week. • SACT oncology and haem busy and maintaining.	

	SHSCT (Mr Conway via email) • COVID inpatient numbers slowing reducing. • General outpatients due to re-start on Monday 1 March • SACT continues to be very busy • Elective surgery still limited due to working off 14 ICU – surgery will start slowly as ICU de-escalates • We continue to follow FSSA guidance for P2 surgery and link to the regional prioritisation process **BHSCT** (Ms Wightman) • ICU remains in high surge. • Medical registrars and F1s released back to Cancer centre. Plan to slowly release nurses. • Will take some time before able to increase surgical capacity. Surgery continues to be very restricted and still large numbers waiting. • SACT continues. **WHSCT** (Ms Tourish) • Fall in COVID cases but slow to discharge. • RF surgery restarted and engaging with regional prioritisation group. • Some endoscopy also restarted in Altnagelvin (no endoscopy at SWAH yet due to redeployment). • Staff sickness levels (non covid) are increasing. • Chemotherapy: very busy and maintaining. • RT maintaining. . **SET** : (Mr McCormac) • Rolling over last 2 weeks surgical lists into next week and will increased if more staff able to return. • Outpatients reopened and significant capacity found in IS. This will impact on increased referrals to endoscopy and radiology. • SACT remains busy.	
6	**Service updates** **Imaging** (Tracy McIvor) • No changes. However anticipating an influx of requests for imaging once outpatient clinics resume. Covid funding has helped with extra capacity and regional transfers are working well however funding will need to be sustained into 2021/22 **SACT** (Dr Scullin) • No change. **Radiotherapy** (Prof Hounsell / Ms Cardin) • Maintaining continuing to treat all patients, no staffing concerns. **Surgery** (Mr Haynes**)** • De-escalation is slow and not allowing any significant increase in surgery. • Belfast Trust hope to resume some activity at BCH week commencing 15th March.	

	• Now entering 'perfect storm' of a backlog in waiting lists and resumption of red flag outpatient's clinics which will add to the lists. • As surgery commences it is likely there will be patients whose cancer has progressed Mr Haynes acknowledged an inevitable rise in SAIs due to the impact of the pandemic and asked how this will be dealt with, and if there is to be a collective approach. Other members agreed this was also a concern in their own trusts. The group acknowledge the additional work in dealing with a number of SAIs amidst significant service pressures and discussed potential for alternative processes. All agreed it is important to be mindful that each patient/family requires due process. Ms Nevin also commented that the public needed to have confidence in whatever processes are put in place and any process should use a co-production approach. **Actions** • Mr Cavanagh to check with Ms McWilliams if any discussions have commenced with regard to a collective approach to dealing with potential SAIs due to Covid related diagnostic and surgical delays. • Ms Anderson, Dr Herron and Mr Haynes to discuss further.	
7	**Elective group update –** Mr Cavanagh updated • Critical care starting to close some ICU beds and release staff back to their home trusts and normal duties. • It is hoped that by end of March complex surgeries can restart at Belfast City Hospital. • It is also hoped that with bed numbers reducing in all hospitals that green pathways can be re-established. • A new procurement system – Dynamic Purchasing System, is coming in to place with independent sector which is hoped will help to expand capacity and help address waiting lists. • Opportunities in England and RoI continue to be explored.	
8	**Cancer recovery plan update** Mr Cavanagh updated that the cancer recovery plan is progressing. • Several actions are being recommended across the cancer pathway covering, screening, early diagnosis and referral, diagnostics, oncology and haematology, care and support and palliative care. • The draft plan is to be prepared for week beginning 8th March for presentation at HSCB SMT, with plans to go to Rebuilding Management Board (RMB)at DoH, mid-march and executive late March. When the plan has been approved by SMT it can be shared with the Trust leads. • Ms Monteverde highlighted the plan covers some areas that are not cancer alone (e.g. diagnostics) and cross references the elective plan. She also highlighted that it straddles the first 3 years of the new Cancer strategy currently under development and the actions are aligned to strategy recommendations. • Ms Carr asked for reassurance that the issue of waiting lists will be addressed in the recovery plan, Mr Cavanagh reassured that the elective plan will focus on the waiting list issue and will complement the cancer recovery plan. Both plans will be addressed together at the DoH	
9	**AOB:** None.	

