Contacts for KSF (Knowledge & Skills Framework)

Lynn Irwin **Senior HR Manager (Vocational Workforce Development)**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Margretta Chambers **Union Representative KSF Advisor**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Ann McCann **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Gemma Cunningham **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Tara Davison **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Carol McGreevy **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Heather Clyde **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI
Forward PDPs to	Tel: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI

Southern Health and Social Care Trust

SECTION 1 – PREPARATION

For period from and to:	From: 1 / 4 / 2012 To: 31 / 3 / 2013

PERSONAL DEVELOPMENT REVIEW (PDR)
Items for Discussion at the PDR Meeting

Note to Reviewer and Reviewee Please use this form as the basis for your preparation and discussion, record brief details from the discussion under each heading in advance of your Review.	
1.	What has your experience been during the past year in your job role? **Working in two different roles in the past year – AD MUSC and AD TYC. Both challenging roles. Has been a difficult 12 months in terms of the volume of work needing to be done in timescales.**
2.	What do you consider to be your most important achievements of the past year? **Building the MUSC Team, establishing relationships with clinicians and introducing improved structures for managing the business across the Division. In relation to the AD TYC role, starting to build relationships in primary care, identifying areas fir improvement and agreeing new patient pathways for implementation**
3.	What elements of your job interest you the most, and least? **Most – working to implement new services** **Least – insufficient time to deliver on the objectives**
4.	What elements of your job do you find most difficult? **Trying to meet numerous deadlines for urgent tasks in the timescales provided**
5.	What do you consider to be your most important aims and objectives in the next year? **In terms of TYC in the near future, identifying and implementing TYC projects which will deliver a better experience and outcome for patients, whilst delivering efficiencies** **In terms of my AD MUSC role, re-balancing the divisional structures, securing support from clinicians for new pathways and models of care – delivering efficiencies as a by-product of this work.**
6.	Do you have any suggestions that would assist in improving effectiveness of the Team? **Greater collaborative working with clinicians, working to deliver an agenda which is clear, owned and accepted by all**

7.	What sort of training/experiences would benefit you in the next year relevant to your current post? **Recently commenced the Beeches Leadership Development course (6 days commencing Monday 10 September'12) – this will help provide support for the challenges ahead and help me expand my networks at AD level across Trusts and Agencies.**
8.	Bring Up to Date personal development experience/training list for discussion. **Priority 1 - I would like to explore options for undertaking a short medical foundation course that is aimed at managers in the NHS that are from a non-clinical background.** **Priority 2 - I would like some formal project management training in due course.**

SECTION 2 – JOINT REVIEW STAGE

Reviewer must interpret the Trust/ Team's Objectives

Key/ Team Objectives (linked to Corporate Objectives)	Individuals Action to achieve these objectives	Comments on attainment
➢ **Providing safe high quality care**	- Delivering safe, high quality care across MUSC Division, ensuring there are robust clinical governance arrangements in place - Continuing with the rollout of patient safety briefings in all service areas to ensure feedback is being provided to frontline staff in terms of quality and actions taken / lesson learned following incidents - Adopt a proactive approach to assuring quality by monitoring key quality indicators – for example, door to balloon time for Primary PCI and door to needle time for stroke thrombolysis - Ensuring timely provision of both unscheduled and elective services for patients across MUSC Division - Working with key staff to ensure robust infection controls measures are in place in all service areas, evidenced though audit and supporting through RCA and learning when issue occur - In the context of TYC, maximising the opportunities for patients to be managed on ambulatory pathways through our Day Clinical (Ambulatory Care) Centres and using these centres to facilitate early discharge - Work collaboratively with colleagues in OPPC to deliver improved patient pathways	

➢ **Supporting people and communities to live healthy lives and to improve their health and well being**	- Implementing the MUSC H&W action plan, linking with the Trust H&W coordinator – for example, promoting smoking cessation with patients that are managed through the coronary care units	
➢ **Being a great place to work, valuing our people**	- To provide protected time for the senior team in MUSC for 1:1s and for PDP and ongoing support - To balance service portfolios across Heads of Service position to manage pressures - To prioritise workload in discussion with Director of Acute to ensure a manageable and deliverable service workload is passed to staff across MUSC - To provide training and development opportunities for staff across MUSC - To acknowledge and reward staff for their achievements, building team morale and strengthening the team for ongoing challenges	
➢ **Make best use of resources**	- Ensure robust financial governance systems are in place across MUSC, moving to a breakeven position - Ensure services are delivering against agreed SBA levels - Work to reduce LOS to national peer groups	

Reviewer must interpret the Trust/ Team's Objectives		

Reviewer must interpret the Trust/ Team's Objectives		

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SECTION 3 – PERSONAL AND PROFESSIONAL DEVELOPMENT PLAN/ACTION

	Identified Learning or Development Need	Link with Trust / Directorate / Divisional Objective	Agreed Activity / Action	Target Date	Date Completed	Comments
Essential for the Post						
Best practice/ Development						

BEST PRACTICE & DEVELOPMENT MUST BE RELEVANT TO CURRENT JOB AND ONLY WHEN THE NEEDS AND RESOURCES OF THE SERVICE PERMIT

Have you completed your PDR - Yes ☐ No ☐		
Name of Reviewee (Please Print)	Date: / /	Name of Reviewer (Please Print)
Reviewee Staff Number		
Signature of Reviewee	Date: / /	Signature of Reviewer
Planned Date(s) of interim 6 month review:		Planned Date of 12 Month Review:

The PDP Form (i.e. all of SECTION THREE) must be forwarded to Vocational Workforce Assessment Centre (KSF) Department, Hill Building, St Lukes Hospital, Armagh. BT61 7NQ

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director, Acute Services – Strategy, Reform and Service Improvement

Staff Number: Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [x] **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:** Personal Information redacted by the USI

Line Manager's Feedback on staff members performance over past year:

- **For discussion with Esther at 1:1 on 1 Feb'17**

Personal Information redacted by the USI

[redacted]

Objectives for Next Year: INITIAL DRAFT - Suggestions for discussion with Esther at 1:1 on 1 February 17 All (below agreed with Esther and changes / additions noted in RED)

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]

Reviewee Staff Name (Print)	Barry Conway	Signature	Date 1/02/2017
Reviewer Manager/Supervisor (Print)	Esther Gishkori	Signature	Date 1/02/2017

Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Completed	
	Departmental Induction/Orientation	Completed	
	Fire Safety	7/04/2016	
	Record Keeping/Data Protection	27/04/2016	
	Moving and Handling	7/04/2016	
	Infection Prevention Control	tbc	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	N/A	
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
	Professional Registration	N/A	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)	Development programme for Assistant Directors – discuss support for application to 'Proteus' programme - 9 days – 4 of which are residential	To commence Mar'17	Agreed by Esther on 1 February 17. Barry to follow up with Will Young in Leadership centre.

Reviewee Staff Name (Print) Barry Conway Signature Personal Information redacted by the USI Date 1/02/2017

Reviewer Manager/Supervisor (Print) Esther Gishkori Signature Date 1/02/2017

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: Personal Information redacted by the USI

Southern Health and Social Care Trust
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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director, Acute Services IMWH and CCS

Staff Number: Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [x] **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:** Personal Information redacted by the USI

	Line Manager's Feedback on staff members performance over past year: - ***For discussion with Melanie at 1:1 on 4 December 2019***

Objectives for Next Year: <u>INITIAL DRAFT</u> - Suggestions for discussion with Melanie at 1:1 on 4 December 2019

Personal Information redacted by the USI

[redacted]

Reviewee Staff Name (Print) **Barry Conway** Signature _____ Date

Reviewer Manager/Supervisor (Print) **Melanie McClements** Signature _____ Date

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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Completed	
	Departmental Induction/Orientation	Completed	
	Fire Safety	Applied for place	
	Record Keeping/Data Protection	Completed	
	Moving and Handling	Completed	
	Infection Prevention Control	Completed	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	Completed	
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
	Professional Registration	N/A	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) Barry Conway Signature _____ Date

Reviewer Manager/Supervisor (Print) Melanie McClements Signature _____ Date

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - Personal Information redacted by the USI

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director, Acute Services IMWH and CCS

Staff Number: Personal Information redacted by the USI

Is Professional Registration up to date? N/A

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [x] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [x] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** Personal Information redacted by the USI **Line Manager's Feedback on staff members performance over past year:**

Objectives for Next Year (draft for discussion at 1:1)

Personal Information redacted by the USI

[redacted]

Reviewee Staff Name (Print) **Barry Conway** Signature _____ Date

Reviewer Manager/Supervisor (Print) **Melanie McClements** Signature _____ Date

Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____ Personal Information redacted by the USI _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction	Completed	
	Departmental Induction/Orientation	Completed	
	Fire Safety	4 May'21	
	Record Keeping/Data Protection	Due	
	Moving and Handling	Dec'19	Due December 22
	Infection Prevention Control	4 May'21	
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults	4 May'21	
	Waste Management	N/A	
	Right Patient, Right Blood (Theory/Competency)	N/A	
	Control of Substances Hazardous to Health (COSHH)	N/A	
	Food Safety	N/A	
	Basic ICT	N/A	
	MAPA (level 3 or 4)	N/A	
	Professional Registration	N/A	
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)	Development programme for Assistant Directors – discuss support for application to 'Proteus' programme - 9 days – 4 of which are residential	Due to start Autumn'21	

Reviewee Staff Name (Print) Barry Conway Signature _____ Date

Reviewer Manager/Supervisor (Print) Melanie McClements Signature _____ Date

PLEASE SEND COMPLETED **PART B** TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - Personal Information redacted by the USI

Glenny, Sharon

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 18 December 2018 11:26
To: Corrigan, Martina
Cc: McVeigh, Shauna; Graham, Vicki; Reddick, Fiona
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi Martina

Please see urology escalation below – this man is at high risk of breaching, CTU has been reported as suspicious for bladder tumour.

We will keep you updated with progress.

Sharon

From: McVeigh, Shauna
Sent: 13 December 2018 13:27
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is on day 28 with no 1st appointment, he has had a CTU performed on day 12. This has been reported and is suspicious for bladder tumour. He may need a date for surgery, he has been sent to DHH for an appointment. This man could be at high risk of breaching if cancer is confirmed which is likely.

Urological
Personal Information redacted by the USI
Personal Information redacted by the USI

Day	Date	Event
0	15/11/2018	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
12	27/11/2018	CTU - REQ'D
25	10/12/2018	CT(Expected on 10/12/18) at Craigavon
26	11/12/2018	e-mailed Clare McLoughlin DHH 11/12/18 to appoint
28	13/12/2018	CTU reported - Two malignant lesions in the right kidney as described. Further frond like mass in the bladder raises possibility of a third pathology,? TCC.
28	13/12/2018	Will escalate this man to OSL as he could be at risk of breaching, he may need a TURBT from CTU findings, 1st OP to be booked.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the USI

Glenny, Sharon

From: Dignam, Paulette <Personal Information redacted by the USI>
Sent: 19 September 2019 11:06
To: Corrigan, Martina; Young, Michael
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan; Graham, Vicki
Subject: RE: Urology escalation - Personal Information redacted by the USI

Mr Young is going to do on emergency list next Friday 27.09.19

Many thanks
Paulette

From: Corrigan, Martina
Sent: 10 September 2019 07:44
To: Young, Michael; Dignam, Paulette
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan; Graham, Vicki
Subject: RE: Urology escalation - Personal Information redacted by the USI

Good morning

Can you please advise of planned date? And if no availability are you happy for me to share with the Team to see if anyone has anything sooner?

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology & Outpatients
Craigavon Area Hospital

Telephone:
EXT Personal Information redacted by the USI (Internal)
Personal Information redacted by the USI (External)
Personal Information redacted by the USI (Mobile)

From: Graham, Vicki
Sent: 04 September 2019 16:25
To: Corrigan, Martina
Cc: Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; Conway, Barry; Carroll, Ronan
Subject: FW: Urology escalation - Personal Information redacted by the USI
Importance: High

Hi Martina,

Please see below patient who is a confirmed cancer who is on Day 63. First appointment was on Day 57 and patient was added to Mr Young's W/L for TURBT. Any assistance securing a date for surgery would be greatly appreciated.

I will keep you updated as patient continues on RF pathway.

Regards

Vicki

From: McVeigh, Shauna
Sent: 04 September 2019 16:14
To: Graham, Vicki
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is a confirmed cancer and is on day 63 of her pathway, delay with 1st OP she was on seen on day 57. She has been added to Mr Young's WL for a TURBT, date to be defined, only added to WL on 29.08.19. This lady will breach her pathway.

Personal Information redacted by the USI
Personal Information redacted by the USI
HCN Personal Information redacted by the USI

Day	Date	Event
0	03/07/2019	Suspect Cancer 'Red Flag' referral from GP referred to Craigavon
37	09/08/2019	FIRST RF APT-29.08.19. LETTER SENT. PT TO CONFIRM. DAY-57. ESCALATED TO ANGELA.
57	29/08/2019	First Seen at Craigavon
63	04/09/2019	Clinic outcome - I did a flexible cystoscopy today to further investigate her haematuria and this revealed small TCC around her right UO. Certainly this needs a TURBT and I?ve booked her for this accordingly as a red flag
63	04/09/2019	Will escalate this lady to OSL as she will be a breach. On MY WL for a TURBT.

Thanks
Shauna

Shauna Mcveigh
Cancer Tracker / MDT Co-ordinator
Ext Personal Information redacted by the

Glenny, Sharon

From: Muldrew, Angela <Personal Information redacted by the USI>
Sent: 26 January 2022 16:46
To: Clayton, Wendy; Carroll, Ronan; Scott, Jane M
Cc: Conway, Barry; Quin, Clair; Glenny, Sharon; McVeigh, Shauna; Glackin, Anthony; Haynes, Mark; Khan, Nasir; ODonoghue, JohnP; Omer, Shawgi; Tyson, Matthew; Young, Michael
Subject: RE: Urology escalations

Thanks Wendy

Shauna – could you put a note on CaPPS please. Thank you

Angela Muldrew
MDT Administrator & Projects Officer
Cancer Services
Tel No. Personal Information redacted by the USI

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 26 January 2022 16:45
To: Muldrew, Angela <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Scott, Jane M <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>; Quin, Clair <Personal Information redacted by the USI>; Glenny, Sharon <Personal Information redacted by the USI>; McVeigh, Shauna <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Khan, Nasir <Personal Information redacted by the USI>; ODonoghue, JohnP <Personal Information redacted by the USI>; Omer, Shawgi <Personal Information redacted by the USI>; Tyson, Matthew <Personal Information redacted by the USI>; Young, Michael <Personal Information redacted by the USI>
Subject: RE: Urology escalations

Thanks Angela

We have 28 red flag TURBT patients and are working through them chronologically. Patients will be scheduled in due course.

Consultants are all aware of the patients requiring to be scheduled but unfortunately demand outweighs current capacity

Regards

Wendy Clayton
Acting Head of Service for ENT, Urology, Ophthalmology & Outpatients
Ext: Personal Information redacted by the
Mob: Personal Information redacted by the USI

From: Muldrew, Angela <Personal Information redacted by the USI>
Sent: 26 January 2022 16:40
To: Clayton, Wendy <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Scott, Jane M <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>; Quin, Clair <Personal Information redacted by the USI>; Glenny, Sharon <Personal Information redacted by the USI>; McVeigh, Shauna <Personal Information redacted by the USI>

Subject: Urology escalations
Importance: High

Hi

Please see below patients who are awaiting TURBT or TP biopsies.

Personal Information redacted by the USI D104 Personal Information redacted by the USI CT D12, 1ST OP D31, had flex and was added to WL for RF TURBT – date for surgery awaited.

Personal Information redacted by the USI D99 Personal Information redacted by the USI 1ST OP D41, MRI D52, added to WL for TP biopsies – await date.

Personal Information redacted by the USI D105 Personal Information redacted by the USI CT D9, 1ST OP D32, added to WL for RF TURBT – await date.

Thanks

Angela Muldrew
MDT Administrator & Projects Officer
Cancer Services
Tel No Personal Information redacted by the USI

Glenny, Sharon

From: Lee, Sinead
Sent: 07 April 2022 14:59
To: Clayton, Wendy
Cc: Glenny, Sharon; Quin, Clair
Subject: FW: UROLOGY ESCALATIONS

Good afternoon,

Please see below Urology escalations for RF patients booked to 1st RF OPD.

As you can see our waits number has decreased due to 100 x patients being sent to 352.

Best
S

From: rf.appointment <Personal Information redacted by the USI>
Sent: 07 April 2022 12:56
To: Lee, Sinead <Personal Information redacted by the USI>
Subject: UROLOGY ESCALATIONS

Hi Sinead,

Personal Information redacted by the USI	GP DAY 30
	GP DAY 28
	GP DAY 43 (OFFERED EARLIER APPT BUT DECLINED)
	GP DAY 28
	GP DAY 30
	OC DAY 27
	GP DAY 29
	GP DAY 26
	GP DAY 26
	GP DAY 24
	GP Day 26
	GP Day 26
	GP Day 26

Thank you

Ann

Southern Health and Social Care Trust

CANCER CHECKPOINT MEETING

Date: Friday 04/03/2022
Time: 2.00pm
Venue: Via Zoom (link issued)

MINUTES

Attendees & Apologies			
Barry Conway	x	Ms H Mathers	x
Sinéad Lee	x	Dr A O'Hagan	x
Mary Haughey	x	Ronan Carroll	x
Angela Muldrew	x	Jane Scott	x
Sharon Glenny	x	Louise Devlin	X
Patricia Loughran	x		
Apologies noted from: Clair Quinn, Wendy Clarke, Dr S Moan.			

1.0	Notes from previous meeting Barry welcomed everyone to the meeting and provided the below update from the last meeting: ➢ IPC arrangements – no update. Staying as is for foreseeable future. ➢ Key Worker – Angela to chase Ailin/Naomi to make changes and advise Trackers to start using this on CaPPs. ➢ MDT Benchmark – Mary shared document after last Checkpoint meeting. ➢ CT/EBUS – Settled. Sharon to run weekly report and circulate. ➢ Qfit longest waiters – Barry sent report to Ronan.	All Sharon to produce for next week's Management meeting
2.0	Update on MDT benchmarking work (linked to the Urology Review) Mary circulated summary document after last Checkpoint meeting. Currently working on: • MDM Proforma for each tumour site • Linking in with MDT leads regarding tumour site AGMs	Mary
3.0	General update: Barry provided an update on referral trends: • Very high referrals numbers • Breast numbers significantly high in January and decreased in February. • High volume of patients waiting over 113+ days – seen some improvement recently. • Very long waits for patients requiring 1st OPD o Haematology, Head & Neck, Upper GI drifting out o Breast, Urology, Skin, Gynae have improved • High numbers for LGI patients partially due to Qfit longest waiters from primary care.	Barry

	Tracking Position – • Increased by 2.9% this week but going well. • 1x Tracker long term sick and a few off with covid this week. Should be in a better position next week. • New staff members are settling in well. • Future plans for continuation of temporary Trackers posts	
4.0	Issues for escalation by tumour site: *Breast –Ms Helen Mathers provided an update:* • Staffing issues with Radiology/Surgical cover • 3x staff retiring • 2 week wait up to 15%, predicting further increase next week • No Assistant cover for UIC *Dermatology– **Dr Art O'Hagan** provided an update:* • High increase in RF referrals received • New Telederm photo service not started in SHSCT yet • Governance issues with patients attending Plastics and coming back to SHSCT for MDT discussion • Staffing – 1x Consultant on mat leave, 1x retiring soon • Plastic surgery capacity decreased • High volumes in patients awaiting surgery • Coding issues re: protocolisation codes – planned meeting for next week. • Recruiting commenced for another Consultant.	Lead Clinicians ADs/ HOS / OSL Helen to email Barry to plan Breast plan meeting for Wednesday AM Mary to log in MDT plan
5.0	Updates from Regional Cancer reset / Issues for escalation: • Rest Cell: Cancer Strategy due to be published 3rd week in March 2022. • Confirmed cancer report discussed regionally – reports a shortfall in patients due to covid. This will have added pressure in future. • NICAN: Cancer Registry for Colorectal surgery by operator. Ronan to link in with Mr McElvanna and Surgeons. • Cytosponge Project – Dr Hussain is Clinical lead and plan is to trial 100 patients. Deadline is planned for December 2022.	Barry/All
6.0	Other issues by exception • Pathology transport issues – Jane advised there was another issue this week but this has been resolved.	All
7.0	Date of Next Meeting – Friday 1st April 2022 @ 2pm	

Southern Health and Social Care Trust

CANCER CHECKPOINT MEETING

Date: Friday 01/04/2022
Time: 2.00pm
Venue: Via Zoom (link issued)

A G E N D A

1.0	Apologises	
2.0	Notes from previous meeting  MINUTES - Cancer Checkpoint Meeting -	All
3.0	Update on MDT benchmarking work (*linked to the Urology Review*) - USI Hearings Update	Mary
4.0	General update: - Referral trends (Barry) - Long waiters (Barry) - Tracking position (Angela)	Barry
5.0	Issues for escalation by tumour site:	Lead Clinicians ADs/ HOS / OSL
6.0	Updates from Regional Cancer Reset / Issues for escalation	Barry
7.0	Other issues by exception - Oncology Physiotherapy	All
8.0	AOB Date of Next Meeting – 2pm Friday 6th May '22	

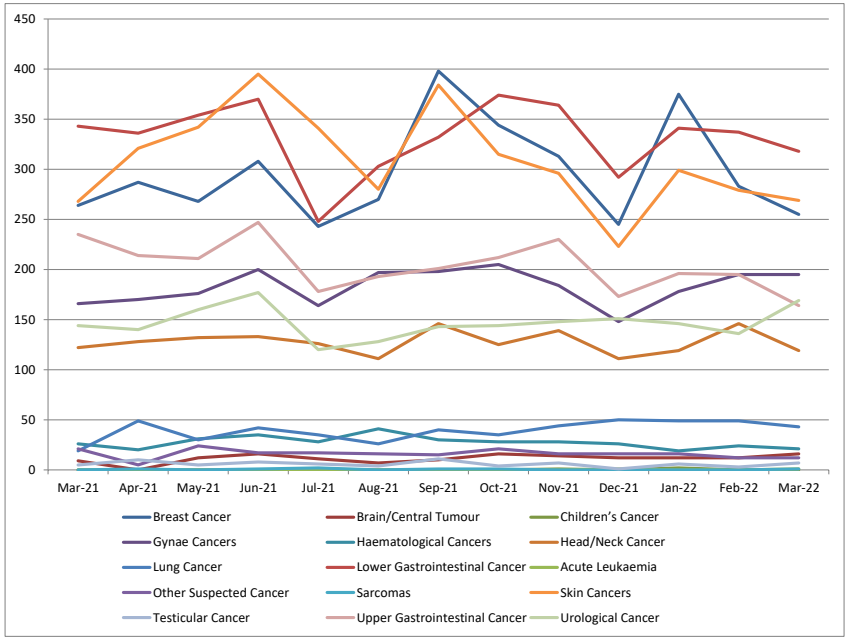
Cancer Rebuild Plan

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 04/01/2022 Red Flag Waiting List Volumes	Position as at 01/02/2022 Red Flag Waiting List Volumes	Position as at 01/03/2022 Red Flag Waiting List Volumes	Position as at 29/03/2022 Red Flag Waiting List Volumes	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 04/01/2022 Red Flag Longest Waiter (Days)	Position as at 01/02/2022 Red Flag Longest Waiter (Days)	Position as at 01/03/2022 Red Flag Longest Waiter (Days)	Position as at 29/03/2022 Red Flag Longest Waiter (Days)	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 04/01/2022 62 Day Active Pathway Waiters	Position as at 01/02/2022 62 Day Active Pathway Waiters	Position as at 01/03/2022 62 Day Active Pathway Waiters	Position as at 29/03/2022 62 Day Active Pathway Waiters	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 04/01/2022 62 Day Longest Waiter (Days)	Position as at 01/02/2022 62 Day Longest Waiter (Days)	Position as at 01/03/2022 62 Day Longest Waiter (Days)	Position as at 29/03/2022 62 Day Longest Waiter (Days)	Key Pathway Pressures	Action Agreed	Action Owner	Outcome	Measurement
Breast	63	121	8	63	90	85	63	21	21	14	21	35	126	190	207	215	227	241	76	92	71	90	119	54	**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	83	298	39	77	88	141	56	189	112	70	42	280	141	489	414	473	492	558	102	376	365	215	244	225	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	1	34	11	15	17	71	1	42	70	28	49	42	31	64	124	167	173	219	61	75	136	98	125	121	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	48	152	16	7	61	154	70	63	42	56	35	63	83	207	209	147	193	240	85	146	105	102	116	144	Reduction of OP activity. Limited OPH activity. Reduced elective activity					
Haematology	26	33	22	24	22	18	98	91	161	147	175	119	40	51	62	52	58	49	126	180	207	220	197	168						
Lung	24	31	17	11	13	31	77	49	49	28	35	56	15	47	47	52	52	67	118	119	98	63	77	90	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)	95	818	45	103	109	132	70	385	518	539	567	497	526	1139	1186	1224	1162	1254	258	413	499	526	555	583	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)	91	175	54	62	63	46	77	287	224	391	280	105	257	439	480	451	555	535	192	361	300	327	326	354	Cessation of OP activity					
Urology - Prostate	99	48	68	101	80	89	133	77	98	119	84	98	308	354	404	403	470	498	230	389	287	314	262	290	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	148	199	89	110	75	103	112	399	84	70	91	147													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	24	34	21	18	26	18	70	49	98	63	84	84													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	7	4	2	6	3	5	56	35	49	56	63	42	18	8	4	7	6	9	76	55	48	75	84	65						
General Surgery - Other	6	15	0	1	1	1	56	119	364	392	420	448			15	18	13	22			74	101	130	158						
Gastro - Other	1	2	0	5	3	1	63	7	28	35	49	63																		
Neurology	0	4	0	0	0	0	0	7	14	14	14	14			12	13	5	14			56	83	70	54						