	Agreed actions **Action 1:** Email Mr A Campbell (DoH NI) re **FIT** budget past March 2021. **Action: 2 Cytosponge** costings estimate for cancer recovery plan. Keep group updated. *(NM & Ms Nevin)* **Actions 3: SAIs query collective process:** Mr Cavanagh to check with Ms McWilliams if any discussions have commenced with regard to a collective approach to dealing with potential SAIs due to Covid related diagnostic and surgical delays. Ms Anderson, Dr Herron and Mr Haynes to discuss further.	
	Next meeting: Fri 12th March 2021 at 2pm.	

Southern Health and Social Care Trust

Quality Care - for you, with you

Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF)

Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development
Directorate responsible for document:	HR & Organisational Development
Issue Date:	16 May 2019
Review Date:	09 October 2021
Reviewed On:	18 May 2021
Next Review Date:	17 May 2023

Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Performance and Personal Development Review Policy
Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development)
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Heather Clyde, Vocational Workforce and Assessment Centre
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	09 October 2018
Date approved by SMT:	N/A
Policy circulated to:	All Heads of Service/Department and Line Managers
Policy uploaded to:	Placed on Intranet and SharePoint

Version Control

Version:	Version 4.0
Supersedes:	Legacy Policies for Craigavon and Banbridge, Craigavon Area Hospital, Newry & Mourne, and Armagh & Dungannon Trusts

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 1.0	Contact Details, Introduction to Policy 1:7, Appendix 2 Revalidation incorporated.	01/12/2008	Assistant Director Human Resources / ELD – Mrs Heather Ellis
Version 2.0	Contact Details, Appendix 2 Revalidation Form Removed	22/03/2016	Director Human Resources Mrs Vivienne Toal
Version 3.0	Hyperlinks added at 3.8 and 3.12 and 8.0. Differentiation between Supervision and Appraisal added at 5.1. KSF PDP Form updated (Appendix 1). Contacted details updated (Appendix 3). 9.4 change in wording due to UK leaving EU – becomes - UK General Data Protection Regulations (UK GDPR) 2018.	15/02/2021	Anne Forsythe, Head of Workforce & Organisational Development

Contents

Appendices

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as "the Trust") is committed to ensuring that robust corporate governance arrangements are in place in the operation of its business.

1.2 The Trust is committed to performance review and personal development and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each of member of staff to develop their potential.

1.3 The Trust will ensure that each member of staff knows what is expected of them including standards of conduct and performance required of them, this will be done through personal feedback from their line manager and set in the context of objective setting and review.

1.4 In support of this, the performance review and personal development documentation has been based on the NHS Knowledge and Skills Framework (KSF). KSF defines and describes the knowledge and skills that Health and Social Care staff need to apply in order to deliver quality services. It provides a single consistent, comprehensive and explicit framework on which to base performance review and personal development for staff. KSF is used to develop outlines for individual jobs. These outlines provide links to gateways for pay progression.

1.5 As part of this process, Continued Professional Development (CPD) will be discussed. Each individual profession will have their own requirements for this and reference should be made to these guidelines as appropriate.

1.6 The Trust is committed to supporting staff in their CPD and expects all qualified staff to undertake the necessary amount/levels of CPD as required by their profession. CPD is a personal commitment to keeping your personal professional knowledge up to date and improving your capabilities throughout your working life. It is about knowing where you are today, where you want to be in the future and making sure you have formulated a direction in association with your line manager in order to help you get there.

1.7 Also with reference to management standards Health & Social Care in Northern Ireland have adopted The Healthcare Leadership Model which has been developed by the NHS Leadership Academy. It is an evidenced based research model that reflects the values of the NHS. It comprises of nine dimensions and the model provides NHS staff with a means of analysing their leadership roles and responsibilities.

1.8 Other agreed competency frameworks may also be used for reference.

2.0 Purpose and Aims

2.1 The Southern Trust, through this policy ensures that staff have a strong and effective performance review and personal development which has a very positive effect on the individual's performance, their development and that of the organisation and can therefore contribute greatly to the improvement and development of the services the Trust provides for its patients and clients.

2.2 Recognise achievements and provide help in overcoming obstacles to successful performance.

2.3 Through this policy the Trust will ensure the roll out of performance review and personal development using the KSF Framework across the organisation.

2.4 The Trust will ensure that all staff are clear about their responsibilities for staff development.

2.5 Provide the basis for future training and workforce development strategies and plans.

2.6 Encourage the development of a flexible learning culture across the organisation.

3.0 Objectives of this Policy

3.1 The process of performance review and personal development process begins with a focus on the review of an individual's work in relation to individual service and organisational objectives. This provides an opportunity to receive feedback from the line manager on work performance, ways in which performance can be sustained or improved, and have these laid out in the form of agreed objectives.

3.2 Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve.

3.3 The framework provided in the documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process - Appendix 1.

3.4 A set of agreed objectives will be formulated from this discussion between the member of staff and the line manager. The action points supporting these objectives should be written using the SMARTER criteria (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Repeated).

3.5 The individual's objectives should reflect those of the Organisation, Directorate and Team. Where improvement is not required objectives may focus upon both maintenance and innovation.

3.6 The personal development review element of performance review focuses upon reviewing an individual's skills, knowledge and experience, and how they are applied in relation to the requirements of their post using the KSF outline. Training and development needs are identified; ways in which these needs can be

addressed are discussed and set out in the form of a Personal Development Plan (PDP).

3.7 Development review is a cyclical process that comprises of four stages:-

- A joint review between the individual and their line manager (or another person acting in that capacity) of the individual's work against the demands of their post, as set out in the KSF outline for that post.

- The formulation of an agreed PDP that identifies the individual's learning and development needs and interests.

- Learning and development by the individual, supported by their manager.

- Evaluation of the learning & development that has occurred and how the individual has applied it in their work.

3.8 Outlines developed for posts within the Trust are available from the Knowledge and Skills Framework link on share-point, (click here). It is only these outlines that should be used in the performance review. These outlines will be reviewed and further developed and are therefore liable to alteration. It is the responsibility of both parties to obtain the relevant and up to date outline as part of the preparation for a performance review. However, in the event of an outline not being available the KSF team within the Vocational Workforce Assessment Centre (VWAC) should be contacted for guidance (see Appendix 2).

3.9 The performance review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. Demonstrable knowledge and skills evident in a person's work will be considered in relation to all the dimensions included in the outline.

3.10 A Personal Development Plan (PDP) is formulated from this performance review. This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post.

3.11 The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

3.12 PDP's need to be completed annually. Line Managers should record completion of a PDP directly on HRPTS (click here for guidance). Alternatively, completed PDP's can be forwarded to the Vocational Workforce Assessment Centre to be recorded centrally. .

3.13 Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to

Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

4.0 Policy Statement

The Trust has an obligation to fully implement the Agenda for Change initiative. The Trust will ensure that there are effective systems in place to support the appraisal process and include ensuring that all supervisors have the appropriate knowledge and skills to completely undertake this role.

5.0 Scope of Policy

This policy applies to all permanent staff and those on a fixed term contract and long term agency staff (6 months) other than Medical, Dental staff, and Directors for which there are separate arrangements.