62 DAY REFERRALS	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Breast Cancer	264	287	268	308	243	270	398	344	313	245	375	283	255
Brain/Central Tumour	9	0	12	16	11	7	10	16	14	12	12	12	16
Children's Cancer	0	0	0	0	0	0	0	0	1	0	2	0	0
Gynae Cancers	166	170	176	200	164	197	198	205	184	148	178	195	195
Haematological Cancers	26	20	31	35	28	41	30	28	28	26	19	24	21
Head/Neck Cancer	122	128	132	133	126	111	146	125	139	111	119	146	119
Lung Cancer	19	49	30	42	35	26	40	35	44	50	49	49	43
Lower Gastrointestinal Cancer	343	336	354	370	248	303	332	374	364	292	341	337	318
Acute Leukaemia	0	0	0	0	0	0	0	0	0	1	0	0	1
Other Suspected Cancer	21	5	24	17	17	16	15	21	16	16	16	12	12
Sarcomas	0	1	0	1	2	0	1	1	0	0	0	0	1
Skin Cancers	268	321	342	395	341	280	384	315	296	223	299	279	269
Testicular Cancer	5	10	5	8	6	4	11	4	7	1	6	3	7
Upper Gastrointestinal Cancer	235	214	211	247	178	193	201	212	230	173	196	195	164
Urological Cancer	144	140	160	177	120	128	143	144	148	151	146	136	169
62D Total	1622	1681	1745	1949	1519	1576	1909	1824	1784	1449	1758	1671	1590

31 DAY REFERRALS	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Breast Cancer	64	20	35	42	30	31	30	25	30	11	36	26	28
Brain/Central Tumour	0	4	0	1	1	0	0	0	1	0	1	0	0
Children's Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0
Gynae Cancers	10	11	13	14	19	10	12	19	19	17	23	18	20
Haematological Cancers	6	11	18	17	13	14	10	13	15	21	14	6	18
Head/Neck Cancer	16	17	20	19	16	15	14	23	27	12	14	11	6
Lung Cancer	20	18	18	23	19	25	21	15	24	22	20	14	25
Lower Gastrointestinal Cancer	16	24	36	42	35	15	25	39	23	25	30	27	17
Acute Leukaemia	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Suspected Cancer	4	13	5	4	2	5	3	3	5	1	2	1	0
Sarcomas	0	0	0	0	0	0	0	0	0	0	0	0	0
Skin Cancers	4	2	4	4	6	9	1	9	12	4	7	4	5
Testicular Cancer	0	2	0	0	0	0	0	0	0	1	0	0	0
Upper Gastrointestinal Cancer	15	12	16	19	20	21	14	17	16	12	20	10	15
Urological Cancer	27	28	28	36	34	34	31	26	30	19	24	26	21
31D Total	182	162	193	221	195	179	161	189	202	145	191	143	155

62D & 31D Total Combined Refs	1804	1843	1938	2170	1714	1755	2070	2013	1986	1594	1949	1814	1745



Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

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	182	10	85	N/A	0	87	182	5	35	LONGEST WAITER:	5	WEEKS	Personal Information redacted by the USI	Appointment planned for 30.03.22 - Patient cancelled previous due to covid
										NEXT LONGEST:	4	WEEKS		Appointment planned for 04.04.22 - Patient cancelled previous appt
Dermatology	193	22	141	N/A	0	30	193	40	280	LONGEST WAITER:	7	WEEKS		Appointment planned for 31.03.22
										NEXT LONGEST:	7	WEEKS		Appointment planned for 04.04.22
ENT	86	5	71	N/A	0	10	86	6	42	LONGEST WAITER:	6	WEEKS		Appointment planned for 31.03.22
										NEXT LONGEST:	5	WEEKS		Out for triage since 25.02.22 - RF Team have chased
Gynae	216	21	154	N/A	1	40	216	9	63	LONGEST WAITER:	9	WEEKS		Appointment planned for 08.04.22
										NEXT LONGEST:	7	WEEKS		Awaiitng appointment - current inpatient in DHH
Haematology	42	7	18	2 PINK Referrals	0	17	42	17	119	LONGEST WAITER:	17	WEEKS		Awaiting date for RF appointment
										NEXT LONGEST:	17	WEEKS		Appointment planned for 31.03.22
Lung	59	16	31	N/A	1	11	59	8	56	LONGEST WAITER:	8	WEEKS		Appointment planned for 29.03.22
										NEXT LONGEST:	8	WEEKS		Awaiting CT before RF OPD arranged
General Surgery - Lower GI	367	98	96	122 QFIT	0	51	245	71	497	LONGEST WAITER:	71	WEEKS		Awaiting Qfit
										NEXT LONGEST:	17	WEEKS		Non Qfit Longest waiter - Wants Virtual OPD with Mr Hewitt Next longest waiter for RF OPD is at 10 weeks
General Surgery - Upper GI	54	30	10	3 QFIT	0	11	51	9	63	LONGEST WAITER:	9	WEEKS		Non Qfit Longest waiter - Awaiting RF appointment with Mr Mark
										NEXT LONGEST:	8	WEEKS		Awaiting Qfit
General Surgery - Other	5	0	1	2 QFIT	2	0	3	64	448	LONGEST WAITER:	64	WEEKS		Awaiting Qfit
										NEXT LONGEST:	3	WEEKS		Non Qfit Longest waiter - RF appointment 29.03.22
Gastro - Lower GI	62	7	36	2 QFIT	1	16	60	15	105	LONGEST WAITER:	15	WEEKS		RF appointment 29.03.22
										NEXT LONGEST:	11	WEEKS		RF appointment 30.03.2
Gastro - Upper GI	88	18	36	N/A	2	32	88	15	105	LONGEST WAITER:	15	WEEKS		RF appointment 04.04.22
										NEXT LONGEST:	9	WEEKS		RF appointment 29.03.22
Gastro - Other	2	0	1	N/A	0	1	2	9	63	LONGEST WAITER:	9	WEEKS		RF appointment 29.03.22
										NEXT LONGEST:	4	WEEKS		Awaiting RF OPD
Neurology	3	3	0	N/A	0	0	3	2	14	LONGEST WAITER:	2	WEEKS		Awaiting triage
										NEXT LONGEST:	1	WEEKS		Awaiting triage
Urology - Prostate	106	0	89	N/A	2	15	106	14	98	LONGEST WAITER:	14	WEEKS		Appointment planned for 23.03.22
										NEXT LONGEST:	9	WEEKS		Appointment planned for 29.03.22
Urology - Haematuria	116	2	103	1 patient on THC/IS booked to clinic	1	9	115	21	147	LONGEST WAITER:	21	WEEKS		Awaiting date for RF OPD
										NEXT LONGEST:	14	WEEKS		Awaiting date for RF OPD
Urology - Testicular	10	3	5	1 Transferred to 352	1	0	9	6	42	LONGEST WAITER:	6	WEEKS		Awaiting date for RF OPD
										NEXT LONGEST:	5	WEEKS		Awaiting date for RF OPD
Urology - Other	27	23	18	N/A	0	6	47	12	84	LONGEST WAITER:	12	WEEKS		Awaiting date for RF OPD
										NEXT LONGEST:	9	WEEKS		Appointment planned for 29.03.22

Received from Barry Conway on 30/06/2022. Annotated by the Urology Services Inquiry.

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		2	4	2	3	2			1											14
Breast Cancer		50	58	67	51	9	3		3											241
Gynae Cancers		38	35	47	37	43	18	9	5		2		1		1					236
Haematological Cancers		3	4	3	9	5	4	5	4	3	1	2	1	1	2	1		1		49
Head/Neck Cancer		28	21	32	29	34	19	18	12	11	5	3	1	1		2	1	1		218
Hepatobiliary/Pancreatic						1											1	1		3
Lower Gastrointestinal Cancer		65	73	85	76	83	71	74	57	79	72	52	30	24	23	31	27	330		1252
Lung Cancer	**N**	5	5	10	12	8	4	7	5	5	3	1	1	1						67
Other Suspected Cancer		2	2	7	3	2			1	3						1		1		22
Sarcomas				1																1
Skin Cancers		69	67	55	80	56	52	46	30	31	14	6	3	1			1	4		515
Testicular Cancer		2	1		4	1					1									9
Thyroid Cancer							1													1
Upper Gastrointestinal Cancer		31	38	56	33	39	47	47	35	34	39	24	23	17	7	19	9	38		535
Urological Cancer		44	40	43	38	50	27	32	24	21	21	26	21	13	9	15	12	61	1	498
	N	339	348	408	375	333	249	239	177	187	158	114	81	58	42	69	51	440	1	3669
Gynae Cancers								1		1		1						1		4
Head/Neck Cancer																		1		1
Lower Gastrointestinal Cancer	**Y**																	2		2
Skin Cancers					1				3	1	3		2	2	2	6	2	21		43
	Y				1			1	3	2	3	1	2	2	2	6	2	25		50
	Sum:	339	348	408	376	333	249	240	180	189	161	115	83	60	44	75	53	465	1	3719

Overview of Cancer & Clinical Services (CCS) / Integrated Maternity & Women's Health (IMWH) Division

Cancer and Clinical Services

Associated Medical Director: Dr Shahid Tariq

Assistant Director: B Conway

Total staff: 730 **Total budget:** £42m

Cancer Services	
Head of Service	Fiona Reddick
Clinical Director	Dr David McCaul

Key Issues / challenges as at June 2019:

- Increasing red flag referral (15% per year)
- Meeting 31 day pathway (96% to start 1st definitive treatment from cancer diagnosis within 31 days)
- Not meeting 62 day pathway (85% to start 1st definitive treat from referral by GP for suspected cancer)
- Medical workforce challenges
- No local acute oncology presence
- Belfast reducing medical outreach to Mandeville OP clinics
- Regional transformation programme – led by Dr Gillian Rankin
- Haematology Service pressures

Radiology Services	
Head of Service	Jeanette Robinson
Clinical Director	Dr Imran Yousuf

Key Issues / challenges as at June 2019:

- Increasing demand – especially for CT and MRI
- Ageing equipment – high cost – unable to source from Capital funding
- Replacing the DHH CT scanner in August 2019
- Business case ongoing for new twin CT scanning suite in CAH
- Business case ongoing for new scanning suite in DHH – CT and MRI
- Working on a 10 year replacement programme
- 2 high costs units now to be replaced – Nuclear Medicine scanner in CAH / mammography scanner in CAH
- Breast consultant (sits with Ronan Carroll but Breast Radiologists and Radiographer sit with me)
- High use of independent sector for scanning and reporting
- Reliance on additionality – WLI
- Reducing uptake of WLI
- Funded for 25wte Consultant Radiologists – 20wte in post
- Staffing is good in radiography
- Accommodation challenges in CAH
- Further rollout of IRMER 18 (radiation protection arrangements for payment)

- Applied for ISAS accreditation – timescale 1 year

Laboratory Services	
Head of Service	Geoff Kennedy
Clinical Director	Dr Kathryn Boyd

Key Issues / challenges as at June 2019:

- Increasing demand
- Increased costs being passed on from Belfast Trust – specialist tests
- Microbiology locum costs
- Limitations around Point of Care Testing
- Ongoing need to main UKAS accreditation – only lab in NI with full accreditation for all parts of the lab
- Ongoing reliance in paper reports – keen to progress e-sign off through NIECR
- Accommodation challenges in CAH
- Regional Pathology modernisation programme – locum awareness event in the Trust at 10am on Friday 28 June (venue – MEC CAH)

Allied Health Professional Services	
Head of Service	Cathie McIlroy (Charlotte Wells from July 2019)
Clinical Director	N/A

Key Issues / challenges as at June 2019:

- Demand and capacity paper completed which shows that all AHP areas need to have staffing uplifted
- Workforce challenges across all AHP disciplines
- Historically under funded
- SLT - down 40% of staff due to vacancies and maternity leave
- Moving to 7 day working for OT and Physio in the Autumn
- Increasing demand in acute paediatrics for Physio
- Urgently need to bring forward a paper to Investment Committee for both SLT and Physio (linked to Acute Paediatrics pressures)
- Unable to appoint to Head of Orthoptics – seeking professional oversight for this service from Belfast
- Charlotte Wells is now shadowing Cathie with a view to taking over at start of July 2019

Integrated Maternity and Women's Health

Associated Medical Director: Dr Martina Hogan

Assistant Director: B Conway

Total staff: 300 **Total budget:** £20m

Integrated Maternity and Women's Health	
Head of Service	Wendy Clarke
Clinical Director	Dr Aoife Currie (CAH) Dr Meeta Kamath (DHH)
Lead Midwives	Joanne McGlade – DHH Paula Boyle – Community Mary Dawson – CAH Michelle Portis - CAH

Key Issues / challenges as at June 2019:

- Workforce challenges in midwifery -especially in CAH and Community
- Increasing inpatient and day case waiting times due to ongoing 30% reduction in theatre lists (due to staff shortages in main theatres – Ronan Carroll)
- Safety issues emerging due to large number of medical outliers in Gynae ward in CAH – post operative Gynae patients staying much longer in theatre recovery ward and key post op follow up actions are being delayed leading to post op complications (one recent case likely to go to litigation)
- Ongoing hold in Mesh surgery
- Number of complex Serious Adverse Incidents ongoing – maternal death (Personal Information redacted by the USI) and Group A Strep death (Personal Information redacted by the USI)
- Urgent need to establish regular elective c-Section lists in CAH to avoid cases drifting into the OOH period – proposal being worked up for 3 lists per week – supported by senior clinicians as a key patient safety improvement
- Accommodation challenges – especially in Dungannon
- Inputting into the regional elective care centres work – Gynae one of the next specialities to be progressed – H Trouton chairing the regional group
- Medical workforce – 11 consultants in CAH and 7 in DHH
- Ongoing reliance on locum input to middle grade tier in DHH – high cost
- Ongoing job planning challenges in DHH – working through these – 2 at facilitation stage
- 2 back pay issues being resolved following resolution of job plans in DHH
- DHH consultant team historically did not have formal job plans – good progress being made but this has been difficult
- 2 services currently struggling due to short term workforce pressures – Urodynamics and Fertility

Cancer Access Standards Meeting
Thursday 18th October 2018 at 10.00am
Meeting Room 2, Admin Floor (VC Available)

Agenda

1. Apologies
2. Notes of last meeting (September)
3. Cancer peer review update
4. Sept 2018 performance reports
5. Sept 2018 Breach reports
6. ITT Issues
7. RF Operational Issues
8. Escalation Policy
9. Any Other Business
10. Date of next meeting: Thursday 15th November @ 10.00am

Cancer Access Standards Meeting
Thursday 17th January 2019 at 10.00am
Meeting Room 1, Admin Floor (VC Available)

Agenda

1. Apologies
2. Notes of last meeting (December)
3. Cancer peer review update
4. Dec 2018 performance reports
5. Dec 2018 Breach reports
6. ITT Issues
7. RF Operational Issues
8. Escalation Policy
9. Failsafe to ensure all patients are relisted for MDM following discussion (? Possibility of having a BOXI report set up)
10. Any Other Business
11. Date of next meeting: Thursday 21st February @ 10.00am

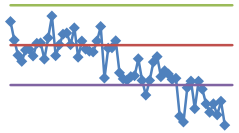
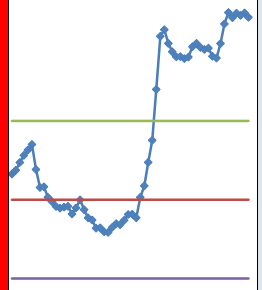
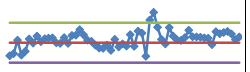
Southern Health and Social Care Trust

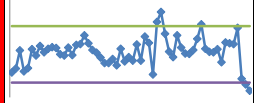
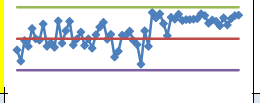
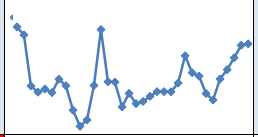
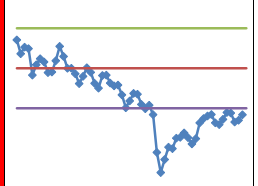
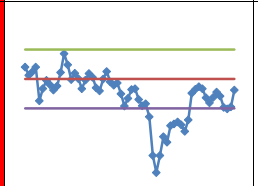
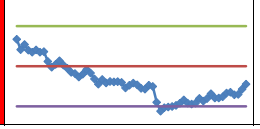
CANCER CHECKPOINT MEETING

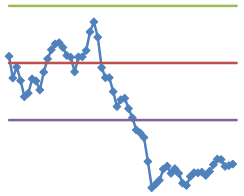
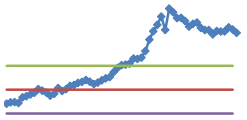
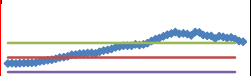
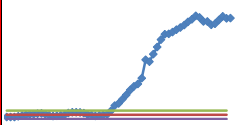
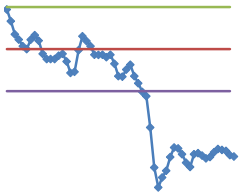
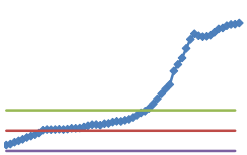
Date: Friday 24/09/2021
Time: 2.00pm
Venue: Via Zoom (link issued)

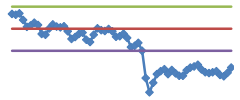
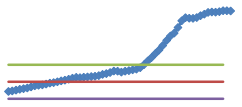
A G E N D A

1.0	Notes from previous meeting	All
2.0	Update on MDT benchmarking work (linked to the Urology Review) - Baseline audit / action plan - Demand & Capacity exercise by tumour site (starting with Urology) - Cancer MDT Coordinator post	Barry / Sharon
3.0	General position / Update by tumour site / issues for escalation: - Update on referrals - Update on tracking position - Communication of outcomes to trackers - Telederm position - Gastro 1st appointment waiting times - Breast pain Clinic request - Urology TP biopsy capacity - Upper GI – Trust link to Regional MDT -	Lead Clinicians ADs/ HOS / OSL
4.0	Update on qFit process – long waiters / discharges / plan for transition to primary care	Ronan / Amie / Jane
5.0	Updates from Regional Cancer Reset / Issues for escalation - Cancer Strategy out for consultation – closing date (currently) 20th October'21	Barry / All
6.0	Other issues by exception	All
7.0	AOB Date of Next Meeting – 2pm Friday 8 October '21	

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Cancer	**ASD**	**Suspect Breast Cancer (14 days)**	During 2021/22, all urgent suspected breast cancer referrals should be seen within 14 days	**67.7%**		100%	**37.0%**	March 2022 demonstrated performance of 14.5% (37 out of 256) red flag patients assessed within 14 days. 219 patients were seen outside of the 14-day target. As at 11 April 2022 there were 1217 patients waiting on the routine out-patient waiting list for first assessment with 480 waiting in excess of 52-weeks. Breast surgical services continue to access limited theatre capacity in the Independent Sector, as allocated to the Trust, and in available core capacity, based on the Regional process for equalisation of access for the most urgent patients. Access to services remains a key corporate risk.
Cancer	**ASD**	**Cancer Pathway (31 days)**	During 2021/22, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.	**92.4%**		98%	**85.8%**	Cancer performance is based on those patients who have completed their pathway. Reduced access to surgical capacity means that an increased number of patients remain on the pathway. In January 2022, performance against this target was 74.7% (71 out of 95 patients). As at 25 April 2022, 118 red flag suspect or confirmed cancer patients had their initial admission cancelled between 1 February 2022 and 25 April 2022, with 15 still to be rebooked. Surgical services continue with available core capacity alongside limited capacity in the Independent Sector, as allocated to the Trust, based on the Regional process for equalisation of access for the most urgent patients. As at 25 April 2022 the Trust is tracking 1404 patients on the active 31 day pathway. Access to services remains a key corporate risk.
Cancer	**ASD**	**Cancer Pathway (62 days)**	During 2021/22, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days.	**57.1%**		95%	**49.4%**	Cancer performance is based on those patients who have completed their pathway. Reduced access to out-patients, diagnostics and surgical capacity means that an increased number of patients remain on the pathway. In January 2022, 39.2% (20 out of 51) patients began their first definitive treatment within 62 days. Of the 39 patients that breached the target, 2 were Breast, 4 Gynae, 1 Head/Neck, 2 Lower GI, 3 Lung, 13 Skin, 5 Upper GI and 9 Urology. As at 25 April 2022, the Trust is tracking 3572 patients. It is anticipated that performance will continue to be challenged as patients complete their pathway. As noted above surgical services continue with available core capacity alongside limited capacity in the Independent Sector, as allocated to the Trust, based on the Regional process for equalisation of access for the most urgent patients. Access to services remains a key corporate risk.
Elective	**ASD CYPS MHD OPPC**	**Allied Health Professionals**	By March 2022, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional	**11,608**		0	**13,054**	At the end of March 2022 there were 13,054 patients (62%) out of 21,125 waiting longer than 13 weeks. The longest waiters are within Occupational Therapy (OT), Physiotherapy (PHY) and Speech and Language Therapy (SLT). Routine patients currently waiting up to 154 weeks (adults) for OT, 120 weeks for PHY and 129 weeks for SLT. The longest paediatric wait is 114 weeks for Physio. Due to staffing pressures, the Trust is limited on the level of additionally it can undertake for elective waiting lists however, a number of additional mega clinics have been undertaken in Physio with higher volume clinics and a 40-50% discharge rate after 1st appointment. As of 28 April 2022, 1972 patients have been offered appointments at the MSK mega clinics and 258 patients offered appointments at the Pelvic Health mega clinics. For the first time, the Trust was able to seek an Independent Sector provider for a distinct cohort of Physiotherapy waits which has seen a total of 450 patients seen between November 2021 and March 2022. The mega clinics and IS capacity has faciliatated a reduction in PHY waits over 13-weeks of -16% (-1352) between October 2021 (8278) and March 2022 (6926). Access to services remains a key corporate risk.
Elective	**ASD CYPS MHD OPPC**	**Allied Health Professionals (Review Backlog)**	**NON-OGI** The number of patients waiting beyond clinically indicated timescale for review (Allied Health Professionals)	**10,588**		Non OGI	**11,698**	As at 2 March 2022 (most recent data) there were 11,698 patients waiting beyond their clinically indicated timescales, including orthoptics. More services have moved on to PARIS, therefore allowing the review volumes to be reported on. The longest waiter for review is aligned to OT (Adult Learning Disability, ICT & Physical Disability only) and dates back to April 2015. Access to services remains a key corporate risk.
Elective	**ASD**	**Diagnostic Reporting (Urgent)**	By March 2022, all urgent diagnostic tests should be reported on within two days.	**85.7%**		100%	**84.1%**	In March 2022, 83.8% of all urgent diagnostic tests, imaging and non-imaging, were reported within two days. Non-recurrently funded capacity in the Independent Sector, for Imaging, continues to be delivered to supplement internal reporting capacity. However, this remains insufficient to meet demand.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Elective	***ASD***	***Diagnostic Reporting (Urgent)*** *Imaging*	*By March 2022, all urgent diagnostic tests should be reported on within 2 days.*	**84.2%**		*100%*	**80.2%**	**Imaging (Radiology)** - Performance remains variable against this objective. In March 2022, 71.7% of tests were reported on within 2 days. Non-recurrently funded capacity in the Independent Sector, for Imaging, continues to be delivered to supplement internal reporting capacity. However, this remains insufficient to meet demand. Consultant vacancies (2 WTE); sabbaticals (2 WTE); and annual leave has impacted performance.
Elective	***ASD***	***Diagnostic Reporting (Urgent)*** *Non-Imaging*	*By March 2022, all urgent diagnostic tests should be reported on within 2 days.*	**98.4%**		*100%*	**98.6%**	**Non-Imaging (Physiological Measurement)** - Performance remains variable but stronger than the position reported above for Imaging. In March 2022, 99.4% of non-imaging diagnostic tests were reported within 2 days.
Elective	***ASD***	***Diagnostic Reporting (Imaging Unreported Plain Film X-Rays)***	***NON-OGI*** *Imaging Plain Film Exams Unreported (that are required to be reported)*	***2,010***		*Non OGI*	***4,334***	As at 4 April 2022, there were 4334 unreported plain film x-rays, with 10 waiting more than 28 days. 50% (5 out of 10) of those waiting >28-days are chest films with the longest unreported at 128-days. The remaining 50% (5 out of 10) are non-chest films with the longest unreported at 130-days. The volumes of films unreported continues to fluctuate associated with leave and are reviewed weekly. *Note further information against DRTT Urgent target for Imaging.*
Elective	**ASD**	**Diagnostic Test**	By March 2022, 75% of patients should wait no longer than 9 weeks for a diagnostic test	**23.5%**		75%	**32.4%**	At the end of February 2022 (most recent cumulative data), 33.5% (13,224 out of 39,509) of patients waited no longer than (less than) 9 weeks. Modalities as a % of total waits demonstrate: 22.7% (8,752) Cardiology; NOUS 9.23% (3,649); Endoscpy 13.5% (5,352); MRI 10.3% (4,070) in MRI; and Dexa 9.5% (3,774). HSCB allocated non-recurrent funding continues to be for an element of in-house additionality along with IS additionality, where capacity can be sourced. Imaging capacity continues to be be shared Regionally to ensure equity of capacity. The Trust has utilised capacity in Northern Trust for NOUS and in Musgrave Park via the Regional CT scanner. The South Eastern Trust (SET) has taken a monthly volume of TTEs (Echo) from our waiting list and this capacity is continuing into 2022/2023. Access to services remains a key corporate risk.
Elective	***ASD***	***Diagnostic Test (Imaging)***	By March 2022, 75% of patients should wait no longer than 9 weeks for a diagnostic test.	**33.6%**		75%	**48.0%**	Imaging (Radiology) - At the end of March 2022, 50.8% (9,603 out of 18,912) of patients waited no longer than (less than) 9 weeks. By modallity, the volume and % of patients waiting, <9-weeks demonstrates: * NOUS 3,391 patients - 17.9%; * MRI 1,688 patients - 8.9%; * Dexa 412 patients - 2.1%; * CT 1,142 patients - 6.0%; and * X-Ray 2,141 patients - 11.3%. The Trust continues to utilise recurrent funding for CT and MRI non-recurrently, until the permanent infrastructure is in place. The Trust also continues to utilise HSCB allocated non-recurrent funding to undertake an element of in-house additionality and additionality in the IS for MRI; CT; NOUS and Dexa.
Elective	***ASD***	***Diagnostic Test (Non-Imaging)***	By March 2022, 75% of patients should wait no longer than 9 weeks for a diagnostic test.	**12.7%**		75%	**19.3%**	Non-Imaging (Physiological Measurement) - At the end of March 2022, 26.5% (3,872 out of 14,597) patients were waiting no longer than (less than) 9 weeks. Cardiology accounts for 59.6% of total non-imaging waits (8,714). Of the 8,714 Cardiology waits there is a total of 4,245 (48.7%) waiting for TTE investigation. The Trust continues to use HSCB allocated non-recurrent funding for an element of in-house additionally in addition to the monthly capacity provided by the South Eastern Trust (SET).

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Elective	***ASD***	***Diagnostic Test (Endoscopy)***	By March 2022, 75% of patients should wait no longer than 9 weeks for a diagnostic test.	**16.9%**		75%	**20.2%**	Endoscopy - At the end of February 2022 (most recent data), 21.6% (1,154 out of 5,352) of Endoscopy patients were waiting no longer than (less than) 9-weeks. Demand for endoscopy continues to be well above recurrent capacity and performance is impacted by lower levels of elective activity being undertaken across all sites. Whilst endoscopy sessions have re-commenced on the STH site, they have not yet returned to pre-pandemic levels. The Trust had used Regional IS capacity, located in SET premises, for red flag / urgent scopes. This capacity has now ceased. Capacity continues to be directed to red flag, urgent and planned repeat patients in the first instance. There is no routine capacity to address the longest waits. Reduced Endoscopy capacity is impacting the journey time for patients on the cancer pathway for upper and lower GI tumour sites. Whilst an element of additionality is being utilised, longer term plans are required to increase endoscopy capacity within the Trust.
Elective	**ASD**	**Diagnostic Test**	By March 2022, No patient waits longer than 26 weeks.	**18,420**		0	**16945**	At the end of February 2022 (most recent cumulative data) 41.7% of patients (16,495 out of 39,509) were waiting longer than 26 weeks for diagnostic tests. Increasing waits are associated with demand above capacity and has been further compounded by reduced core elective capacity impacted by Covid-19 management arrangements. Cardiac Non-Invasive Investigations accounts for the largest percentage, 37.9% (6,260) of those waiting >26 weeks. *Note information reported against the 9-week target*
Elective	***ASD***	***Diagnostic Test (Imaging)***	*By March 2022, No patient waits longer than 26 weeks.*	**4,445**		*0*	**5,070**	Imaging - At the end of March 2022, 26.8% of patients were waiting longer than 26 weeks for Imaging Tests (5,070 out of 18,912). The longest wait is 146 weeks for Fluoroscopy. *Note information reported against 9 week target.*
Elective	***ASD***	***Diagnostic Test (Non-Imaging)***	*By March 2022, No patient waits longer than 26 weeks.*	**10,679**		*0*	**7,440**	Non-Imaging - At the end of March 2022, 50.9% of patients were waiting longer than 26 weeks (7,440 out of 14,597). Of those currently waiting longer than 26 weeks, 80.3% (5,978) are within Cardiology. The longest wait is 197 weeks in Cardiology (DSE). *Note information reported against the 9 week target.*
Elective	***ASD***	***Diagnostic Test (Endoscopy)***	*By March 2022, No patient waits longer than 26 weeks.*	**3,296**		*0*	**3,421**	Endoscopy - At the end of February 2022 (most recent data), 63.9% of patients were waiting longer than 26 weeks (3,421 out of 5,352). The longest wait is 357 weeks. In addition to these waits, there is a volume of repeat procedures which are beyond their clinically indicated timescale for review. *Note information reported against the 9 week target. Data for Planned Backlog (Endoscopy) is referenced in Row 61.*
Elective	**ASD**	**Inpatient/Day Case Treatment**	By March 2022, 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment	**12.8%**		55%	**14.2%**	At the end of March 2022 only 13.6% of patients were waiting no longer than (less than) 13 weeks (2,362 out of 17,431). The majority of patients waiting longer than 13 weeks are within Orthopaedics (4,056). Reduced theatre capacity associated with the Covid-19 response had seen capacity significantly reduced and was insufficient to meet red flag and urgent demand. Thus impacting on patients' journey time on the cancer pathways. As at 25 April 2022, 118 red flag suspect or confirmed cancer patients had their initial admission cancelled between 1 February 2022 and 25 April 2022, with 15 still to be rebooked. The Trust continues to access limited theatre capacity in the Independent Sector, as allocated to the Trust, and in available core capacity, based on the Regional process for equalisation of access for the most urgent patients. The Trust also continues to participate in Regional waiting list validation exercise, co-ordinated by HSCB. Access to services remains a key corporate risk.
Elective	**ASD**	**Inpatient/Day Case Treatment**	By March 2022, no patient waits longer than 52 weeks.	**9,880**		0	**10,724**	At the end of March 2022, 61.5% (10,724) patients were waiting longer than 52 weeks. The main specialties (volumes and % of total waits) are: * Orthopaedics 3,307 patients - 31%; * General Surgery 2,455 - 23%; * ENT 1,492 - 14%; and * Urology 1,263 - 12%. The longest waiter is currently 399 weeks (circa 7.5 years) within Urology. Recurrent investment for capacity gaps along with non-recurrent backlog clearance is required to see improvement against this objective. *Note information reported against the 13 week target.*

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Elective	**ASD**	**Out-Patient Appointment**	By March 2022, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment	**14.6%**		50%	**16.2%**	At the end of March 2022, 17.4% (11,717 out of 67,277) of patients were waiting no longer than 9-weeks for an outpatient appointment. With the ongoing impact of Covid-19, core and additional capacity continues to be directed to red flag/urgent referrals in the first instance with limited capacity for routine waits. Accommodation continues to be key a constraint to further increase face to face clinic activity across all professions. The Trust continues to seek to maintain its virtual capacity and will be taking part in a Regional waiting list validation exercise, co-ordinated by HSCB. Access to services remains a key corporate risk.
Elective	**ASD**	**Out-Patient Appointment**	By March 2022, no patient waits longer than 52 weeks.	**31,276**		0	**33,891**	At the end of March 2022, 50.4% (33,891) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 321 weeks. A parallel process of recurrent investment for recognised capacity gaps and non-recurrent backlog clearance is required to demonstrate sustainable improvement. *Note information reported against the 9 week target.*
Elective	**ASD CYPS OPPC**	**Service Delivery Plans - Out-Patients**	NON-OGI Projected delivery of out-patient activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**108%**	The Service Delivery Plan projections for out-patients include both new and review activity; and face to face and virtual activity. For March 2022 the projected total level of activity was 16,810 with actual activity at 18,143. Therefore, overperformance of 8% (+1,333) is noted. Out-patient activity continues to demonstrate variability subject to workforce.
Elective	**ASD CYPS**	**Service Delivery Plans - In-Patients**	NON-OGI Projected delivery of in-patient activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**117%**	The Service Delivery Plan projections for in-patients include elective in-patients and non-elective Trauma as this non-elective specialty uses the core elective theatre capacity. For March 2022 the projected level of activity was 267, with actual activity of 313 Therefore, an overperformance of +17 % (+46). Regular monitoring, and consideration of prioritisation of the available elective capacity, is in place via the Regional Prioritisation Oversight Group (RPOG).
Elective	**ASD CYPS**	**Service Delivery Plans - Day Cases**	NON-OGI Projected delivery of day case activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**149%**	The Service Delivery Plan projections for day cases include theatre and non-theatre based day cases, along with regular attenders for Chemotherapy. For March 2022 the projected level of activity was 1,590, with actual activity of 2,376. Therefore, an overperformance of +49% (+786). Performance against the day case projections is, like in-patients, variable due to the casemix of the theatre and non-theatre cases to be undertaken.
Elective	**ASD**	**Service Delivery Plans - Cancer**	NON-OGI Projected performance against the: 14-day Suspect Breast Cancer; 31-Day Cancer Pathway; and 62-Day Cancer Pathways as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**March Performance 45% 84% 51%**	The Service Delivery Plan projections for Cancer performance includes the 14-Day Suspect Breast Cancer; 31-Day Cancer Pathway; and 62-Day Cancer Pathway. Performance against these areas is based on those patients that have completed their pathways i.e. have been assessed and/or their first definitive treatment undertaken. For March 2022 the projected level of performance for these three areas was 15%; 84%; and 50% respectively. Actual performance was 14%; 89%; and 57%. Therefore 31 Day and 62 Day overperformed against projections. Performance against these cancer areas continues to demonstrate variability subject to workforce and infrastructure eg. diagnostic tests; theatre capacity.
Elective	**ASD**	**Service Delivery Plans - Diagnostics (Imaging and Physiological Measurement)**	NON-OGI Projected delivery of diagnostic activity: CT; MRI; and NOUS; and Echo as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**106% 122%**	The Service Delivery Plan projections for diagnostics include three key Imaging areas (CT; MRI; and NOUS) and one key physiological measurement area (Echo including TTEs; DSEs; TOEs). For March 2022 the projected level of activity was 7,350 (Imaging) and 815 (Physiological Measurement), with actual activity of 7,808 and 993 respectively. Therefore, overperformance of +6% (+458) and +22% (+178) respectively.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Elective	**ASD CYPS MHD OPPC**	**Service Delivery Plans - Allied Health Professions**	NON-OGI Projected delivery of AHP activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**103%**	The Service Delivery Plan projections for AHPs include: Dietetics; Occupational Therapy; Orthoptics; Physiotherapy; Podiatry; and Speech & Language Therapy. For March 2022 the projected level of activity was 13,782 attendances, with actual activity of 14,158. Therefore, overrperformance of +3%(+376). Whilst collectively the AHP performance is strong, four out of the six professions (Physio, OT, SLT & Podiatry), are significantly challenged with vacancies and staff absences associated with either Covid or self-isolation requirements for close contact. Vacancies and absences were unknown at the time the projections were completed. In general AHP service delivery continues to be impacted by workforce challenges and clinic facilities.
Elective	**CYPS MHD**	**Service Delivery Plans - Mental Health**	NON-OGI Projected delivery of Mental activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**105%**	The Service Delivery Plan projections for Mental Health include: Adult Mental Health; CAMHS; Dementia; Psychological Therapies; and Autism Adults & Children. For March 2022 the projected level of activity was 10,174 attendances, with actual activity of 10,687. Therefore, overperformance of +5% (+513). Performance against these plans remains variable associated with workforce challenges; demand; and higher than anticipated CNA/DNA rates.
Elective	**MHD OPPC**	**Service Delivery Plans - Day Centres**	NON-OGI Projected delivery of Day Centre attendances as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**135%**	For March 2022 the projected level of activity was 3,352 attendances, with actual activity of 4,514–an over performance of +35% (+1,162). Statutory Day Care remains below pre covid levels collectively reflecting 69% of the baseline activity with incremental increase month on month reflective of social distance challenges, covid concerns, self-isolation and testing requirements. Trust are continuing to work to improve daycare provision in line with daycare re-mobilisation pathway plan for adult social care services.
Elective	**MHD OPPC**	**Service Delivery Plans - Day Opportunities**	NON-OGI Projected delivery of Day Opportunities attendances as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**58%**	The Service Delivery Plans for Day Opportunites include; Learning Disability and Physical Disability. For March 2022, the projected level of activity was 1,945 with actual activity of 1,119 (-42%). Performance continues to be impacted by a higher level of offers and a lower level of uptake.
Elective	**CYPS**	**Service Delivery Plans - Health Visiting**	NON-OGI Projected delivery of Health Visiting contacts as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**170%**	Health Visiting Activity reporting for Health Visiting operates on a delay. October - December (Q3) performance is available. Projected level of activity was 12,900 with actual delivery of 21,960 therefore over performance of +70% (+9,060). Activity reports are under review and information is subject to amendment therefore this figure may change.
Elective	**CYPS**	**Service Delivery Plans - Community Paediatrics**	NON-OGI Projected delivery of Community Paediatric out-patient activity (excluded from Out-Patient activity above) as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**96.0%**	The Service Delivery Plan projections for Community Paediatric out-patients include both new and review activity; and face to face and virtual activity. For March 2022 the projected total level of activity was 463, with actual activity at 444. Therefore, an underperformance of -4%(-19) is noted. Overall activity has been impacted by unexpected sick leave and increased annual leave; Covid related absences; and cover of the Consultant of the Week rota.
Elective	**CYPS**	**Service Delivery Plans - Community Dental**	NON-OGI Projected delivery of Community Dental out-patient activity as part of corporate service delivery planning (rebuild process)	**NON-OGI**		**NON-OGI**	**107%**	The Service Delivery Plan projections for Community Dental are for their out-patient clinic based assessments and treatments. For March 2022 the projected total level of activity was 525, with actual activity 561, therfore overperformance of +7% (+36).
Optimisation of Resources	**ASD**	**Out-Patients Registrations**	The volumes of patients with open PAS outpatients registrations and no appointments	**13,215**		*Non OGI*	**11,481**	A data validation exercise is ongoing across all Trusts in respect of patients who have a referral noted on the Hospital Patient Administration System, and have no active outpatient appointment noted. Whilst some referrals can be routinely 'closed' on-going volumes will require further individual review to eliminate risk. The total number of open OP registrations as at 20 April 2022 is 11,481.
Health and Wellbeing- Children's	**ASD**	**Breastfeeding (at Discharge)**	By March 2022, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge as recorded in the Child Health System (CHS). This is an important element in the delivery of the "Breastfeeding Strategy" objectives for achievement by March 2025.	**51.4%**		>52%	**52.0%**	Cumulative performance at the end of March 2022 demonstrates 52% of children breastfeeding upon discharge (from birth). The service endeavours to maintain current breastfeeding rates.

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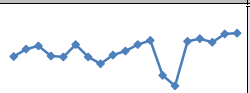
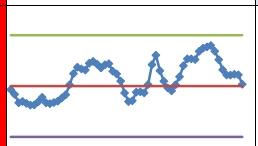
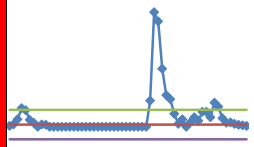
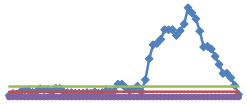
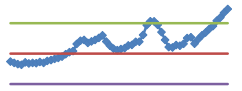
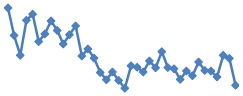
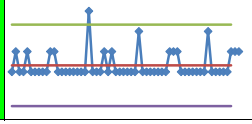
Health and Wellbeing- Children's	**CYP/ASD**	**Breastfeeding (at 6 months)**	By March 2022, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the "Breastfeeding Strategy" objectives for achievement by March 2025.	**15.0%**		>15%	**20.5%**	Performance during Q3 of 2021/2022 (most recent data)demonstrates 21.2% of children at the 6-9 month review were being totally or partially breast fed. Virtual Breastfeeding Support groups have been implemented in conjunction with Sure Start as a response to the cessation of face to face groups due to Covid 19.
Mental Health	**MHD**	**Adult Mental Health Service**	By March 2022, no patient waits longer than 9 weeks to access adult mental health services.	**788**		0	**392**	At the end of March 2022, 392 out of 1,465 (26.8%) patients were waiting longer than 9 weeks. Primary Mental Health Care waits account for 82% (322 out of 392) waits over 9-weeks and access times continue to be in excess of pre-Covid levels. The longest wait was 32 weeks. Work with the East London Foundation Trust (ELFT) continues to to undertake combined service additionality along with waiting list validation and service improvement measures. This has had a positive imapct on performance. Whilst a number of staff vacancies have been filled, vacancies remain and these continue to impact on the service. Access to services remains a key corporate risk.
Mental Health	**CYPS**	**Child and Adolescent Mental Health Services**	By March 2022, no patient waits longer than nine weeks to access child and adolescent mental health services.	**12**		0	**2**	As at March 2022, 0.7% (2 out of 282) patients were waiting longer than 9 weeks. This is the lowest level of excess waits since December 2020. The longest wait is 10 weeks (achieving the 9-week target in-month). Virtual consultations via telephone/video platform continue for both new and review patients. Face to face appointments continue to be constrained by clinic space and infection control measures associated with Covid-19. The ADHD team (non-target area) has 121 patients waiting more than 9 weeks and the longest wait is 42 weeks.
Mental Health	**MHD**	**Dementia**	By March 2022, no patient waits longer than 9 weeks to access dementia services.	**366**		0	**4**	As at the end of March 2022, 1.8% (4 out of 218) of patients were waiting longer than 9-weeks. This is the lowest level of excess waits since April 2017. The longest wait is 10 weeks (achieving the 9-week target in-month). The growth in waits, in excess of 9-weeks, was as a direct consequence of the management response to Covid-19 during which time only urgent referrals were seen. Capacity for routine referrals continues with improvement in the volumes of waits in excess of 9-weeks evident.
Mental Health	**MHD**	**Psychological Therapies**	By March 2022, no patient waits longer than 13 weeks to access psychological therapies (at any age).	**241**		0	**577**	At the end of March 2022, 577 out of 837 (68.9%) patients were waiting longer than 13-weeks. The longest wait is 102 weeks. The Psychological Therapies service continues to be impacted by long-term vacancies with the service which is further impacted by a regional staff shortage. Access to services remains a key corporate risk.
Optimisation of Resources	**ASD**	**Hospital Cancelled Outpatient Appointments (%)**	By March 2022, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	**67.5%**		**-5%**	**-21.00%**	Cumulatively, at the end of February 2022 (most recent data) there were 5,695 cancelled outpatient appointments, compared to 7,453 in the same period of 2020/2021 and 8,736 in 2019/2020. Outpatient cancellations have been impacted by the response to Covid-19 with limitations on the availability of clinical facilities and face to face contacts which required scheduled appointments to be cancelled. Out-patient activity continues via a mix of virtual and face to face clinics.
Optimisation of Resources	**ASD**	**Hospital Cancelled Outpatient Appointments (Number)**	By March 2022, seek a reduction of 5% of the number of cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.	**7,859**		**7466 (622 per month)**	**5,695**	The number of cancelled outpatient appointments which resulted in the patient waiting longer in February 2022 was 560. *Note narrative above.*
Optimisation of Resources	**ASD**	**Service and Budget Agreement (Day Cases)**	By March 2022, reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Day Cases)**	**-56.0%**		**>7%**	**Not available**	**Daycases - 2021/2022 Performance will be presented in the Year-End Performance Scorecard.**

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Optimisation of Resources	**ASD**	**Service and Budget Agreement (Elective In-Patients)**	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Elective In-Patients)**	**-80.0%**		**>-45%**	**Not available**	**Inpatients - 2021/2022 Performance will be presented in the Year-End Performance Scorecard.**
Optimisation of Resources	**ASD**	**Service and Budget Agreement (New Out-patients)**	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(New Out-Patients)**	**-74.0%**		**>-19%**	**Not available**	**New Outpatients - 2021/2022 Performance will be presented in the Year-End Performance Scorecard.**
Optimisation of Resources	**ASD**	**Service and Budget Agreement (Review Out-Patients)**	By March 2022, to reduce the percentage of funded activity associated with elective care service that remains undelivered. **(Review Out-Patients)**	**-51.0%**		**>-18%**	**Not available**	**Review Outpatients - 2021/2022 Performance will be presented in the Year-End Performance Scorecard.**
Safe Systems of Care	**Medical**	**Antibiotic Consumption**	At least 55% of antibiotic consumptions should be antibiotics from the WHO access aware category OR an increase of 2% of antibiotics from WHO access aware category as a proportion of all antibiotic use. By March 2021 reducing total antibiotic prescribing by 15%.	**58.3%**		55% or above	**58.8%**	At the end of February 2022 (most recent data), the cumulative antibiotic consumption from the WHO Access Aware category was above the 55% target (58.8%). (There are no monthly figures available for June - February).
Safe Systems of Care	**Medical**	**Antibiotic Use (Total)**	A reduction in total antibiotic prescribing(DDD per 1000 admissions) of 1-2%	**8787**		8,611 - 8,699 DDD/1000 admissions	**9,144**	At the end of February 2022 (most recent data), the cumulative total antibiotic use, DDD per 1000 admissions, was above target at 9144. (There are no monthly figures available for June - February). *PHA figures, measured in Defined Daily Doses (DDD) per 1000 admissions, are reported.*
Safe Systems of Care	**Medical**	**Antibiotic Prescribing (Carbapenem)**	A reduction in **carbapenem** use of 3% measured in DDD per 1000 admissions	**65**		63 DDD/1000 admissions	**74**	At the end of February 2022 (most recent data), the cumulative use of carbapenem is above target at 74 DDD/1000 admissions. (There are no monthly figures available for June - February). *PHA figures, measured in DDD per 1000 admissions, are reported .*
Safe Systems of Care	**Medical**	**Antibiotic Prescribing (Piperacillin -Tazobactam)**	A reduction in **piperacillin-tazobactam** use of 3%, measured in DDD per 1000 admissions.	**365**		354 DDD/1000 admissions	**386**	At the end of February 2022 (most recent data), the cumulative use of piperacillin-tazobactam is above target at 384 DDD/1000 admissions. (There are no monthly figures for June - February). *PHA figures, measured in DDD per 1000 admissions, are reported.*
Safe Systems of Care	**OPPC**	**GP Appointments**	By March 2022, to increase the number of available appointments in GP practices compared to 2018/2019	**12,558**		12558	**5,696**	This GP Practice is no longer under the management of the Trust and therefore the Trust is no longer required to report on this. As at the end of August 2021 there had been 5,696 appointments.
Safe Systems of Care	**Medical**	**Healthcare Acquired Infections: Gram-Negative Bloodstream Infections**	By 31 March 2022 secure an aggregate reduction of 17% of Escherichia coli, Klebsiella spp. And Pseudomonas aeruginosa bloodstream infections acquired after two days of hospital admission, compared to 2018/2019.	**59**		56 (<5 per month)	**72**	Healthcare associated Gram-Negative Bloodstream infections on or after 2 days of hospital admission, as per PHA, are reported. In February 2022 (most recent data) there were 7 reported cases, giving a total of 72 year to date, which is above the apportioned target of 51.
Safe Systems of Care	**Medical**	**Healthcare Acquired Infections: MRSA**	In the year to March 2022 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection compared to 2018/2019.	**3**		3	**5**	In March 2022 there was 1 case of MRSA within SHSCT and a total of 5 cases this year to date which is in excess of the target level.