5.1 It is important to differentiate between supervision and appraisal. Whilst Supervision activities should inform, and are informed by, the KSF PDR process, neither activity should be substituted for the other, as each activity has a different purpose.

6.0 Responsibilities

In the Southern Trust there are key individuals with responsibility for ensuring KSF PDR process is implemented.

6.1 Chief Executive

The Chief Executive has overall responsibility and accountability for the quality of service provision. Appraisal plays an important role in ensuring the delivery of high quality, safe and effective care.

6.2 Directors

All Directors have responsibility for ensuring that arrangements are in place to implement and ensure compliance with this policy and that resources are available to support the process including that supervisors have the appropriate skills and knowledge to undertake appraisal. Directors also have responsibility to complete KSF reviews and PDP's for all those staff they manage.

6.3 Assistant Directors

Assistant Directors have responsibility for coordinating and facilitating implementation of the KSF process. They are responsible for agreeing the models to be employed within their area of responsibility and must ensure that appropriate resources are in place to meet the requirements of this policy. They are responsible for monitoring the level and quality of activity and supporting operational and professional Heads of Services and managers in the implementation of this policy. They also have responsibility to carryout KSF reviews and PDP's for all staff they manage.

6.4 Head of Service / Line Managers

The Head of Service/Line Manager has a responsibility to carryout KSF reviews for all those staff they manage. The Head of Service/Line Manager must also avail of KSF reviews and act as a supervisor for identified staff. S/he is also responsible for ensuring that arrangements are in place for the implementation and local monitoring of KSF activities.

6.5 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relevant to KSF review in line with this policy. They have a responsibility to participate in and prepare for agreed KSF meetings. It is their responsibility to keep a record of the appraisal meeting and implement agreed action.

6.6 Supervisees

Supervisees have a responsibility to engage fully in the KSF process. They have a responsibility to participate in and where relevant, prepare for the agreed meeting. Where required supervisees should keep a record of appraisal and implement agreed actions.

7.0 Evaluation & Review

Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

8.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

Policy on Professional and Operational Management Interface within the Integrated Care Teams – click here

9.0 Equality & Human Rights Considerations

9.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

9.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to equality impact assessment.

9.3 Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention

Rights contained in the Act.

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

9.4 Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:-

UK General Data Protection Regulations (UK GDPR) 2018.

10.0 Sources of Advice & Further Information

Further information about the Performance and Personal Development Review Policy can be obtained from the: Vocational Workforce Assessment Centre, St Luke's Hospital, Hill Building, Armagh, BT61 7NQ.

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: _____ **Staff Number:** _____

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** **Line Manager's Feedback on staff members performance over past year:**
Objectives for Next Year:	

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Equality, Good Relations and Human Rights – Making A Difference		
	Fire Safety		
	Infection Prevention Control		
	Information Governance Awareness		
	Cyber Security Awareness		
	Moving and Handling		
	Safeguarding People, Children & Vulnerable Adults		
Role Specific Essential Training	Basic ICT		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	MAPA (level 3 or 4)		
	Professional Registration		
	Right Patient, Right Blood (Theory/Competency)		
	Waste Management		
Best practice/ Development (Relevant to current job role)	(eg Coaching)		

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO:
VWAC, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL: [redacted] Personal Information redacted by the USI

Appendix 2

Flowchart for completing KSF

Personal Development Review and Plan

	Line Manager	Staff Member
BEFORE MEETING	Read post outline and job description for staff member	Read post outline and job description Reflect on how you have achieved the levels
DURING MEETING	Discuss general performance and progress Evaluate skills against post-outline and job description Agree areas for further development where necessary Discuss career development Complete PART A of form including staff member's comments and line manager's feedback from discussion	
AFTER MEETING	Keep a copy of completed form Set an annual review date (or sooner if actions identified in Part A require on-going meetings)	Keep a copy of completed form Undertake any actions identified in Part A Undertake agreed learning and development activities

FORWARD PART B TO VWAC TEAM