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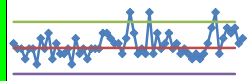
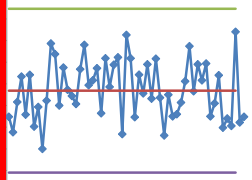
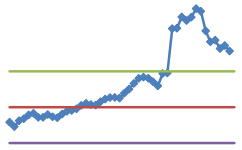
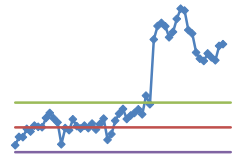
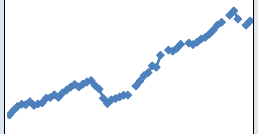
Safe Systems of Care	**Medical**	**Healthcare Acquired Infections: Clostridium Difficile**	In the year to March 2022 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over compared to 2018/2019.	**50**		49 (<4 per month)	**72**	In March 2022 there were 6 cases of C Difficile within the Trust and a total of 72 cases this year to date which is in excess of the target level.
Safe Systems of Care	**ASD**	**Ischaemic Stroke**	By March 2022, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	**14.1%**		16%	**12.4%**	Cumulative performance for the period (January 2021 - December 2021) is 12.4%. The in-month performance at December 2021 was 7.4%. Monthly performance illustrated in the trending graph is impacted by the variable presentation of strokes and clinical decisions which consider risks and benefits of administrations of thrombolysis. Wider qualitative indicators continue to be monitored and an action plan is in place to improve SSNAP indicator performance. Stroke reporting operates on a delay and operational observations indicate that there has been a recent downturn in performance associated with a number of factors affecting patients reaching hospital and progressing through the pathway within required timeframes.
Safe Systems of Care	**ASD CYPS OPPC**	**Out- Patients Review Backlog (Acute inc. Paediatrics & ICATS)**	**NON-OGI** The number of patients waiting in excess of their clinically required timescale for outpatients review. (Consultant led review only)	**43,089**		**NON-OGI**	**34,418**	At the end of February 2022 (most recent available) there were 34,418 patients waiting beyond their clinically indicated timescale for review. If 37 of the longest waiting patients (out of the 34,418 patients) were seen it would reduce the longest waiting backlog patient from 2013/2014 to 2017/2018. The ability to increase face to face clinical activity continues to be impacted by the availability of clinical accommodation. The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Endocrinology, General Surgery and Rheumatology. Access to services remains a key corporate risk.
Safe Systems of Care	**MHD**	**Out-Patients Review Backlog Consultant Led Memory Service**	**NON-OGI** The number of patients waiting in excess of their clinically required timescale for out-patient review. (Consulted led review only)	**1,086**		**NON-OGI**		Note: This waiting list has now moved to PARIS. See composite information detailed below in Row 59.
Safe Systems of Care	**MHD**	**Out-Patients Review Backlog MDT (PARIS)**	**NON-OGI** The number of patients who are currently on a recall list on PARIS (MDT).	**1,066**		**NON-OGI**	**1,758**	*Please note this is a new data source and historic data is not available.* At the end of March 2022 there were 1,758 patients on the MDT OP Review Backlog report on PARIS. This is inclusive of Consultant-Led and MDT-Led activity.
Safe Systems of Care	**ASD CYPS OPPC**	**Inpatient/Day Case Treatment Planned Backlog (Excluding Endoscopy)**	**NON-OGI** The number of patients waiting in excess of their clinically required timescale for inpatient/day case review	**1,446**		**NON-OGI**	**1,165**	At the end of March 2022, there were 1,165 patients waiting beyond their clinically indicated timescale for repeat procedure. If the longest waiting 30 patients (out of 1,165) were seen it would reduce the longest waiting backlog patient from 2017/2018 to 2019/2020. The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology). The planned repeat backlog remains under focus, however, opportunities to target waiters is challenged due to capacity issues and has been further impacted by the Covid-19 response. Available elective capacity continues to be directed to red flag / urgent surgeries in the first instance and the Trust is participating in regional schemes to utilise available IS capacity. Access to services remains a key corporate risk.
Safe Systems of Care	**ASD**	**Inpatient/Day Case Treatment Planned Backlog (Endoscopy)**	**NON-OGI** The number of patients waiting in excess of their clinically required timescale for inpatient/day case review (Endoscopy only).	**3,128**		**NON-OGI**	**3,598**	At the end of March 2022, there were 3,598 patients waiting beyond their clinically indicated timescale for planned repeat Endoscopy. This figure represents an increase of +1567 (+77.2%) since December 2019. The longest wait is from February 2018. As patients on the planned repeat waiting list require surveillance of their condition, QFIT testing is not utilised. Endoscopy sessions and wait times have been impacted by the Covid-19 response. The previous Regional IS capacity, that the Trust utilised, has now ceased. Access to services remains a key corporate risk.

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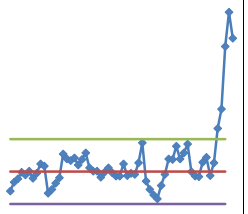
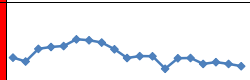
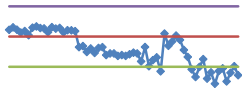
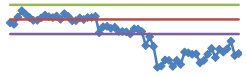
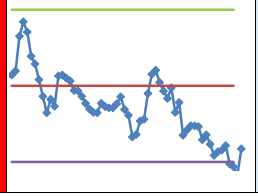
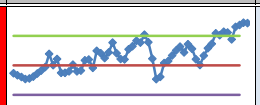
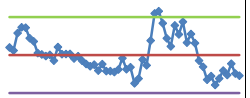
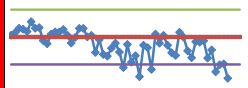
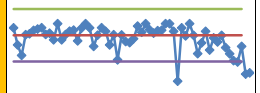
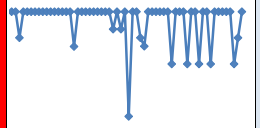
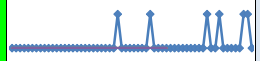
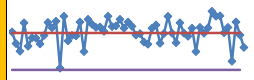
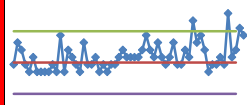
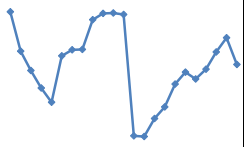
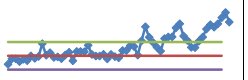
Safe Systems of Care	**CYPS**	**Family & Children's Social Care Cases**	By March 2022, reduce the number of unallocated family and children's social care cases by 20%.	**120**		96	**311**	At the end of March 2022 there were 311 unallocated child care cases waiting in excess of 20 days. 182 cases are waiting in excess of 40-days and 117 in excess of 60 days. The longest wait is in the Family Support Team (241 days). There were no Child Protection cases unallocated. Child Protection referrals are prioritised over family support referrals and are much more complex and resource demanding. Growth in unallocated cases is impacted by significant staffing pressures with the Gateway team operating at 50% capacity and the Family Intervention team operating between 40-70% capacity. A number of measures implemented to recruit additional staff have not seen a sufficient improvement given the deficit in social work posts. Staffing pressures are reflected Regionally and have been escalated to HSCB and DoH. *For further information see the Unallocated Cases Report .*
Safe Systems of Care	**CYPS**	**Family & Children's Social Care Cases**	Number of Looked after Children (LAC) cases.	**NON-OGI**		**NON-OGI**	**587**	At the end of February 2022 the number of Looked after Children (full time) was 587.
Safe Systems of Care	**CYPS**	**Family & Children's Social Care Cases**	Number on Child Protection Register (CPR).	**NON-OGI**		**NON-OGI**	**591**	At the end of March 2022 the number on the Child Protection Register (CPR) was 591.
Support for Patient and Client	**OPPC**	**Carers' Assessments (%)**	By March 2022, secure a 10% increase (based on 2019/2020 figures) in the number of carer's assessments offered to carers for all service users.	**-30.4%**		10%	**-16.6%**	At the end of Q3 2021/2022 (most recent data), 1597 Carers' Assessments had been offered. This is -317 below the objective level for 2021/2022 and reflects an underperformance of -16.6%. Covid-19 has negatively impacted on the number of offers made. Carer's assessments continue to be offered as required with telephone contacts and face to face offers made to client groups with urgent need.
Support for Patient and Client	**OPPC**	**Carers' Assessments (Number)**	By March 2022, secure a 10% increase (based on 2019/2020 figures) in the number of carer's assessments offered to carers for all service users.	**2318**		2550 (638 per quarter)	**1597**	At the end of Q3 2021/2022 (most recent data), 1597 assessments had been offered which is below the target of 1914 (579 in Q1, 538 in Q2 and 480 in Q3).
Support for Patient and Client	**OPPC**	**Outstanding Domiciliary Care Packages**	Number of outstanding domiciliary care packages.	**NON-OGI**		**NON-OGI**	**588**	At of 31 March 2022 there were 588 outstanding domicilary care packages. *This information is a snapshot taken from weekly reports.*
Support for Patient and Client	**OPPC**	**Review of Care Packages**	Commissioned Packages - % of reviews within 1 year.	**NON-OGI**		**NON-OGI**	**62.9%**	At the end of March 2022, 62.9% of reviews had taken place within 1 year and 37.1% (2155 ot of 5806) were in excess of 1 year.
Support for Patient and Client	**OPPC**	**Review of Care Packages**	Domiciliary Care Packages - % of reviews within 1 year.	**NON-OGI**		**NON-OGI**	**62.2%**	At the end of March 2022, 65.2% of reviews had taken place within 1 year and 34.8% (1509 out of 4338) were in excess of 1 year.
Support for Patient and Client	**OPPC**	**Review of Care Packages**	Nursing Home Packages - % of reviews within 1 year.	**NON-OGI**		**NON-OGI**	**56.0%**	At the end of March 2022, 56% of reviews had taken place within 1 year and 44% (507 out of 1151) were in excess of 1 year.
Support for Patient and Client	**OPPC**	**Review of Care Packages**	Residential Home Packages - % of reviews within 1 year.	**NON-OGI**		**NON-OGI**	**56.2%**	At the end of March 2022, 56.2% of reviews had taken place within 1 year and 43.8% (139 out of 317) were in excess of 1 year.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Support for Patient and Client	**OPPC**	**Community Based Short Break (%)**	By March 2022, secure a 5% increase (based on 2019/2020 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	**-1.3%**		5%	**16.4%**	Cumulative performance at the end of Q3 2021/2022 (most recent data) demonstrates an increase of +16.4% in the number of community based short break hours provided, which is above the apportioned target.
Support for Patient and Client	**OPPC**	**Community Based Short Break (Hours)**	By March 2022, secure a 5% increase (based on 2019/2020 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	**531,592**		558,172 (139,543 per quarter)	**464,242**	At the end of Q3 2021/2022 (most recent data), 464,242 community based short break hours have been provided. Within the Trust a further 274,152 hours of adult short break hours were provided in Residential and Nursing Homes which are not included in this reporting.
Support for Patient and Client	**MHD**	**Direct Payments**	By March 2022, secure a 10% increase in the number of direct payments to all service users.	**14.6% increase (1043)**		10% increase on 1043 = 1147	**2.2% increase (1066)**	In Q4 2021/2022 there were 1,066 service users in receipt of direct payments. Whilst this is a 2.2% increase on the baseline, of 1043, however, it is below the target increase of 10%. The Trust has implemented Emergency Self-Directed Support within Acute Services to facilitate timely patient discharges. This is available for those patients assessed as needing support post discharge to access a personal budget to manage their needs. There have been challenges for patients finding carers and taking on employment responsibilities.
Support for Patient and Client	**CYPS**	**Young Carers Short Break**	By March 2022, secure a 5% increase in the number of young carers attending day or overnight short break activities	**198**		5% increase on 198 cumulative total = 208	**196 (-5.8%)**	The number of young carers receiving short breaks in 2021/2022 is 196. The contract to assess and support young carers in the Southern Trust is with Action for Children. Covid-19 has impacted how the service is provided with a reduction in physical outings and an increase in virtual activities. A plan is ongoing to implement face to face contact with young carers. In order to meet social distancing requirements there has been a move from large group activities with risk assessed small group sessions offered more regularly.
Unscheduled Care	**ASD**	**Acute Hospital Discharges (48 hours)**	By March 2022, ensure 90% of complex discharges from an acute hospital take place within 48-hours.	**70.0%**		90%	**39.1%**	In March 2022, 47.1% of patients (57 out of 121) were discharged within 48 hours, in comparison to 42.9% (24 out of 56) in March 2021. Work continues to ensure all discharges are captured and recorded correctly and improvements in this area remain a key focus for the Trust. The Trust, through Workstream 5 of the Urgent and Emergency working groups (under No More Silos) is focusing on patient flow which incorporates complex discharge.
Unscheduled Care	**ASD**	**Acute Hospital Discharges (7 days)**	By March 2022, ensure no complex discharge takes more than 7-days.	**98**		0	**305**	In March 2022, 27.3% of patients (33 out of 121) were discharged in excess of 7-days in comparison to 17.85% (10 out of 56) patients in March 2021.
Unscheduled Care	**ASD**	**Acute Hospital Discharges (6 Hours)**	By March 2022, ensure all non-complex discharges from an acute hospital, take place within six hours.	**84.5%**		100%	**85.6%**	In March 2022, 85.5% of patient (2015 out of 2357) were discharged within 6 hours, in comparison to 86% (2213 out of 2572) in March 2021. An analysis of performance of non-complex discharges has been undertaken through Workstream 5 - Discharge and Patient Flow ('No More Silos') and showed an opportunity for improvement in this area. Service improvement projects are currently being undertaken at ward level to increase non complex discharges before 12noon.
Unscheduled Care	**ASD**	**Emergency Department (4-hour)**	By March 2022, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department;	**66.7%**		95%	**55.3%**	In March 2022, 55.4% of patients were treated and discharged/admitted within 4-hours. Whilst the 4-hour % performance is decreased in comparison to March 2021, the actual number of attendances seen within 4-hours is increased to 7,487 in March 2022 versus 6,390 in March 2021. In addition total attendances in March 2022 were increased, 13,511, in comparison to 10,471 in March 2021. However, attendances have not yet returned to pre-Pandemic levels. Performance continues to be impacted by insufficient bed capacity, which causes overcrowding in the ED, therefore reducing cubicle capacity to see patients. The Trust, through Workstreams 2, 3 and 5 of the Urgent and Emergency working groups (under No More Silos) focuses on the Emergency Department, Ambulatory Pathways and Patient Flow.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Unscheduled Care	**ASD**	**Emergency Department (12-hour)**	By March 2022, no patient attending any emergency department should wait longer than 12 hours.			0	**17562**	In March 2022, 1838 patients waited more than 12 hours in the ED. This equated to 13.6% of the total attendances, in comparison to 489 (4.7%) in March 2021. The waits in excess of 12 hours, as a % of the site attendances, for CAH is 20.3% (1387 out of 6824) and DHH 9.6% (451 out of 4710). There were no waits in excess of 12 hours in STH. *Note information reported against the 4-hour target.*
Unscheduled Care	**ASD**	**Emergency Department (Triage to Treatment)**	By March 2022, at least 80% of patients to have commenced treatment, following triage, within 2 hours.			80%	**67.8%**	During February 2022 (most recent data), 65.1% of patients commenced treatment within 2 hours of triage compared to 81.2% in February 2021 and 71.9% in February 2020.
						95%	**59.5%**	In March 2022, only 32.1% of acute/urgent calls were triaged within 20 minutes. This is the lowest level of performance demonstrated since recording began. The service continues to be challenged to secure GP cover with March 2022 having only 51% of available GP hours filled.
Unscheduled Care	**ASD**	**Hip Fractures**	By March 2022, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	**89.5%**		95%	**77.1%**	In March 2022, 60.5% of patients (26 out of 43) were treated within 48 hours against a Regional position of 74%. The cumulative performance to date is 77%, against a Regional position of 78%. The SHSCT performance has decreased from 94% in April to 60% in March. The volume of NOF fractures has remained relatively static in 2021/2022 in comparison to the same period in 2020/2021. However, the volume of non-NOF fractures has demonstrated an increase of 9.5% (+74). Performance against the NOF target can be impacted by more clinically urgent non-NOF fractures or by the complexity of some of the NOF fractures.
Unscheduled Care	**MHD**	**Learning Disability Discharges**	During 2021/2022, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge	**89.5%**		99%	**81.0%**	In March 2022, 100% of patients (2 out of 2) were discharged within 7 days of the patient being assessed as medically fit for discharge. Patients will remain within inpatient accommodation pending the sourcing of suitable accommodation options. Information provided is on discharges completed. At 31 March 2022 there were 3 patients, identified for discharge, but who remain as an in-patient associated with availability of appropriate accommodation.
Unscheduled Care	**MHD**	**Learning Disability Discharges**	During 2021/2022 ensure no discharge taking more than 28 days.	**0**		0	**4**	In March 2022, of the 2 patients discharged, none of these waited in excess of 28 days. *Note information reported against the 7 day target.*
Unscheduled Care	**MHD**	**Mental Health Discharges**	During 2021/2022, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge.	**94.4%**		99%	**95.0%**	In March 2022, 92.2% of patients (71 out of 77) were discharged within 7-days. Focus continues on the MH complex discharge meeting with performance remaning variable due to the challenges of securing appropriate accommodation. At 31 March 2022 there were 16 patients, identified for discharge, but who remain as an in-patient associated with lack of packages of care available in the community and the difficulty in securing suitable nursing home / residential placements.
Unscheduled Care	**MHD**	**Mental Health Discharges**	During 2021/2022 ensure no discharge taking more than 28 days.	**33**		0	**37**	In March 2022, of the 77 patients discharged, 5 patients waited in excess of 28 days. *Note information reported against the 7 day target.*
Workforce	**HROD**	**Seasonal Flu Vaccine**	By December 2022, to ensure at least 75% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.	**47.0%**		75%	**37.0%**	As at 27th April 2022, 37% of all staff have been vaccinated (4362). This includes 36% of frontline staff (3621) and 43% of non frontline staff (741). The Flu Vaccination Programme ended on 31 March 2022.

Themes	Directorate	Title	OGI (2019/2020 OGIs continued for 2021/2022)	Cumulative 2020/2021 Performance	Trend Graph	OGI (2021/2022) Recalculated from 2019/2020 Cumulative Performance	Cumulative 2021/2022 Performance	Narrative
Workforce	**HROD**	**Seasonal Flu Vaccine**	Trust frontline Health Care Workers	**51.0%**		75.0%	**40.0%**	As at 27th April 2022, 40% of all Frontline HCW have been vaccinated (2871). The Flu Vaccination Programme ended on 31 March 2022.
Workforce	**HROD**	**Seasonal Flu Vaccine**	Trust frontline Social Care Workers	**37.0%**		75.0%	**26.0%**	As at 27th April 2022, 26% of all Frontline SCW have been vaccinated (750). The Flu Vaccination Programme ended on 31 March 2022.
Workforce	**HROD**	**Staff Sick Absence**	By March 2022, to reduce Trust staff sick absence levels by 3.5% compared to the 2019/2020 figure.	**53.2%**		-3.50%	**10.0%**	In February 2022 (most recent data) the cumulative absence rate was in excess of the baseline, by 11.3%, in comparison to the same period in 2020/2021. However, in comparison to the same period in 2019/2020 performance is in excess, by 52.2%. The monthly % hours lost for February were 8.9%. This data includes those with Covid-19 related sickness but excludes absences when staff were self-isolating. The Attendance Management Team continues to support Directorates in reducing their sickness absence levels and whilst Attendance Management Panels have been paused, sickness absence meetings (3, 6 and 9-months), led by HROD continue virtually.
Workforce	**HROD**	**Staff Sick Absence**	By March 2022, to reduce Trust staff sick absence levels by a Regional average of 5% (SHSCT reduction is 3.5%) compared to the 2019/2020 figure.	**1,296,444**		1,251,068 (< 104,255 per month)	**1,322,755**	In February 2022 the hours lost due to absence was 133,951 (8.9%). Absence hours includes those off sick with Covid but not those self isolating. *Note information reported above.*
Workforce	**HROD**	**Annual Appraisal (Medical Staff)**	Improve take up in annual appraisal of performance during 2021/2022 by 5% on previous year towards meeting existing targets - 95% of medical staff.	**2018 97% 2019 70%**		5% Increase	**2019 = 94.7% 2020 = 79.4% 2021 = 1.2%**	Medical staff - The Trust will seek to sustain and improve the current appraisal rate. As at 23 March 2022, 94.7% of 2019's appraisals have been completed; with a further 2.2% in progress. In respect of 2020 appraisals there has been 79.4% completed to date and a further 8.5% in progress and for 2021 1.2% completed and 2.5% in progress.
Workforce	**HROD**	**Annual Appraisal (Other Staff)**	Improve take up in annual appraisal of performance during 2021/2022 by 5% on previous year towards meeting existing targets - 80% of other staff.	**39% 4,488 out of 11,626**		5% Increase (4,712)	**7.8% decrease 4,137 out of 11,797**	AfC staff - For the period 1 July 2020 to 31 December 2021 35% of AFC staff (4,137) have completed their annual appraisal. This demonstrates, in percentage terms a decrease of 4% from September 2021. In numerical terms it demonstrates a 7.8% decrease in the number of PDP's completed, with 4,137 out of 11,797,compared with 4,529 out of 11,763 in September 2021, 4,573 out of 11,696 in June 2021 and 4,488 out of 11,626 in March 2021.

Southern Health and Social Care Trust

Quality care – for you, with you

SMT COVER SHEET

Meeting/Date	Performance Committee Thursday, 19 May 2022	
Accountable Director	Lesley Leeman Interim Director of Performance and Reform	
Title	Corporate CPD Performance Scorecard (March 2022 Performance)	
Report Author	Name	Lynn Lappin
	Contact details	Personal Information redacted by the USI Personal Information redacted by the USI
This paper is presented for: *Approval*		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	√	Supporting people to live long, healthy active lives
	√	Improving our services
	√	Making best use of our resources
	√	Being a great place to work – supporting, developing and valuing our staff
	√	Working in partnership

This report cover sheet has been prepared by the Accountable Director.

Its purpose is to provide SMT with a clear summary of the paper being presented, with the key matters for attention and the ask of SMT.

It details how it impacts on the people we serve.

1. Detailed summary of paper contents:

This report is developed to comply with monitoring requirements aligned to the Trust's approved Performance Management Framework.

- Historic CPD objectives have been maintained for 2019/2020, 2020/2021 and 2021/2022.
- Regrettably, improvements have not been achieved in the majority of areas and performance further impacted in year as result of the current pressures / pandemic response.
- High level Service Delivery Plan monitoring against project levels of core activity (previously Corporate Rebuild) is now included in the CPD Performance Scorecard report.

2. Areas of improvement/achievement:

- Adult Mental Health (row 38) – Whilst the numbers of patients waiting longer than 9 weeks is still of concern, a period of continued improvement is noted with volumes reduced by -61% (-619) since July 2021. In March 2022, 392 patients were waiting in excess of 9-weeks, 82% of these (322) are within Primary Mental Health Care. Whilst the volumes of excess waits have reduced by 61% the longest wait has only reduced by 9-weeks, from 42-weeks in July 2021 to 33-weeks in March 2022. Waiting list validation, new models of assessment and workforce recruitment have impacted positively on Performance.

- Dementia (row 40) – The number of patients waiting longer than 9 weeks at March 2022 (4) has demonstrated a significant improvement with volumes reduced by -99% (-385) since February 2021 (389). Furthermore, the longest wait has reduced by 49-weeks, from 60-weeks in February 2021 to 11-weeks in March 2022.

3. Areas of concern/risk/challenge:

- Suspect Breast Cancer (14 Days) (Row 2) – Performance against this objective remains variable and an area of concern with only 14.5% (37 out of 256) red flag patients assessed within 14 days as at March 2022. In comparison, March 2020 performance was 100%. The percentage of patients seen within 14 days in March 2022 is similar to the position in March 2021 when performance was 14.8% with the number of patients seen relatively static (43 out of 291). Whilst the Trust has escalated these pressures to the SPPG (previously HSCB), for consideration of equalisation of wait times, a number of other Trusts are also challenged. Regional performance against this target in January 2022 was 55%.

- Cancer 31 Day Pathway (Row 3) – Performance against this objective remains variable with performance in January 2022 demonstrating 74.7% (71 out of 95 patients received their first definitive treatment within 31 days). In comparison January 2021 demonstrated 83.3% whilst January 2020 demonstrated 97.8%. Performance against the 31-day pathway is based on those patients who have

completed their pathway. Reduced access to surgical capacity means that an increased number of patients remain on the pathway. As at 22 March 2022 the Trust is tracking 1,382 patients on the active 31 day pathway. Internal and Regional capacity continues to be targeted to the patients with greatest need.

- Cancer 62 Day Pathway (Row 4) – Performance against this objective remains variable with performance in January 2022 demonstrating 39.2% (20 out of 51 patients received their first definitive treatment within 62 days). Performance against this target has seen a fluctuating but sustained reduction from 60.7% at January 2020 to 43.1% in January 2021. January 2022 performance of 39.2% is the lowest level of performance seen since monitoring against this objective began in 2017. Performance against the 62-day pathway is based on those patients who have completed their pathway. As at 22 March 2022 the Trust is tracking 3,591 patients on the active pathway. As noted above Internal and Regional capacity continues to be targeted to the patients with greatest need.

- AHPs (Row 5) – Volumes of patients waiting continues to present a significant challenge within AHP services with 13,054 patients, out of 21,125 patients (62%) waiting longer than 13 weeks as at March 2022. The longest wait at the end of March was 154-weeks, within Occupational Therapy. Performance has been impacted due to a loss of activity, as an impact of the pandemic responses, coupled with a longstanding capacity gap. 'Mega clinics' providing, in-house additional capacity, have seen 2,230 long waiting routine patients with a further 450 patients seen via the IS contract. The impact of these measures has seen a reduction in Physiotherapy waits over 13-weeks of -16%. These impacts will be demonstrated in the short to medium term, however, a longer-term solution will be required to sustain reductions.

- Diagnostic Reporting – Imaging (Rows 8 and 10) – March 2022 performance demonstrated a further reduction to 71.7% of imaging tests reported on within 2 days. This demonstrates the worst level of performance against this objective since monitoring began in 2017. As at 4 April 2022, there were 4,334 unreported plain film x-rays, with 10 waiting more than 28 days. 50% (5 out of 5) of the plain films in excess of >28 days are chest films, with the longest wait at 128-days. The remaining 50% (5 out of 10) are non-chest films, with the longest wait at 130-days. Capacity previously sourced in the IS has reduced due to demands from other Trusts. Consultant vacancies (2 WTE); sabbaticals (2 WTE); and annual leave has impacted on performance.

- Diagnostic Test Endoscopy 26 weeks (row 18) – Performance for Diagnostic Test Endoscopy remains challenged with 63.9% of waits longer than 26 weeks (3,421 out of 5,352) at February 2022 (most recent data available). The longest of these routine patients waiting for symptomatic endoscopy is waiting in excess of six and a half years (357 weeks). Performance has been impacted due to a loss of activity, as an impact of the pandemic responses, coupled with an identified capacity gap. Whilst endoscopy sessions have re-commenced on the STH site, they have not yet returned to pre-pandemic levels. The Regional IS Endoscopy capacity has now ceased.

  Performance is further compounded with the backlog of patients waiting for a repeat scope procedure of which there were 3,598 waiting beyond their clinically

indicated timescale at March 2022 with the longest wait from February 2018.

- In-Patients/Day Cases (rows 19 and 20) – As at March 2022, only 13.6% of patients were waiting no longer than 13 weeks (2,362 out of 17,431). 61.5% (10,724) were waiting more than 52 weeks. Performance has been impacted due to a loss of activity with reduced in-patient and day case theatre capacity, as an impact of the pandemic responses, coupled with longstanding capacity gaps. The Trust continues to engage in the Regional process to prioritise available elective capacity, between Trusts, to ensure equitable access based for priority cases.

  Whilst de-escalation of critical care arrangements in line with Regional response will see increased in-patient capacity, challenges still prevail within the nursing workforce. March 2022 demonstrates IP/DC activity at 89% in comparison to pre-pandemic levels at February 2020 (March 2020 data reflects pandemic impact).

  As part of the Regional Elective Care Framework the Trust is participating in a Regional waiting list validation exercise, co-ordinated by HSCB.

- Out-Patients (rows 21 and 22) – As at March 2022, 17.4% (11,717 out of 67,277) of patients were waiting no longer than 9 weeks with 50.4% (33,891) waiting longer than 52 weeks. Performance remains impacted due to loss of activity related to pandemic responses coupled with long standing elective capacity gaps. March 2022 demonstrates OP activity at 86% in comparison to pre-pandemic levels at February 2020 (March 2020 data reflects pandemic impact).

  As part of the Regional Elective Care Framework the Trust is participating in a Regional waiting list validation exercise, co-ordinated by HSCB.

- Psychological Therapies (row 41) – At the end of March 2022, 68.9% of patients (577 out of 837) were waiting longer than 13-weeks. The longest wait is 102 weeks. Regionally recognised workforce planning and capacity issues continue to impact the ability to make in-roads to this position.

- Family and Children's Social Care Cases (Row 62) – As at March 2022, there were 311 unallocated child care cases recorded demonstrating a -13% reduction from February 2022. Whilst this is an improvement it is not yet of statistical significance. 182 cases are waiting in excess of 40-days and 117 in excess of 60 days. The longest wait is in the Family Support Team (241 days). There were no Child Protection cases unallocated. Significant social work vacancies and a high prevalence of maternity leave has impacted on performance. Staffing pressures are reflected Regionally and have been escalated to the SPPG (HSCB) and DoH. Further information available in the Unallocated Cases report.

- (Non OGI) Number of Outstanding Domiciliary Care Packages (Row 67) – The number of outstanding domiciliary care packages as at 31 March 2022 was 588. Since April 2020, this figure has increased by +250% (+420). Whilst the current unallocated position is related to workforce challenges, it should be noted that there has been a steady increase in the level of domiciliary care hours actually provided.

- Emergency Department (4 hour) (Row 79) – In March 2022, 55.4% of patients were treated and discharged/admitted within 4-hours. Whilst the 4-hour % performance is increasingly challenged, the actual number of attendances seen within 4-hours increased to 7,487 in March 2022 versus 6,390 in March 2021. In addition total attendances in March 2022 were increased, 13,511 in comparison to 10,471 in March 2021. Whilst an increase in attendances is noted, attendances have not yet returned to pre-Pandemic levels. Performance continues to be impacted by insufficient bed capacity which causes overcrowding in the ED, therefore, reducing cubicle capacity to see patients.

  The Trust, through Workstreams 2, 3 and 5 of No More Silos continues to focus on the Emergency Department, Ambulatory Pathways and Patient Flow.

- Emergency Department (12 hour) (Row 80) – In March 2022, 1838 patients waited more than 12 hours in the ED (13.6% of total attendances). This position is compared to 489 (4.7%) in March 2021.

  The percentage of patients waiting more than 12 hours, as a % of the site attendances, for CAH is 20.3% (1387 out of 6824) and DHH 9.6% (451 out of 4710). There were no patients waiting more than 12 hours in STH. Insufficient bed capacity which causes overcrowding in the ED, therefore, reducing cubicle capacity to see patients.

- GP OOH (Row 82) – In March 2022, only 32.1% of acute/urgent calls were triaged within 20 minutes. For the second consecutive month performance has gone below 50%. The service continues to experience challenges to securing GP cover with only 51% of GP hours filled. Regional review of services is ongoing.

- Learning Disability and Mental Health Discharges (Rows 85 – 87) – In March 2022, 100% (2 out of 2) of Learning Disability and 92.2% (71 out of 77) of Mental Health discharges were completed within 7-days. Cumulative performance for Learning Disability and Mental Health demonstrates 81% and 95% respectively. Whilst performance is variable the target reflects only those patients who have been discharged and does not reflect those currently delayed.

  Within both the Learning Disability and Mental Health Units there are a number of patients for whom a decision to discharge has been taken, but who are still in hospital. Within the Dorsy Unit (Learning Disability) there are 3 patients with 3 waiting in excess of 28-days; whilst within the Bluestone Unit (Mental Health) there are 16 patients with 14 waiting in excess of 28-days. This impacts on flow and in-patient bed capacity.

- Staff Sickness Absence (Rows 91 and 92) – In February 2022, staff sickness absence was +11.3% higher than the 2020/2021 baseline level and 52.5% higher than 2019/2020. The monthly % hours lost for February were 8.9%. This data includes those with Covid-19 related sickness but excludes absences when staff were self-isolating.

4. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	Access to services; Workforce capacity; Infrastructure
Board Assurance Framework	
Equality and Human Rights	As above

- End -

Southern Health and Social Care Trust

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MDT Administrator & Projects Officer Band 6

Southern Health and Social Care Trust

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JOB DESCRIPTION

JOB TITLE	MDT Administrator and Projects Officer
BAND	Band 6
DIRECTORATE	Acute
INITIAL LOCATION	CAH
REPORTS TO	Operational Support Lead
ACCOUNTABLE TO	Assistant Director of IMWH & CCS

JOB SUMMARY

The post holder will play a pivotal role in and have overall responsibility for the administrative management of the Cancer Multidisciplinary Team (MDT) process for the Trust. They will provide a robust audit function, developing action plans and implementing failsafe mechanisms with the aim of improvement the care and experience of cancer patients within the Trust. The post holder is expected to ensure effective co-ordination, organisation and functioning of the Cancer Multidisciplinary Team (MDT) meetings.

S/he will also manage the Trust's peer review process which evaluates each MDT against a set of national measures to ensure an adequate level of patient care. S/he will be responsible for the development of monthly/quarterly business information reports, with particular focus on key aspects of the MDT process. S/he will have the management function for the cancer tracking team, linking key learning from audit back to the team.

S/he will be responsible for the management of key service development work within cancer services and will support the delivery of Quality Improvement Initiatives through facilitation and collaboration with clinical teams as directed by the Assistant Director

(AD) and Head of Service (HOS), ultimately improving quality, safety and performance for cancer pathways and services. This would include implementation of key projects in order to deliver service change, as well as providing specialist data analysis to the AD and HOS to support both service monitoring and opportunity for service improvement.

S/he will provide key transformational capacity in cancer services, supporting both local and regional improvement work, as well as the design and implementation of policies and procedures to ensure the integrity and success of projects/change.

S/he will require excellent project leadership, organisational, communication and interpersonal skills, will have a degree of autonomy and be expected to organise and plan a demanding workload and manage conflicting priorities with minimal supervision to deliver tight deadlines.

KEY DUTIES / RESPONSIBILITIES

MDT Administrator

1. Provide specialist and professional advice to support provision of an effective and efficient administrative service for cancer tracking.

2. To manage the cancer tracking administrative services to meet performance targets, identify risks associated with achievement of performance targets and develop and implement plans to improve performance.

3. Provide management support and leadership to the MDT leads, Team Leads and MDT Co-Ordinators

4. Support clinical teams and Group managers in the development and implementation of their Cancer Action Plans, working with them to develop and implement appropriate project monitoring and reporting arrangements

5. Develop a culture where high quality and improved outcomes for patients diagnosed with cancer are consistently delivered, working with AD for Cancer Services, HOS, Lead Clinician and MDT leads to develop long term strategies for each tumour site

6. Develop a programme of audit and undertake regular reviews, including annual review, of each tumour site pathway, identifying delays in diagnosis or treatment, identifying omissions in key data; working the MDT leads to resolve issues and identify solutions to support improvements as required

7. Prepare audit reports in a variety of formats (e.g. written reports, tables, charts, presentations) to enable services to assess their performance against national, regional, and local standards and targets, ensuring that reports are available according to agreed deadlines

8. Take responsibility for the forward planning and co-ordinating of a programme of monthly/quarterly/annual reports on behalf of Cancer Services

9. Work in partnership with the MDTs and management teams to identify and assist in resolving problems in managing patients along their care pathway, as well as providing specialty specific reports which feedback performance to the MDT team and management team

10. Act as the first point of escalation for issues which inhibit effective MDT management of patient pathways, supporting MDT teams in taking corrective action if progress or outcomes are not being achieved as agreed, escalating to the Lead Clinician for Cancer, AD and HOS themes and trends contributing to performance challenges

11. Ensure the effective working of the MDTs through management of the Trust's Cancer Tracking/MDT Co-Ordinator Team, ensuring a high standard of data quality and data collection for analysis and benchmarking

12. Work with MDT leads and cancer management team to support the clinical governance arrangements for all tumour sites

13. Design and undertake on-site observations and patient tracking as part of service review

14. Ensure that all mandatory data is completed in a timely manner before deadline dates and submissions to National Cancer Registry

15. Support the cancer peer review process of tumour sites as required, including the provision of tumour site data, presentation of data in various reporting formats and statistical information required for Annual General Meetings for each tumour site.

16. Liaise with external Trusts and other agencies with regard to shared documentation and collaborative working

Projects Officer

17. Provide high quality project/systems support to the cancer services management team to deliver the effective and timely implementation of service changes/projects set out as part of the cancer reform agenda, cancer services work plan and cancer services strategy, supporting the out-workings of the modernisation of cancer services in Northern Ireland.

18. Successfully lead and deliver the implementation of service development and change projects in respect of administrative services, using effective and appropriate skills covering planning, influencing, leadership, drive for results and collaborative working.

19. Support the cancer services management team in the delivery of key projects and service development e.g. Cancer Services Workplan

20. Contribute to the development and agree an effective change management approach with project stakeholders, including process mapping, co-ordination of consultation process and ensuring any follow up action required is managed appropriately, without adverse impact on service delivery to patients.

21. Ensure that key stakeholders are aware of the capabilities and potential of the service developments and projects when planning and managing for change within the Trust.

22. Collating, analysing and presenting project data, as well as requests for change, during the project life cycle.

23. Support Trust wide change, collecting and analysing data to monitor outcomes and benefits of service and pathway redesign.

24. Assist cancer services management team when required with the detailed design of new service models including design of new policies, procedures, processes, protocols, etc.

25. Provide project management support to the Assistant Director as required for specific projects outside of cancer services.

26. Develop excellent working relations with key stakeholders to encourage collaborative working.

27. Attend, participate and assume the role of directorate or divisional representative at various meetings as required by the senior management team.

28. Employ a range of communication techniques to impart complex information to a range of audiences (large and small), both internal and external, and build support for change initiatives overcoming resistance.

29. Support effective communication of quality improvement aims and outcomes by maintaining high standards in documentation and production of presentation materials, reports, meeting notes and briefing materials.

30. Flexible with regard to working arrangements to facilitate the demands of the post in full.

GENERAL MANAGEMENT RESPONSIBILTIES

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

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

- Review the 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.

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

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

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

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

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

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

9. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

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

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

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

May 2021

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND	MDT Administrator and Projects Officer
DEPARTMENT / DIRECTORATE	CCS
SALARY	Band 6
HOURS	37.5

Ref No: <to be inserted by HR> **May 2021**

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Qualifications/ Registration	Relevant university degree or equivalent in a business/management related subject AND two years' experience in a Band 4 or equivalent role to include both people management and the management of administrative services to meet performance targets **OR** Relevant HNC/HND or equivalent higher	Shortlisting by Application Form

	qualification in a business/management related subject AND three years' experience in a Band 4 or equivalent role to include both people management and the management of administrative services to meet performance targets **OR** Five years' experience in a Band 4 or equivalent role, to include both people management and the management of administrative services to meet performance targets	
Experience	Experience in the use of Microsoft office products to include Word, Excel and PowerPoint.	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. ***This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post***.	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	Effective planning and organizational skills with an ability to prioritise own workload and work autonomously. Effective communication skills to meet the needs of the post in full. Ability to undertake surveys/audits incorporating analytical and judgement skills in interpreting information and providing comparison. Ability to analyse data and trends in order to draw conclusions and assist decision-making, identifying solutions to problems and implement them effectively. Ability to work to tight timescales and meet targets.	Interview

	Excellent numerical and analytical skills with ability to apply strict attention to detail. Demonstrate evidence of involvement in change within an organisation. Demonstrate experience of contributing to projects involving stakeholders from different professional backgrounds within a health or social care services setting. An interest and commitment to making a difference to service users, highly committed to a patient centred approach and high quality of care.	
Knowledge	Demonstrate an up to date and excellent working knowledge of the tools and methods available to ensure effective administrative processes and their assessment. Understanding of patient/service user experience needs in a caring environment.	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	Experience of working with cancer services team, particularly working with multi-disciplinary teams.	Shortlisting by Application Form

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

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

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
 **Working Together**	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
 **Compassion**	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
 **Excellence**	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
 **Openness & Honesty**	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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Area	Principle	Quality Indicator	Evident	Yes/No/Na	Additional info
1. Operational	1.1 All relevant professions/disciplines (core & extended members) are represented in the team in line with the Manual of Cancer Services >95% of the time with cover. Their role should be added to their Job Plan with dedicated time for preparation & attendance at MDT	Quoracy	Annual report		
	1.2 MDM Etiquette: The team has agreed what is acceptable team behavior/etiquette including: • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear Mobile phones should be turned off or on silent during MDM discussions. If calls need to be taken the core member should leave the room	MDM etiquette agreed	Operational Policy		
	1.3 The MDT will meet at the regular agreed times. All MDT members should make every effort to be punctual. The chair is responsible for ensuring the meeting is paced appropriately and the meeting length is not excessive.	Annual Audit	Audit		
	1.4 The role of MDT chair and deputy should be supported through regular appraisal at least every 12 months. The position of MDT Lead will be supported by a defined role specification and the time required to effectively chair, including preparation time, should be recognised in job plans.	Job description and job plan allowance in place	Operational Policy		
	1.5 The MDT co-ordinator is recognised as a core member of the team. Each MDT should have adequate MDT co-ordinator support to ensure smooth preparation, running and communication of the MDT, including cross-cutting specialties where necessary. MDT coordinators should be supported to fulfil their role with clear line management, training and development.	There is a dedicated MDT co-ordinator who is provided with adequate training and support along with cross cover when needed	Operational Policy		
	1.6 Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible. Extended members/non-members attend for cases relevant to them.	Quoracy	Annual Report		
	1.7 User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice – they are given feedback in response to their advice including actions taken in response to their recommendations.	Use off PPI engagement	Annual reports		
	1.8 The MDT chair will be made aware of any absences (and cover arrangements) and/or new attendees in advance, and introduce them at the start of the meeting. Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list. The observor should sign a confidentiality agreement form.	There is advance notice to MDT chair	Operational Policy		
	1.9 The MDT is the forum for clinicians with differing areas of expertise to input into the management of patients with cancer, and will include investigation, treatment, follow up, ethical and social matters, comorbidities and practical problems. Each MDT should agree a policy for discussion of newly suspected/confirmed and recurrent malignancies. Processes should be in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place. There is information on when to refer patient to local and regional MDMs.	There is a weekly or fortnightly MDT. Details in operational Policy	Operational Policy		
	1.10 For some tumour sites, certain subgroups of patients now follow very well-established treatment protocols. MDTs for tumour types for which a protocolised approach has been developed should agree and document their approach to administering protocols. This could include a 'pre-MDT triage meeting'. Patients on predetermined agreed algorithms will be recorded and not discussed by the full MDT. Decision making for patients put on a protocolised pathway should be regularly reviewed.	Standards of Care pathways	Operational Policy		
	1.11 The Trust will ensure appropriate IT support for audio-visual teleconferencing equipment, able to respond to issues during meetings if required. A dedicated and appropriate meeting room should be available which has access to other essential technology and software for example access to projected digital images.	Audit	Annual Audit		
		There is a dedicated meeting room equipped with appropriate technology. Audiovisual and teleconferencing equipment working well with technical support available	Escalation protocol if issues		

2. Communication	**2.1 MDM recommendations are only as good as information they are based on. A communication protocol should be in place for all MDMs to cover aspects such as Pre/During MDM. If there are concerns that key data is missing this should be documented. The Minimum dataset must include** **- Clinical summary to include co-mobrbities, psycholosocal and specialist palliative care needs along with patient preferences where known** **- Question to MDM** **- Person responsible** **- Summary of the record** **Post MDM** **- Informing GP/referring clinician** **- Filing of MDM record** **- Communication to core/non core members** **- Referrals/Actions from MDM** **- MDM sign off** **- Discrepancies noted and audited** **2.2 The Chair should ensure a clear plan is in place for communication with the patient. The decision of the MDT should be recorded on CaPPs in real time in full view of the MDM with person responsible for action listed where appropriate. The MDM outcome should be communicated to the relevant professionals (e.g. referring MDT, GP, CNS) to enable early discussion and management ideally on the same day and within 1 working day**	**Annual Audit against MDT communication protocol & number of cases deferred with reason**	**Annual Audit**		
	2.3 The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are: **• evidence-based (eg. in line with NICE and/or cancer network guidelines);** **• patient-centered (in line with patient views & preferences when known and taking into account co-morbidities);** **• in line with standard treatment protocols unless there is a good reason against this, which should then be documented.**	**Audit**	**Audit**		
	2.4 There is a locally agreed cut off time for inclusion of a case on the MDT/list agenda and team members abide by these deadlines - there is flexibility for cases that may need to be added last minute due to clinical urgency.	**Detailed in operational policy and agreed by team**	**Operational Policy**		
	2.5 Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.	**Detailed in operational policy and agreed by team**	**Operational Policy**		
	2.6 There are processes in place: **• to ensure actions agreed at the meeting are implemented;** **• to ensure the MDT is notified of significant changes made to their recommended treatment/care plan;** **• to manage referral of patient cases between MDTs (including to MDTs in a another provider);** **• to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable.**	**MDM outcomes audit, ITT protocol, tracking of NEW cancer patients to First treament tretament**	**Audit**		
	2.7 The MDT should be patient centred in its approach ensuring that wherever possible someone who has met the patient and can express their views, wishes and needs is in attendance.	**Patient preferences are discussed at MDT where appropriate**	**Annual Audit**		
	2.8 The MDT/Service has responsibility for identifying a key worker for the patient.	**Patient experience survey**	**Annual survey**		
	2.9The MDT has responsibility for ensuring all clinically appropriate treatment options for a patient even those they cannot offier/provide locally are considered and that the patients information needs have been (or will be) assessed and addressed.				
	2.10 Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.				
	2.11 Every patient discussed should be considered for appropriate/available clinical trials, and this should be recorded.	**Annual Audit**	**Annual Audit**		
	2.12 Patients are aware of the MDT, it's purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe. A leaflet about the MDM working is provided to patients.	**Website/Patient Information**	**Operational Policy**		
	2.13 Each MDT should have a patient information leaflet on the MDT and permanent record of consultation given out to them by the CNS, this is one of the peer review standards.	**Patient Information**	**Operational Policy**		
	2.14 A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda and the appropriate reimbursement arrangements are completed				

	When patients are referred into an MDT the specific MDT referral form should be completed, and any relevant imaging made available for the scheduled discussion. When a patient's care is being transferred into the NHS, the imaging should be uploaded onto the relevant imaging viewer (eg: PACS). In addition, a letter of referral should be generated from the Independent Sector for the NHS records. Pathology reports should be included in the referral and samples should be sent to the MDT pathologist(s) on request. This process should be facilitated by the private medical practitioner. It is not the responsibility of the MDT chair or co-ordinator to organise transfer of images, pathology or clinical information into the MDT.	Annual Audit against MDT communication protocol	Audit		

3. Governance/Audit/Research	**3.1 MDT decisions are guidance for the responsible treating clinician. Accountability for any intervention remains with the clinician responsible for that intervention.**	**MDM outcomes audit**	**Quarterly audit**		
	3.2 Clear governance arrangements should be in place to ensure that patients, relatives, medical and nursing staff in primary, secondary and tertiary care are all clear who is responsible for taking forward MDT action.	**Audit against MDT communication protocol**	**Audit**		
	3.3 MDT members are encouraged to raise any concerns about the functioning of the MDT with the MDT chair. The MDT should agree a process for regularly monitoring and reviewing the functioning of the MDT and undertake continuous improvement activities and identify if there are any areas of training required.	**Annual MDM improvement Survey/Business meeting**	**Annual report/Survey**		
	3.4 Audit of MDT outcomes, processes and data will be central to the assurance of quality and results will be communicated with all core members of the MDMs and discussed at annual business meetings. Agreed audits include: **1. MDM communication (Referral proformas, communication with GPs and filing of MDM outcomes)** **2. MDM outcomes**	**Audit**	**Audit**		
	3.5 Each service area supporting the MDM should ensure they have oversight and ownership of mortality and morbidity data to ensure all adverse outcomes can be discussed by the relevant professional group and learned from. All core members attend Trust M&M and ensure cancer patients are discussed. If required a selection of learning from M&M can be presented for educational purposes at the annual/bi annual business meetings.	**Clear mortality and morbidity review in place**	**Operational Policy**		
	3.6 The implementation and outcomes of protocolised approaches should be audited and reviewed by the full MDT in an operational meeting. Patients who are not discussed but who are recorded at the MDT will have their data, treatment and outcome regularly audited for compliance to mandatory dataset collection requirements.	**Audit**	**Annual report**		
	3.7 Peer support and external scrutiny of MDT processes, functioning and outcomes are welcomed by all MDTs and NICaN Clinical Reference Groups (CRGs). The review should take place against peer review standards as set out in the manual of cancer standards. MDT members work in partnership with other peers to offer reciprocal peer support. Nominated members who attend the CRG should routinely feed back to the MDT	**CRG attendance**	**Annual report**		
	3.8 MDTs should be a part of a formal governance framework within the Southern Trust. Members of the MDT should ensure that they are aware of this governance framework and those relevant policies and procedures are followed by the MDT. The Clinical Lead should be responsible for raising issues through this governance process on behalf of the MDT however all members of the team should take responsibility for raising issues.	**Clear governance processes, policies and procedures in place**	**Operational Policy**		
	3.7 There is organisational (employer) support for MDT meetings and MDT membership demonstrated via: **· Recognition that MDTs are accepted model by which to deliver safe and high quality cancer care** **· Adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document)**	**Adequate funding/resources and facilities**	**Annual report - quoarcy - Cancer Improvement plan**		
	3.8 Trusts consider their MDT's annual reports via discussion of these at annual business meetings and act on issues of concern. Please confirm date of last meeting **MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.** **3.9 MDT policies, guidelines and protocols are reviewed at least annually. All annual reports, operational policies, cancer improvement plans are discussed at annual business meetings and signed off by all core members of the team.**	**Annual/Bi-annual business meetings**	**Minutes/Cancer Improvement Plans**		

Southern Health and Social Care Trust

Cancer information pathway recording form

Version 1 February 2015

Place addressograph here

Assessment and provision codes:

P	Patient accepted paper copy		D	Patient declined information
DC	Patient declined, carer accepted		NA	Information not relevant
S	Patient was signposted and assisted to seek own copy		O	Other; you may wish to write a note

KEY WORKER DETAILS:	

Information Given	**Code**	**Date**	**Completed by**
CNS contact details			
Macmillan Cancer Guide			
Macmillan CAB Flyer			
Cancer Survivorship website flyer			
Information for you & About this pack			

Site specific information for patients

Southern Health and Social Care Trust

Quality Care - for you, with you

Cancer Information & Audit Officer

Band 5

Cancer Services

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Cancer Information and Audit Officer
BAND	5
DIRECTORATE	Cancer & Clinical Services, Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	MDT Administrator & Projects Officer
ACCOUNTABLE TO	Operational Support Lead

JOB SUMMARY

- To assist the Cancer Services Management Team in auditing the systems and processes around the Cancer Multi-disciplinary Meetings (MDMs).
- To participate in audit collection and production of audit reports
- To provide high quality information to clinical and management staff for clinical and operational purposes.
- To provide a key role in taking forward information improvement initiatives in line with strategic priorities such as peer review of cancer MDTs.
- To undertake processes to ensure the completeness and validity of cancer datasets held in Trust systems

KEY DUTIES / RESPONSIBILITIES

1. To work with Cancer Services Management team to audit the systems and processes for Cancer Multi-disciplinary Meetings (MDMs).

2. Support the MDT Administrator & Projects Officer in Cancer MDM audits e.g. Cancer MDM Attendances & Cancer MDM Outcomes

3. Collect audit data and information for Cancer Services

4. Data validation to ensure complete and accurate performance reports, MDT annual reports and operational policies

5. To provide regular reports of audit activity at the request of management.

6. To produce data analysis and create, validate and develop reports as required by the Cancer Services Management Team, Peer Review and Governance Lead or clinicians within the MDT.

7. Participate in developing information reports to support:
    - Monitoring data quality and information completeness in the Cancer Patient pathway System (CaPPS).
    - Cancer MDM Audits and annual submission to National Cancer Audits
    - Production of MDT annual reports
    - The upload of peer review data to the CQUINS database

8. Provide accurate and timely data to the Cancer Management Team

9. Use Trust information systems to facilitate collection of data for all cancers and enter this onto CaPPs in conjunction with clinical leads and MDT Administrator & Projects Officer.

10. Maintain timely and accurate data collection, maintaining Cancer Patient Pathway System (CaPPS) and taking corrective action when data is incomplete or inaccurate.

11. To ensure that a detailed and up to date record is kept of the progress of all allocated projects

12. To assist with other cancer-related audit projects as required.

13. Assist in the production of activity information reports required to support the Trusts clinical and managerial objectives for cancer.

14. Provide cover in the absence of the MDT Administrator & Projects Officer

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

<May 2022>

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND **Cancer Information & Audit Officer, Band 5**

DEPARTMENT / DIRECTORATE **Cancer Services, Acute Services**

SALARY

HOURS **37.5 hours**

Ref No: <to be inserted by HR> **<May 2022>**

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Experience/ Qualifications	1. Degree or equivalent qualification in a Business /Management/Information field with 1 years' experience within a business administrative role at Band 4 level or above. **OR** HNC/HND or equivalent in a Business/Management Information field with 2 years' experience within a business administrative role at Band 4 or	Shortlisting by Application Form

	equivalent/above including 1 year at Band 4 or above **OR** 4 years' experience within a business administrative role, including 1 year at Band 4 or equivalent/above. 2. A minimum of 6 months experience of using Microsoft Word and Excel 3. Experience of the using Hospital IT systems i.e. Cancer Patient Pathway System (CaPPS), NIECR, Patient Administration System (PAS) which should include inputting and updating data 4. Experience working in Cancer Services	
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	1. Effective communication skills to meet the needs of the post in full. 2. Effective planning & organisational skills with an ability to prioritise own workload. 3. Ability to work to tight timescales whilst meeting targets 4. Ability to work accurately and confidentially 5. Ability to work as part of a team whilst using own initiative	Interview

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

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

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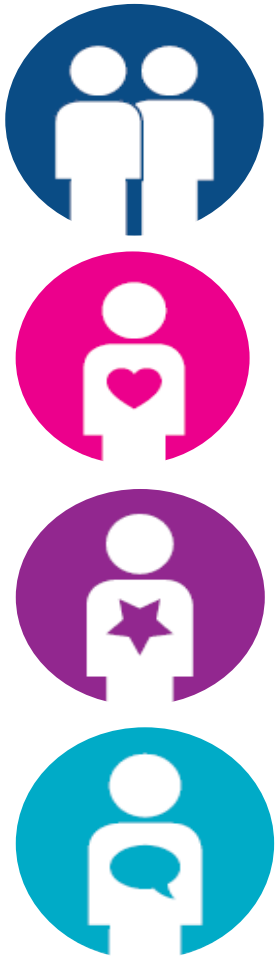

All staff are expected to display the HSC Values at all times

Southern Health and Social Care Trust

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	Jan-22			Feb-22			Mar-22			Apr-22			May-22			Jun-22			Jul-22			Aug-22			Sep-22			Oct-22			Nov-22			Dec-22		
	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate	No. of meetings	No. of meetings Quorate	% Quorate
Breast	4	4	**100**	4	4	**100**	5	5	**100**	3	2	**67**																								
Colorectal	4	3	**75**	4	2	**50**	4	3	**75**	4	3	**75**																								
Gynae	4	0	**0**	4	2	**50**	5	1	**20**	3	3	**100**																								
Lung	4	4	**100**	4	3	**75**	5	2	**40**	4	3	**75**																								
Skin	4	4	**100**	4	4	**100**	4	4	**100**	4	4	**100**																								
Thyroid	1	0	**0**	1	0	**0**	1	0	**0**	1	0	**0**																								
Upper GI	4	2	**50**	4	2	**50**	4	2	**50**	4	1	**25**																								
Urology	3	1	**33**	4	2	**50**	4	2	**50**	3	1	**33**																								

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 unchanged. 06/08/2019 - Ongoing increase in red flag referrals across multiple tumour sites continues, leading to pressures throughout pathways with 1st appointment, investigation and diagnostics and surgery- in particular	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. Situation continually monitored.	HIGH
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

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
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
4177	ACUTE	20/06/2018	Safe, High Quality and Effective Care	Chiller Faults causing loss of time- MRI	Chillers are required to supply chilled water to the MRI scanner to remove heat produced during scanning and facilitate circulation of liquid helium which maintains the operation of the superconducting magnet. For the scanner to operate at the highest levels of efficiency, the magnet inside the scanner has to be kept as cool as possible. Any increase in temperature will result if the the chiller is not operating will cause the scanner to no longer operate. This is a safety mechanism for the scanner to prevent boil off the liquid helium "quenching". This is when the wire in the electromagnet stops being superconducting and starts to generate a lot of heat. At this point, any liquid helium around the magnet repeatedly boils off and escapes from the vessel housing the magnet.	Single chiller per scanner with no back up available. Alarm system in place to business management system when chiller is not operating- no communication from switch or estates re this during recent breakdowns. Siemens will test this to check if the system is working.	08/07/2021- recent chiller failure- temporary chiller installed until fault can be replaced. Several days scanning lost while this was ordered and installed. RED FLAG exams delayed due to downtime. 21/11/2020- no change- still awaiting estates action ongoing follow up with estates for progress. 20/06/2018- automatic emergency bypass system needs integrated instead of manual- to be referred to capital department for design team. Additional secondary chiller with associated pipework as a backup- D/W David Thompson needs referred to capital department design team. Discussion with Estates Team and Switch in relation to procedure for notifying estates and MRI if chiller alarm goes off. Alarm system to be tested.	HIGH
4176	ACUTE	20/09/2021	Accessible and Responsive 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 cafMake the best use of resourcesBe a great place to work	Haematology Outliers	Currently only providing a 6 bedded inpatient side room, augmented care capacity for Haematology patients. All other admitted Haematology patients are cared for throughout both medicine and surgery, without the necessary environment to ensure patient safety 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 Care 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 Care 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, incorrect reading/interpretation of results. Other issues are staffing levels within the POCT team and the problems	- 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 policy which will go live in July and will be disseminated to all AD'S and appropriate leads.	HIGH
4157	ACUTE	06/05/2021	Provide safe, high quality care 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
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 work 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

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4156	ACUTE	19/08/2021	Provide safe, high quality care 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
4143	ACUTE	11/03/2021	Best use of resources 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. Potential for undue distress to baby and parents.	Continual monitoring of the staffing situation to make best use of existing resources. Transfer accepted when staffing levels permit.	16/03/2021- Ability to accept inutero transfers remains limited due to staffing and capacity ongoing recruitment continues, increased pressures to accept transfers due to regional neonatal capacity. Will continue to monitor Jun20 continue to monitor Dec19 Specific focus on recruitment - recruitment fayre undertaken and appointments made awaiting registration within next year. Retention of staff also focus within division to retain and recruit staff	MOD

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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 assessesment 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
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 Medl 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 alleviate some of the declaratory orders asTrust Authorisation panels are being set up. 7.3.18 Risk remains unchanged	LOW
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
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
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 possible IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents 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 assurance response to the required external agency. It also has the risk of creating 'siloed' implementation processes within each applicable directorate which in turn has the potential to produce inconsistency in any new processes that are being developed, especially across the different care boundaries. This is a risk.	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 Committee with submission of relevant reports / assurance statements.	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

Glenny, Sharon

From: Conway, Barry
Sent: 05 May 2021 20:08
To: McGalie, Clare
Cc: Tariq, Shahid; Kennedy, Geoff; McClements, Melanie; Turbitt, Andrea
Subject: New Consultant Pathologist Job

Clare,

Im delighted to confirm that Melanie has agreed that we can proceed with an additional consultant pathologist post using the available PAs supplemented with additional funding.

Can you start to progress this with the team please? I know this will be a great benefit to the team and will help address many challenges.

Andrea – Melanie asked me to flag this to you – 1PA is already referenced in the Urology SAI IPT. The remaining is to the logged against the cost pressures list. Could you let me know if you need anything further information from me end.

A huge thank you to Melanie for agreeing this for the team.

Barry.

From: McGalie, Clare
Sent: 04 May 2021 11:11
To: Conway, Barry
Subject: FW: Re proposal for new job

From: McGalie, Clare
Sent: 02 April 2021 12:31
To: Conway, Barry; Kennedy, Geoff; Tariq, S
Subject: FW: Re proposal for new job

Dear Barry,

Aaron has a detailed explanation below however this is a summary of the evidence of the need for another Consultant Cellular Pathologist:-

- Deficit of 6PA's essentially due to part time working
- ~ 2 PA's to cover the work being carried out as long term WLI's
- 1-2PA's to allow Pathologist cover at all Multidisciplinary meetings
- SPA allowance – 2 SPA's for a new Pathologist

It is expected that the Implementation of the new RCPath workload guidelines will lead to less cases reported per Pathologist
There will be a temporary need to reduce each Pathologist's workload by an estimated 10 % during validation of digital pathology.

Let me know what else you need me to do to progress this.

Best wishes

Clare

From: Ervine, Aaron
Sent: 30 March 2021 16:41
To: McGalie, Clare
Subject: FW: Re proposal for new job

Hi Clare,

If we look at a reference timepoint of July 2019 then as far as I can tell we have the following DCC / reporting PA deficit / requirements.

Dr McKenna dropping his PAs from 9.5 to 4 reduced his Histo / NG PAs by 3.9 and increased his Gynae cytology PAs by 0.65 (Covering any histology backlog is easier than Gynae cytology backlog hence his move to purely Gynae cytology). We also managed to redistribute 1 PA of his original duties to BMS staff.

Dr McGalie = 1.5 Histo / NG PAs (2 PAs re CD but also increased overall PAs by 0.5 at the same time)

Dr Clarke retiring 1PA Histo / NG and 1.75 Gynae cytology

Backlog being facilitated by WLI sessions = 2 (In Q1 2019 as a department we utilised 23 out of hour sessions to maintain the flow of work so on average 2 PAs worth per week.) I have no figures since then but I don't think there was a major change in WLI work until COVID hit

Just a note in case it is queried, Rosey had taken on an additional PA in Histo / NG cytology in the interim which may have reduced the WLI requirement by 1 PA per week during that time. If we ignore that however, and compare what she was doing in Feb 2019 and the impact on her retirement then the deficit is as above. Also, she was doing a number of additional sessions of Gynae cytology reporting to try to keep on top of the backlog hence one of the reasons that backlog may not have been a major issue at that time (I don't have a figure for the number of these sessions).

So taking that together since July 2019, we have lost 6.4 DCCPAs in Histo / Non-gynae cytology (see below re potential modification of this pending implementation of the Gynae cytology SLA with the WHSCT)and 1.1 DCCPAs in Gynae cytology. To cover for the deficit in Gynae cytology Dr McClean has temporarily displaced 1 PA of histology / Non-gynae but the total will still be the same.

Re Gynae cytology. The proposed SLA with WHSCT should free up approximately 1.5PAs of reporting time. This can be set against the histology deficit.

In addition, the following need to be factored in

We need 1 – 2 PAs to allow MDM cover for colleagues on annual leave (in "normal times" we are not able to facilitate this).

Added to this, there is the plan to implement digital pathology and new RCPath guidelines on consultant workload are due to be published.
The digital pathology will require a reduced workload for the validation period (which on average is said to be 9 months but is some cases is much longer). It's not clear what the required reduction is but if it is even 10% then there would be a further reporting deficit of 3.84 PAs per week for this period.
The new RCPath guidelines in general will mean a somewhat reduced workload although it is difficult to quantify at this time. For the purposes of this e-mail I have not accounted for this but it needs to be borne in mind.

Thus, overall, the deficit I can easily identify is

Dr McKenna / Dr Clarke / Dr McGalie impact = 7.5 DCCPAs or 6 DCCPAs once the SLA with the WHSCT re Gynae cytology is implemented.

Work being done as WLI = 2 PAs

Core SPA time will of course have to be added on (I believe this is 2PAs for new starts) giving a total of 11.5PAs or 10PAs (re WHSCT SLA) as a minimum.

Additionally,

MDM cover allowance of 1 or 2 PAs

The impact of digital pathology (3.84 DCCPAs at least although this would be temporary)

The above does not take into account any workload reduction within the new RCPath guidelines..

I'm sure there may be other pressures on the service and it is not possible to predict the impact of staffing changes but these are the main points as I see them at present.

I hope this helps.

Aaron

Dr Aaron Ervine
Consultant Cellular Pathologist
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
Ext(AVAYA): Personal Information redacted by the

Glenny, Sharon

Subject: FW: radiology presence?

From: Reddick, Fiona <[redacted]>
Sent: 27 November 2018 11:06
To: Conway, Barry <[redacted]>
Subject: FW: radiology presence?

Barry

Can we also discuss this at our 1:1 meeting later

Regards

Fiona

From: Glackin, Anthony
Sent: 26 November 2018 10:19
To: Yousuf, Imran; McCaul, David
Cc: Reddick, Fiona; Haynes, Mark; Hennessey, Derek; Jacob, Thomas; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Dear Imran and David,
Please see the email trail below setting out the concerns of our Consultant Radiology colleagues at the Belfast Trust regarding the Craigavon Urology MDT meeting and Radiology cover.
As you are aware this is an ongoing issue. Since the departure of Dr McClure we have had Dr Williams attending as the sole Consultant Radiologist. Due to other clinical priorities he has not been able to attend every week.
The clinicians and Trust are in a very exposed position if a clinical decision made at the Craigavon Urology MDT meeting without the review of a Radiologist turns out to be incorrect and a patient(s) comes to harm.
I am seeking your advice on how we should proceed until such time as a Radiologist can attend all meetings.
For completeness it should be noted that we do not have oncology input present at the Craigavon Urology MDT meeting, except over the video link from the Specialist Urology MDT meeting when we link in for cases listed for central discussion. That is to say that the majority of cases do not have the benefit of an oncology opinion either.

I await your response.

Yours sincerely

Tony Glackin

Chair of Urology MDT

From: McVeigh, Shauna
Sent: 21 November 2018 12:04
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; Jacob, Thomas; ODonoghue, JohnP; Young, Michael
Subject: FW: radiology presence?

Hi,

Please see below email from BCH regarding regional cases and radiology.

Thanks
Shauna

From: Evans, Angelae [mailto:[redacted]]
Sent: 21 November 2018 12:02
To: McVeigh, Shauna
Subject: FW: radiology presence?

Hi Shauna,

Just to keep you informed – please see response from our radiologist below

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: [redacted]
Email : [redacted]

From: Grey, Arthur
Sent: 21 November 2018 11:22
To: Vallely, Stephen <[redacted]>; Evans, Angelae <[redacted]>
Cc: Mitchell, Darren <[redacted]>; OKane, Hugh <[redacted]>; Lee, Davinia <[redacted]>
Subject: RE: radiology presence?

Hi all,

I have not reviewed these cases.

I would be happy to display the cases and read out the reports.

This whole situation is dangerous and unsatisfactory.

This issue has been raised numerous times before.

It is up to the clinical director to assign a radiologist to cover Marc Williams. This may involve having to outsource clinical work or to allocate as WLI to accommodate this.

An mdm cannot function without a radiologist.

Given the number of patients on the lists and the debacle of the SRMs, we cannot offer a review service for them.

Art

From: Vallely, Stephen
Sent: 21 November 2018 10:47
To: Evans, Angelae <[redacted]>; Grey, Arthur <[redacted]>

Cc: Mitchell, Darren <Personal Information redacted by the USI>; OKane, Hugh <Personal Information redacted by the USI>
Subject: RE: radiology presence?

No but this means there will be no radiology review of the significant number of CAH cases which is not really satisfactory from anyones point of view. Did they give a reason why they could not provide a radiologist?

S

From: Evans, Angelae
Sent: 21 November 2018 10:46
To: Vallely, Stephen <Personal Information redacted by the USI>; Grey, Arthur <Personal Information redacted by the USI>
Cc: Mitchell, Darren <Personal Information redacted by the USI>; OKane, Hugh <Personal Information redacted by the USI>
Subject: FW: radiology presence?

Hi both,

See reply below

Will Hugh's patient need to wait until next week?

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: Personal Information redacted by the USI
Email : Personal Information redacted by the USI

From: McVeigh, Shauna [mailto:Personal Information redacted by the USI]
Sent: 21 November 2018 10:26
To: Evans, Angelae
Subject: RE: radiology presence?

Hi Angela

Unfortunately we don't have radiology this week.

Thanks
Shauna

From: Evans, Angelae [mailto:Personal Information redacted by the USI]
Sent: 21 November 2018 10:03
To: McVeigh, Shauna
Cc: Vallely, Stephen; Grey, Arthur
Subject: radiology presence?
Importance: High

Hi Shauna,

Can you check re: below?

Many Thanks

ANGELA EVANS
PATIENT TRACKER & MDM CO-ORDINATOR – UROLOGY
SPECIALIST AND CANCER SERVICES
OLD GENERATOR HOUSE
BELFAST CITY HOSPITAL
Telephone: Personal Information redacted by the USI
Email : Personal Information redacted by the USI

From: Vallely, Stephen
Sent: 21 November 2018 10:02
To: Mitchell, Darren; Evans, Angelae; Grey, Arthur
Subject: RE: addition to MDM?
Importance: High

Angela

Please confirm that there will be a Southern trust radiologist available to present their cases this week as we will not have reviewed them due to volume of Belfast radiology cases

Thanks

Stephen

MDM Date	Mr Anthony Glackin	Mr Mark Haynes	Mr John O'Donoghue	Mr Matthew Tyson	Mr Nasir Khan	CONSULTANT UROLOGIST (x2)	Dr Gareth McClean	CONSULTANT PATHOLOGIST (x1)	Dr Marc Williams	Dr Richard McConville	Dr Ryan Connolly	CONSULTANT RADIOLOGIST (x1)	Dr Adam Uprichard	MEDICAL ONCOLOGIST (x1)	Dr Elizabeth Baird	CLINICAL ONCOLOGIST (x1)	Mrs Leanne McCourt	Mrs Kate O'Neill	Mrs Patricia Thompson	CLINICAL NURSE SPECIALIST (x1)	Miss Shauna McVeigh	Cover	MDT CO-ORDINATOR/TRACKER (x1	QUORATE	Reason for not being quorate
06/01/2022	1	1	1	1	1	Y	1	Y	1	0	0	Y	1	Y	0	N	1	0	0	Y	1	0	Y	No	No Clinical Oncologist
13/01/2022	No MDM																								
20/01/2022	1	1	1	1	0	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
27/01/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	1	1	Y	1	0	Y	No	No Radiologist
03/02/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
10/02/2022	1	0	1	0	0	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
17/02/2022	1	1	1	0	1	Y	1	Y	0	0	0	N	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
24/02/2022	1	0	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	0	1	Y	Yes	
03/03/2022	1	0	1	1	0	Y	1	Y	0	0	0	N	1	Y	0	N	1	0	1	Y	0	1	Y	No	No Radiologist or Clinical Oncologist
10/03/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Radiologist
17/03/2022	No MDM																								
24/03/2022	1	0	1	1	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	Yes	
31/03/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	0	Y	1	0	Y	Yes	
07/04/2022	1	1	1	0	1	Y	1	Y	1	0	0	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	Yes	
14/04/2022	1	0	0	1	0	Y	1	Y	1	0	0	Y	0	N	0	N	1	0	1	Y	1	0	Y	No	No Clinical or Medical Oncologist
21/04/2022	1	0	1	0	1	Y	1	Y	0	0	0	N	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Radiologist
28/04/2022	No MDM																								
05/05/2022	1	1	1	0	1	Y	0	N	1	0	1	Y	1	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
12/05/2022	1	0	0	1	1	Y	0	N	1	0	1	Y	1	Y	1	Y	0	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
19/05/2022	1	1	1	1	0	Y	0	N	0	0	1	Y	0	Y	1	Y	1	0	1	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced
26/05/2022	0	0	1	0	1	Y	0	Y	1	0	0	Y	0	Y	1	Y	1	1	0	Y	1	0	Y	No	No Pathologist (Note: pathology reports were sent to MDM room before meeting commenced

Appendix 4: Service Improvement Action plan based on patient feedback 2020

Urology Patient Experience feedback & action plan 2020

The Public Health Agency with support from Macmillan Cancer Support commissioned a second regional Cancer Patient Experience Survey (CPES) in 2018. A total of 6,256 patients who had received treatment for cancer during March 2017 to October 2017 were included in the sample for the regional Cancer Patient Experience Survey 2018. The response rate for NI was 57% (3,478) and 473 questionnaires returned were from Southern trust patients. Reports are available at regional and trust levels.

At the Urology business meeting on 23rd January 2020, it was agreed to carry out a local patient survey using some of the CPES questions. A patient survey was issued during March 2020 to 118 patients who were diagnosed with a prostate, renal or bladder cancer in the preceding 12 months. There was a response rate of 58% (i.e.68 patients).

The results of the local patient survey and CPES results were reviewed and a local action plan developed to address some of the areas highlighted by patients. Where applicable, the scores of the CPES local and regional scores are provided along with the local patient survey results.

Issues for Consideration		Action Required	Person Responsible	Date for Completion
Finding out what was wrong with you				
1	74% of respondents were asked which name they prefer to be called by **CPES SHSCT: 76% (NI 73%)**	Continue to ensure that all staff ask patient what name they preferred to be called by	All staff	Ongoing
2	62% of respondents were given the chance to sit in a private place after being given their diagnosis	Continue to ensure that patients are offered the opportunity to sit in a private place after diagnosis	All staff	Ongoing
3	72% of respondents advised that staff discussed or gave them information about the	Written information is available and offered to patients as appropriate	CNS / Consultant	Ongoing

	impact of cancer on their work-life or education. **CPES SHSCT – 77% (NI – 72%)**	Patients who are continuing to work or are in education are given information about the impact of cancer/treatment Patients are referred to Macmillan information and support centre for further information	core members	
4	44% of respondents advised that hospital staff gave information about how to get financial help or any benefits **CPES SHSCT – 35% (NI – 44%)**	Written information is available about the Macmillan Benefits Service and offered to patients as appropriate Patients who are continuing to work or are in education are given information about the impact of cancer/treatment Patients are referred to Macmillan information and support centre for further information	CNS / Consultant core members	Ongoing
4	57% of respondents were offered a written record of their diagnosis and summary of first consultation	Ensure all patients are offered a Permanent Record of Consultation at diagnosis This was previously piloted by the team. Following the business meeting in January 2020, it was agreed to review and implement.	CNS / Consultant core members CNS's M.Haughey	Ongoing
5	35% of respondents advised they were offered a holistic needs assessment and care plan **CPES SHSCT – 34% (NI – 28%)**	Due to staffing levels in the Unit, the two CNS's have not been able to fully implement this for all newly diagnosed patients. A recruitment process is currently underway for an additional x2 Nurse Specialists which will enable this to be fully implemented. Formal HNA clinics will be set up as part of this.	CNS's	To be reviewed in 6 months
6	85% of respondents advised that they were able to find/offered a staff member to talk about their worries and concerns	The CNS will ensure to see as many patients as possible on the ward before and after their surgery in order to discuss with patients any worries or concerns in relation to their diagnosis, prognosis, treatment and care	CNS's	Ongoing

	CPES SHSCT – 50% (NI –49%)			
8	82% of respondents were definitely told about future side effects before treatment **CPES SHSCT – 65% (NI – 51%)**	Continue to give Information on possible future side effects of treatment Encourage patients to attend information session (if appropriate) prior to commencement of treatment Educate on late effects of treatment through health and wellbeing events	All core members CNS's	Ongoing
9	57% of respondents thought their family were given all the information needed to help care for them at home **CPES SHSCT – 69% (NI – 62%)**	Ensure that families are given appropriate and adequate information to help care at home and are provided with details of who to contact if they have any concerns or queries Families are signposted to relevant support services as appropriate	Consultant / Ward staff / CNS	Ongoing

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

December 2011

The Review Team would like to thank the Project Team:

Pamela McCreedy – Project Leader
Angela Hodkinson, Elaine Hunter, Seamus Carey – Project Managers
Ffiona Dunbar, Maria Higgins, Jonathan Houston – Project Support

1. INTRODUCTION

The task faced by the Review was both challenging and daunting. Health and Social Care is of interest to everyone in Northern Ireland and the team approached their task fully aware of the responsibility it had been given.

It was also aware that whilst it was important to look to best practice and examine data from outside the province the deliberations had, in the end, to make sense for Northern Ireland. Many drivers exist in this context: the importance of health and social care to the economic wellbeing of NI; the contribution staff make; the shadow of our recent history in NI, particularly in the mental well being of the citizenry; and the very powerful affinity the NI society has to the core NHS principles.

The team approached its task with that knowledge and these matters were reflected exhaustively in their deliberations. However, the overriding desire of the team was to describe and build a system of health and social care which would place the individual, family and community that use it at the heart of how things are done. That meant using evidence to explain why there needs to be change and concentrate on the outcomes that individuals could reasonably expect in a modern system of care and treatment.

The Review is therefore about change; not careless or haphazard change but planned change over a 5 year period that can and should improve care. The report may be contentious to some, but the Review team saw clearly that there are no neutral decisions as it looks to the future. It has taken the view that a managed and transparent change is better than unplanned, disorganised change.

Finally on behalf of the team I should like to thank the very many people, citizens, professionals and representatives of interest groups who gave freely of their time to help the Review. I should also like to extend thanks to the independent panel members for their honesty, challenge and contribution to the Review.

John Compton
Chair of the Review Team
December 2011

EXECUTIVE SUMMARY

2. EXECUTIVE SUMMARY

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. Crucially it was to bring forward recommendations for the future shape of services and provide an implementation plan. The Review team was not asked to bring forward proposals which reduced the budget published by the Northern Ireland Executive, but was asked to ensure that it was used to best effect.

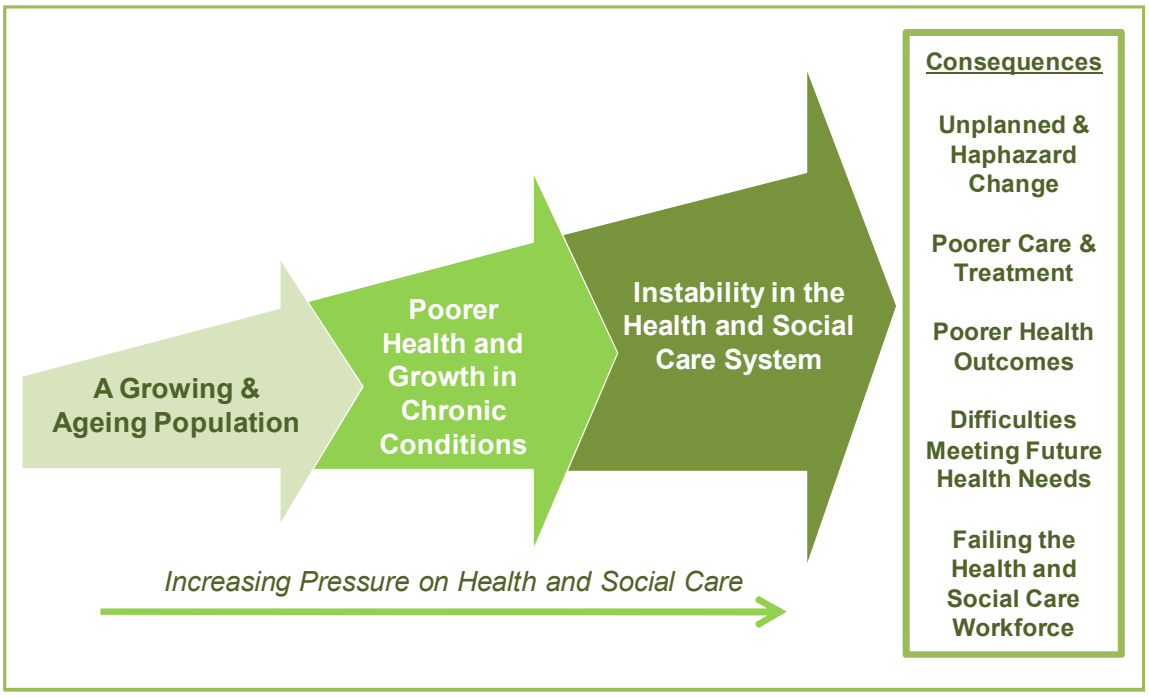
The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. Therefore, he appointed John Compton, Chief Executive of the Health and Social Care Board, to complete the task in an ex-officio capacity. However, the Minister did want a strong independent overview to the process, helping to shape and providing challenge to any proposals. Therefore he also appointed an independent panel comprising: Professor Chris Ham (Chief Executive of the King's Fund), Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus), Dr Ian Rutter (General Practitioner), Mr Paul Simpson (retired senior civil servant), and Mr Mark Ennis (Executive Chair of SSE Ireland).

The Review was to complete by 30 November 2011. Within the timescale available, the Minister was keen to ensure maximum engagement with the public, clinical and professional leaders, health and social care organisations and stakeholders in the voluntary, community, private and independent sectors. In particular the Minister highlighted the importance of engaging with the health and social care workforce through the Partnership Forum. Following their appointment in August, the Review team designed its approach as shown below.

Figure 1: Overview of Approach

The Review concluded that there was an unassailable case for change. The figure below illustrates the core of the argument.

Figure 2: Future Model for Integrated Health and Social Care



Responding to these pressures, the Review identified eleven key reasons which support the need for change (summarised in the adjacent box) along with a model of health and social care which would drive the future shape and direction of the service.

Figure 3: Reasons for Change

To be better at preventing ill health
To provide patient-centred care
To manage increasing demand across all programmes of care
To tackle health inequalities
To deliver a high-quality, evidence-based service
To support our workforce in delivering the necessary change

In developing a new model, the Review engaged with over 3000 members of the public, clinicians, providers and interest groups. It also reviewed evidence to ensure that any changes required had at their heart better outcomes for patients and clients and their families.

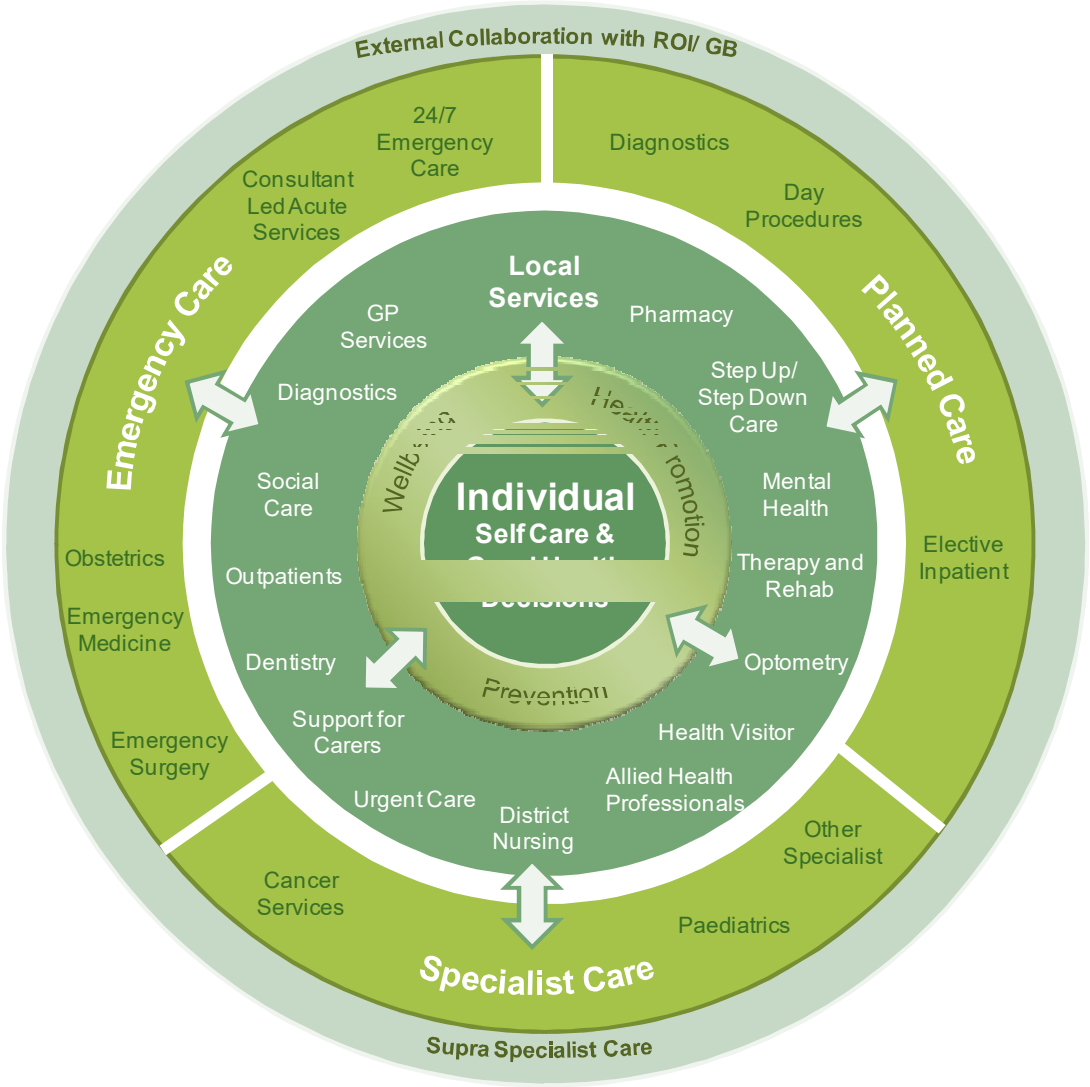
The Review was clear about the purpose of change namely, what changes would make the greatest difference to outcomes for patients, users and carers. In doing so the Review looked beyond the geographical boundaries of Northern Ireland.

The Review identified twelve major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

The model devised by the Review team is shown in the figure overleaf.

Figure 4: Future Model for Integrated Health and Social Care



Briefly described the model means:

- every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- services will regard home as the hub and be enabled to ensure people can

be cared for at home, including at the end of life;

- the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- some very specialist services needed by a small number of people will be provided on a planned basis in the ROI and other parts of the UK.

To help illustrate what this would mean, case studies were developed to explain the model. In essence they show it to be simpler to use, clearer about the key worker, and crucially providing an improved outcome for those who use the service.

Following on from this, the impact on ten major areas of care was examined:

Population Health and Wellbeing
Older People
People with Long-Term Conditions
People with a Physical Disability
Maternity and Child Health
Family and Child Care
People using Mental Health Services
People with a Learning Disability
Acute Care
Palliative and End of Life Care

The model was applied to these service areas and each has a series of recommendations. The full list of 99 proposals is provided Section 19 of the report.

The key themes in the recommendations are summarised below.

Quality and outcomes to be the determining factors in shaping services.
Prevention and enabling individual care for patients and carers.
Care to be provided as close to home as practical.
Greater choice of service provision, residential sector.
New approach to pricing and regulation in the nursing home sector.

Development of a coherent 'Headstart' programme for 0-5 year old children, to include early years support for children	
A major review of inpatient paediatrics.	Modernising technological infrastructure
In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.	Following from this, the Review considered and presented the methodology to make the change over a 5 year period.
Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model.	This initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It goes on to describe as integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented
A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.	
Recognising the valuable role the workforce will play in delivering the outcomes.	In conclusion, the Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. The Review team commends its report to the Minister.
Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.	
Population planning and local commissioning to be the central approach for organising services and delivering change.	

BACKGROUND TO THE REVIEW

3. BACKGROUND TO THE REVIEW

This part of the report explains the nature and purpose of the Review. It sets out who was involved and why, then describes the objectives set for the Review, the scope of the task and the approach taken to complete it.

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care Services in Northern Ireland would be undertaken, asking how it should change and requesting an implementation plan to manage the change. The full terms of reference is included at Appendix 1.

The key objectives of the Review were to:

- undertake a strategic assessment across all aspects of health and social care services;
- undertake appropriate consultation and engagement on the way ahead;
- make recommendations to the Minister on the future configuration and delivery of services; and
- set out a specific implementation plan for the changes that need to

The Review was not to be fully independent and Mr John Compton, Chief Executive of the Health and Social Care Board, was invited to lead the process. The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. However he did want a strong independent overview to the process providing challenge to any proposals. Accordingly he appointed five independent panel members:

- Professor Chris Ham (Chief Executive of the King's Fund);
- Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus, University of Ulster);
- Dr Ian Rutter (General Practitioner);
- Paul Simpson (retired senior civil servant); and
- Mark Ennis (Executive Chair of SSE Ireland).

The appointments reflected the desire to ensure proper scrutiny was applied to the process.

The Minister's over-riding concern is driving up the quality of care for clients and patients, improving outcomes and enhancing the patient experience. In initiating the Review, the Minister explained that he wanted it to ensure that health and social services are focused, shaped and equipped to improve the quality of care and outcomes for the population, and to provide value for money in financially challenging times. He wants to see a shift in care currently carried out in hospitals into the community with patients being treated in the right place, at the right time and by the right people.

The Minister also made it clear that in deciding to have a Review no criticism was implied about staff working in the current system. Quite the reverse, he concluded that the current model was unsustainable going forward and that he wanted to see a service which was developing not declining, a service which built upon the commitment and expertise of those working in health and social care.

OBJECTIVES

Accordingly the objectives of the Review were to:

- provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements in terms of outcomes, accessibility, safety, standards, quality of services and value for money;
- undertake appropriate consultation and engagement on the way ahead with the public, political representatives through the Assembly Health Committee, HSC organisations, clinical and professional leaders within the system, staff representatives through the Partnership Forum, and stakeholders in the voluntary, community, independent and private sectors;
- make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community and other settings; and
- set out a specific implementation plan for the changes that need to be made in the HSC, including proposals in relation to major sites and specialities.

SCOPE

In delivering these objectives the Review was to take account of the following:

- extant policy and strategies approved by the Minister, in particular the aims of improving public health, the prevention of illness and of improving outcomes for patients and clients;
- statutory duties on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities; and

- primary care, community care, social care and hospital services.

Certain areas were deemed to be outside the scope of the Review:

- the new organisational structures created as a result of the RPA process within Health and Social Care; and
- the Review should work within the constraints of the current level of funding for the coming period. The current Performance and Efficiency Unit (PEDU) review of the scope to make savings in the health and social care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

However, the Minister indicated that if the Review felt it should comment on any of these areas, it should not feel constrained in doing so.

Public health and social wellbeing is at the heart of health and social care. The Review team is aware that there is a separate piece of work being undertaken by the Department of Health Social Services and Public Safety (DHSSPS) and the Public Health Agency (PHA) to create a new public health strategy, as set by the Executive and Minister. Notwithstanding this, the Review considered it appropriate to look at public health and wellbeing in its work.

The Terms of Reference had asked the Review to make recommendation on the future configuration of hospital, primary care, community care and other settings. During the course of the Review, the team proposed to the Minister that it was better to describe a framework for the future of care rather than including specific proposals in relation to sites and specialties. The rationale for this presented to the Minister was the critical need to enable professionals and communities to devise local solutions within a very clear framework and criteria for success. The Minister agreed to this approach to applying the Terms of Reference.

APPROACH

Giving consideration to the Terms of Reference set by the Minister (Appendix 1), a project plan was developed. The approach to the Review involved five key strands of activity, as shown in the figure below.

Figure 5: Overview of Approach

In particular the Minister highlighted the importance of engagement with stakeholders and a comprehensive engagement plan was developed. The objective was to enable informed debate and to present information to the public.

This resulted in more than 3,000 people engaging directly with the Review, and many more being exposed to debate on the key issues affecting health and social care provision through media coverage of the Review on TV, radio, online and by the printed media.

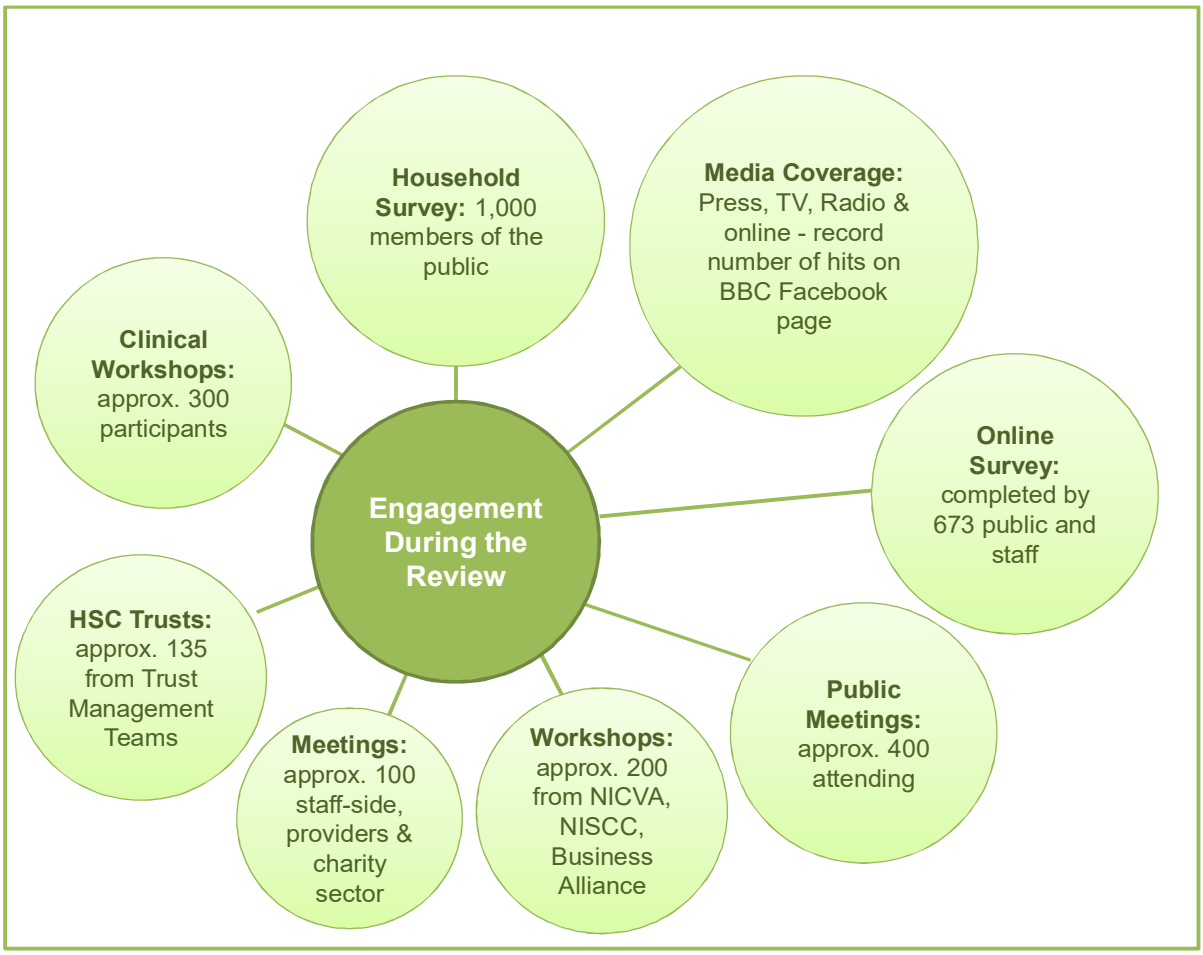
The engagement plan for the Review involved:

- An **online survey** completed by 673 individuals, of which 91% worked for an organisation providing health and social care (see Appendix 2 for a summary of results);
- Engagement with local **media** to promote press, television and radio features on the Review to raise public awareness of the issues involved and stimulate debate. The BBC e-panel received 641 views on aspects of the health and social care system;
- A **household survey** (completed by IpsosMORI) of 1,009 adults aged over 16, selected to be representative of the Northern Ireland population in terms of gender, age, social class and geography (see Appendix 3 for a summary of results);
- Six **public meetings** were held in Londonderry, Omagh, Ballymena, Belfast, Lisburn and Armagh. These were facilitated by the Patient and Client Council (PCC). (See Appendix 4 for details of the questions raised during the meetings);
- A series of **workshops with clinicians** from HSC Trusts, General Practitioners (GPs) and HSC managers to discuss current provision and future needs of specific service areas (see Appendix 5 for details of attendees and areas covered at each workshop);
- A series of **sector workshops**, with representatives from the voluntary and community sector (facilitated by the Northern Ireland Council for Voluntary Action), registered social care workforce (facilitated by the Northern Ireland Social Care Council), and private sector (facilitated by the Business Alliance) (see Appendix 6 for details of attendees);
- **Small group meetings** with a range of stakeholders including HSC arm's length bodies, trade unions (via the Partnership Forum), professional and regulatory bodies, voluntary and community sector organisations, political representatives, independent care providers, and colleagues within health and social care in other parts of the UK and the Republic of Ireland (see Appendix 7 for a full list of the stakeholders engaged with);
- Submission of **written responses** to the Review (see Appendix 8 for a list of written submissions); and
- Meetings with **HSC Trusts'** Senior Management Teams.

A Glossary is included in Appendix 9.

An overview of the stakeholders engaged with throughout the review is shown in the figure below.

Figure 6: Engagement during the Review



STRUCTURE OF REPORT

This report begins by outlining the reasons why our health and social care system needs to change, based upon the evidence that the Review has collected during the Review process. It then sets out the principles the Review considers should underpin this change.

A new model of care is described and contrasted with the existing model of care using case studies. The report details the impact of the new model across 10 areas of care.

- Population Health and Wellbeing
- Older People
- People with Long-Term Conditions
- People with a Physical Disability
- Maternity and Child Health
- Family and Child Care
- People using Mental Health Services
- People with a Learning Disability
- Acute Care
- Palliative and End of Life Care

It moves on to describe the implications for the health and social care system. This takes account of integrated working across health and social care, workforce issues and enhanced use of technology. Finally, an implementation roadmap outlines how this change will be implemented and delivered over a five year period.

THE CASE FOR CHANGE

4. THE CASE FOR CHANGE

Making the case for change is at the centre of this Review. It is not a critique of the current provision but rather a fundamental recognition that the existing model of care is not fit for purpose as one looks to the future.

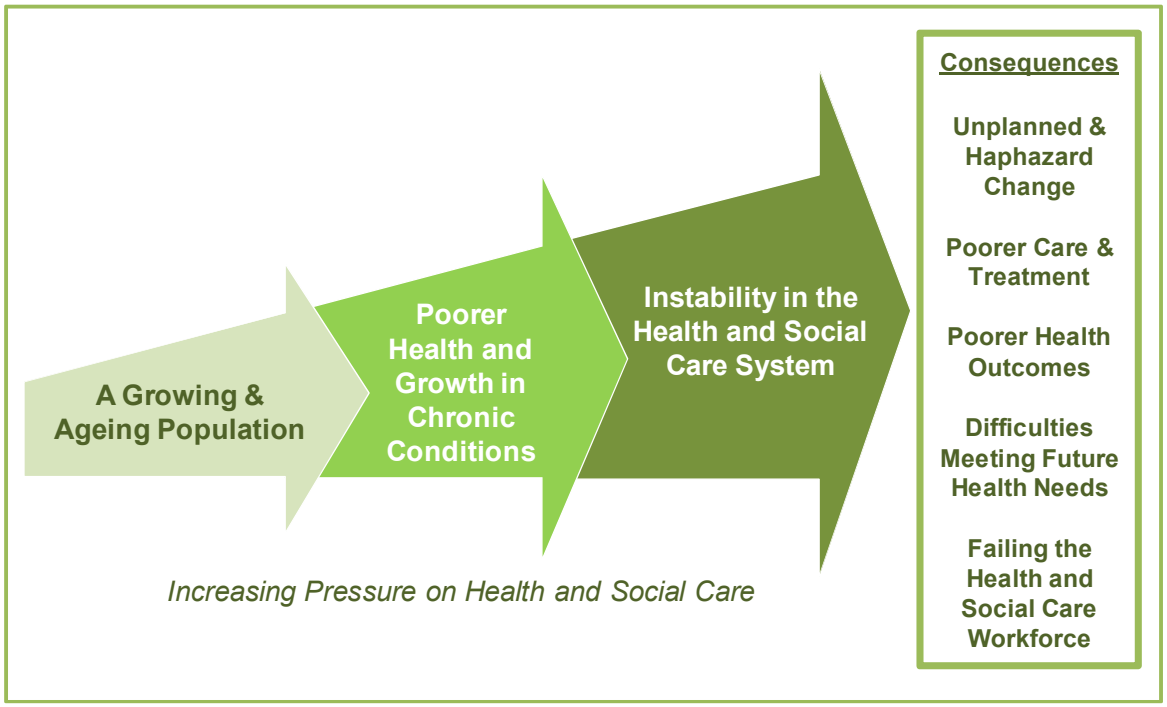
The figure below illustrates the pressures currently facing the system and the potential consequences of doing nothing.

There are no neutral decisions in this regard. If we do nothing, the system will not be able, in its current form, to continue to deliver a high quality service that will meet the needs of the population.

Figure 7: Pressure facing the system

The fundamental changes to our population in terms of age and need are clear. We must design a model which acknowledges this and is based on the needs of this changing population rather than its historic configuration. If we do not plan to change the system we will continue to be faced with unplanned changes that will not be in the best interest of the patient. This will result in a prioritisation of who gets care and a reduction in access to many important services for a large proportion of our population.

We have a highly skilled and dedicated workforce who are being failed by a system which is no longer fit for purpose. This has resulted in staff working within a system which does not deliver the quality



of service to which they strive.

The Review also acknowledges that throughout this process everyone spoken to has asked the Review to promote the **'making it better'** principle and has affirmed that it **can be better**.

WHY DO WE NEED CHANGE?

Despite the many positive aspects of the current model of health and social care, compelling factors reflect the need for change:

- a growing and ageing population;
- increased prevalence of long term conditions;
- increased demand and over reliance on hospital beds;
- clinical workforce supply difficulties which have put pressure on service resilience; and
- the need for greater productivity and value for money.

Against this backdrop, the Review identified 11 keys reasons supporting change. In a new model, how these are responded to will be key to shaping the decisions for the future configuration of specific services.

Reason 1 – The need to be better at

Reason 2 - The importance of patient

Reason 3 – Increasing demand in all

Reason 4 – Current inequalities in the

Reason 5 – Giving our children the best

Reason 6 – Sustainability and quality of

Reason 7 – The need to deliver a high

Reason 8 – The need to meet the

Reason 9 – Making best use of resources

Reason 10 – Maximising the potential of technology

Reason 11 – Supporting our workforce

Reason 1 – The need to be better at preventing ill health

The population of Northern Ireland can become a healthier society through prevention of ill health and the promotion of health and wellbeing. People wish to be responsible in taking decisions to support better personal health. In this regard it is important to communicate evidence to enable people to choose a lifestyle where healthier outcomes can happen.

Smoking - In Northern Ireland around 340,000 people aged 16 and over smoke. Smoking contributes to not only many cancers, heart disease, bronchitis and asthma, but other illnesses including stroke, which causes around 2,400 deaths per year. These deaths are avoidable. Around 86% of lung cancer deaths in the UK are caused by tobacco smoking and, in addition, the International Agency for Research on Cancer states that tobacco smoking can also cause cancers of the following sites: upper aero-digestive tract (oral cavity, nasal cavity, nasal sinuses, pharynx, larynx and oesophagus), pancreas, stomach, liver, bladder, kidney, cervix, bowel, ovary (mucinous) and myeloid leukaemia. Overall tobacco smoking is estimated to be responsible for more than a quarter of cancer deaths in the UK, that is around 43,000 deaths in 2007.[1] Half of all smokers eventually die from cancer, or other smoking-related illnesses.[2] A quarter of smokers die in middle age, between 35 and 69.

Obesity – in the most recent survey of Northern Ireland's health and wellbeing, 59% of all adults measured were either overweight (35%) or obese (24%)[3]. The impact of this increase has resulted in complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

Alcohol and drug misuse cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals including children and young people, families, and communities in Northern Ireland.

Not to act on these facts will condemn the population and the system to failure.

Reason 2 – The importance of patient centred care

Evidence suggests that people are best cared for as close to home as possible. It is also what people have told us through the Omnibus survey - 81% of people

[1] Cancer Research UK

[2] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

[3] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

surveyed said that more health and social care services should be delivered in GP surgeries, local centres and in people's homes.

Inpatient hospital care will always be an important part of how care is provided, but it is only best for a patient with acute medical needs. There are many benefits associated with delivering care within people's homes and in their local communities. Providing patient choice about where they are cared for is critical. Integrated teams working together in the community provide this opportunity and would deliver better quality.

A central theme of 'Quality 2020 - a 10 year Strategy to protect and improve Quality in Health and Social Care in NI[4]' is to ensure the patient and client receives the right care, at the right time in the right place, with the best outcome. The 'High Quality Care for all NHS: Next Stage Review Final Report' also identified the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and it has become clear that a health and care economy-wide approach is needed for an effective and sustainable model of care that is more convenient for patients.

A bed utilisation audit of 2011 showed that, on the day in question, up to 42% of the inpatients reviewed should not have been in hospital.[5] Furthermore in 2009/10, 28% of the deaths of people admitted from a nursing home, occurred within 2 days of admission into hospital[6].

The care closer to home approach is not about challenging hospital provision, but about defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve patient/ client care and experience. The evidence again points to a need for change.

Reason 3 – Increasing Demand

The evidence of increasing demand is compelling whether from a population or disease perspective.

<u>Demography</u>

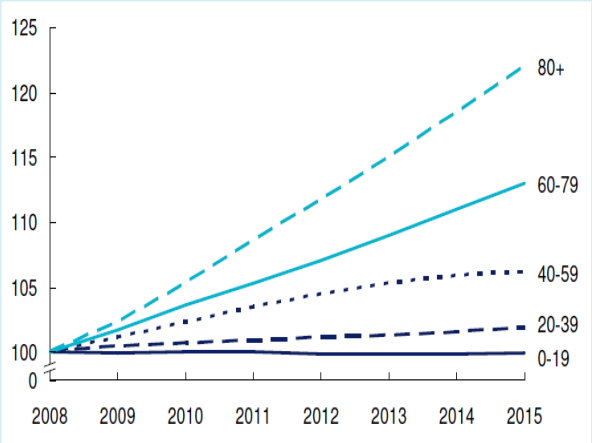
Northern Ireland has a population of approximately 1.8m people. It has the fastest growing population in the UK and it continues to grow. The number of people over 75 years will increase by 40% by 2020. The population of over 85 year olds in NI will increase by 19.6% by 2014, and by 58% by 2020 over the 2009 figure (see the figure below).

[4] Quality 2020, A 10-year Strategy to Protect and Improve Quality in Health and Social Care in NI, DHSSPS

[5] Bed Utilisation Audit of 8 acute hospitals in NI, April – September 2011

[6] HIB, DHSSPS, 2011

Figure 8: Northern Ireland Population Projections



Source: NI Neighbourhood Information Service

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. In particular, older people are identified as important social resources in rural areas, providing informal care and supporting the cultural and social lives of their communities.[7] The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

There is however, a high level of dependence on institutional and hospital care for older people, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations and, since they account for a large proportion of health and social care expenditure, defining a new model to successfully meet the needs of older people is an overwhelming priority. Older people have said they want care, support and treatment in or close to home. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

Disease Prevalence

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. The disease prevalence levels reported via the Quality Outcomes Framework (QOF) are summarised below[8].

- QOF reported prevalence for hypertension has increased year on year across all UK regions, with the rates reported in NI lowest of the 4 UK countries at 12.54%, showing an absence of managing this condition.
- Diabetes is an increasingly common condition. Prevalence in the UK is rising. NI prevalence is 4%.

[7] Commission for Rural Communities (2008) The Personalisation of Social Care

[8] Source: PHA Health Intelligence Briefing on QOF 2009/10).

- QOF reported prevalence of Atrial Fibrillation is increasing year on year across the whole of the UK. In NI, rates have increased from 1.25% in 2006/07 to 1.33% in 2009/10, equating to an additional 1,500 patients with AF.
- Stroke/ Transient Ischaemic Attack (TIA) reported prevalence has increased yearly across the UK. In NI prevalence has increased from 1.37% in 2004/05 to 1.71% in 2009/10, representing over 6,400 additional patients.
- NI has the lowest QOF reported prevalence of asthma at 5.86 per 1,000 patients compared to the rest of the UK. Notwithstanding this prevalence has increased in the last 5 years.
- QOF reported prevalence of Chronic Obstructive Pulmonary Disease has risen steadily since records began in 2004. The prevalence in NI was 1.63% for 2009/10.

All of this describes the unremitting increase in chronic conditions in NI. Individuals with long-term conditions very often have multiple conditions – around a quarter of those in the UK with a long-term condition have three or more conditions[9]. Our system often does not deal with multiple conditions in an integrated way, which for the individual can mean having to engage with multiple clinicians and services which are not well joined up. The consequent personal experience is often very frustrating.

Keeping Pace with Developments

Best practice in health and social care provision is developing all the time. There are new technologies, new care pathways, new partnerships, new drugs and new levels of regulation. Our population will expect access to these improvements. The need to understand demand patterns and work with providers in primary, community and secondary care to ensure more effective management of demand will be a central issue in the future.

It is estimated that the demand for services could grow by around 4% per year by 2015[10]. Examples of the potential consequences without change are listed below:[11]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

If we were to continue to deliver services in the way that we do today, we would

[9] NHS Scotland (2005) National Framework for Service Change. Long Term Conditions Action Team Report.

[10] Reshaping the System (2010) McKinsey

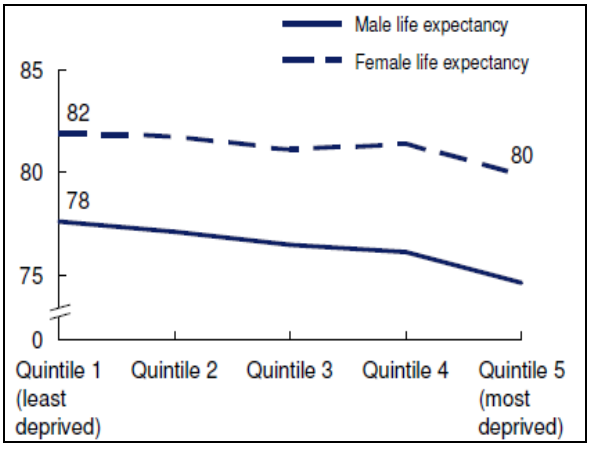
[11] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

quite simply fail the popula#tion as the system struggled to cope. The quality of outcome for the individual and their family would inevitably decline.

Reason 4 – Current inequalities in the health of the population

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. People who live in the 20% most deprived areas are 40% more likely to die before 75 than the NI average. Life expectancy against deprivation level is shown in the figure below.

Figure 9: Life Expectancy and Deprivation in Northern Ireland



Source – NISRA: Independent Review of Health and Social Services Care in Northern Ireland

For example, along the bus route from Donegall Square to Finaghy Road South, there is an increase in life expectancy of 9 years, as shown in the figure overleaf. Similar patterns exist in rural areas.

Across NI there is also variability in the health of the public. Belfast had the highest rate of births to mothers aged 19 or under in 2004 (25.9 per 1000) compared to other Local Government Districts in Northern Ireland. Indeed there is considerable variation even within the Greater Belfast area. In 2009, of the 349 births to teenage mothers in Belfast Trust 37% were in west Belfast, 28% in north Belfast, 15% in east Belfast, 11% in south Belfast and 8% in Castlereagh.

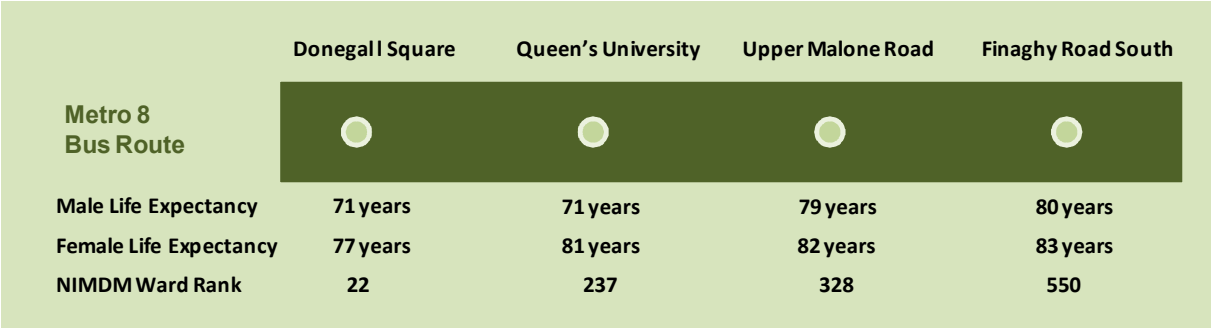
The most deprived group of the population has an admission rate to Neonatal Intensive Care of 19% above the regional average for Northern Ireland.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are highlighted below:[12]

- lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;

[12] NISRA Inequalities Monitoring Report 2010

Figure 10: Life Expectancy, Donegall Square to Finaghy Road South



- self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths; and
- 120% higher rates of alcohol related deaths.

Health and Social Care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population, we need meaningful partnerships and a common agenda to be developed with local government, housing, education, the environment, and our local communities. Making joined up government more tangible is essential. However, it is incumbent on health and social care to look to change and how it can contribute to better outcomes for the citizen.

Reason 5 – Giving our children the best start in life

The 2007 Unicef review of Children and Wellbeing ranked the UK 21 out of 21 developed countries.[13]

There is growing evidence that a child's early years of development have a significant impact on their health in later life.

The Californian Adverse Childhood Experience study (1998) linked childhood maltreatment and later-life health and well-being.[14] The consequences for society include: adult mental health

[13] UNICEF (2007) *Child Poverty in Perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7, UNICEF Innocenti Research Centre, Florence.
[14] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med.;14(4):245-58

problems, poor physical health and high health expenditure.

Early Intervention: Good Parents, Great Kids, Better Citizens report argues 1 in 8 children are currently growing up in an environment of unacceptable risk.[15] Neglect and abuse in early years creates emotionally, mentally and physically damaged adults thus perpetuating problems into the next generation. An early intervention approach counteracts this outcome. The study identified the need to respond differently to the childhood years through structured early intervention.

The review of research found that targeted, intensive programmes such as the Family Nurse Partnership can help improve outcomes for vulnerable children and families, for example: reduced child abuse and neglect, reduced crime, reduced drug and alcohol abuse, and reduced school grade repetition.[16] These result in reduced victims' costs and increased earnings, highlighting a ratio of return of £3 for every £1 invested.

The Review noted that it has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. It had been predicted that the number of births in Northern Ireland was to decline but in fact birth rates have remained broadly static. This overall position has led to an increased demand, particularly for family support services.

Given this evidence, failure to do better will prevent any opportunities to break the cycle of poor life outcomes for many in our society.

Reason 6 – Sustainability and quality of hospital services

Given the increasing and changing nature of the population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. If we were to continue to provide services as they currently are, it would lead to unplanned and unmanaged collapse of key services. This would ultimately lead to detrimental impact on patients and clients. The choice is stark: it is not principally about money but about sustainability and clinical evidence. The conclusion is clear: plan and manage the transition or accept a more haphazard set of changes. In this regard there are no neutral decisions.

Historically, in Northern Ireland, there has been an over-reliance on hospital services. Given its rurality and based on recognised norms, a population the size of NI is likely to have between 5 and 7 major acute hospital networks, each

[15] Good Parents, Great Kids, Better Citizens. Graham Allen MP and Rt Hon Iain Duncan Smith MP, Centre for Social Justice and Smith Institute 2008

[16] The Family Nurse Partnership Programme, Department of Health, http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128402.pdf

serving a population of some 250,000 to 350,000. Currently we have 10 hospitals for a population of 1.8million, in other words one per 180,000. The rurality of Northern Ireland has historically influenced the number of hospitals provided, and this must also be taken into consideration when developing a new model of care. There is however evidence to show that whilst important in a Northern Ireland context that travel per se does not create worse outcomes. For example the Rural Trauma Outcome Study in Scotland[17] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The Royal College of Surgeons has stated that in a fragmented emergency surgical set-up a patient is four times more likely to have a poorer outcome than in a more organised model. It goes on to say that where the model is not organised, patients have prolonged hospital stays with significant cost implications, both physical and emotional to the patient and their family[18].

Trying to maintain acute services across the current number of sites has proved increasingly difficult. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, on a 24/7/365 basis (24 hours a day, seven days per week and 365 days per year). Currently, many sites rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost. It also creates service fragility.

The Chairman of the British Medical Association's Council in Northern Ireland stated that "the present situation is untenable: we cannot maintain top flight A&Es in every town. Reconfiguration... is currently happening by crisis rather than by taking difficult decisions". He goes on to cite recent changes at the Mid-Ulster, Whiteabbey and Belfast City Hospital as examples of how reconfiguration is currently occurring by crisis rather than in a structured and planned approach.[19]

More people are admitted to our hospitals than in other areas of the UK and lengths of stay are significantly longer.

In simple terms, we know it is possible and better to provide services closer to home but we have continued to use hospitals. This is an unsustainable model which will deliver poorer outcomes for the patient in the future.

Reason 7 – The need to deliver a high quality service based on evidence

The responsibility of the HSC is to deliver a high quality, safe and accessible service

[17] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

[18] The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group, Royal College of Surgeons of England and Department of Health

[19] News Letter, November 7 2011

to the population of Northern Ireland, with good outcomes. Currently there are indications that there is room for improvement in how things are done.

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. Yet evidence suggests lower than appropriate access to general practice is achieved.

Although improving, daycase rates are lower when compared to England at 64.7% compared to the England average of 75.5%.

The number of registered suicides rose from 146 in 2005 to 313 in 2010. The rates per 100,000 of the population vary greatly across the region with a rate of 24.9 in the most deprived area compared to 7.6 in the least deprived area.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, but we still fall behind European survival rates in a number of cancers, so further work needs to be done. A study[20] funded by Cancer Research UK and the Department of Health, England was carried out by researchers from a number of institutions in Australia, Canada, Denmark, Norway and the UK that were the focus of the study. Survival rates were found to be "persistently lower" in Denmark, England, Northern Ireland and Wales.

In obstetric services, 55.6% of deliveries are normal, compared with 61.2% in England and 61% in ROI. Our caesarean section rate is high at 30.2% compared to 24.1% in England and 25% in ROI.

Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision.

At March 2010 there were 2,606 looked after children in Northern Ireland, up by 6% (143) from 2009 (2,463). 11% (about 270) of these children were in residential care, where the outcomes are likely to be very poor, and 65% were foster care placements.[21] The recruitment of foster carers to meet rising demand continues to be a challenge to ensure choice and the matching of carer skill to the needs of the child.

Every year in Northern Ireland around 3,000 people suffer a stroke. Stroke is the third biggest killer and the leading cause of severe disability in Northern Ireland. Up to 40 per cent of strokes are preventable.[22]

The Royal College of Physicians, National Sentinel Audit 2010, found NI had a higher length of stay of 21.3 days (to

[20] The study was published in the peer-reviewed medical journal The Lancet.

[21] Children Order Statistical Tables for NI 2009/10

[22] National Stroke Association 2005

discharge or death) compared to the National average of 19.5 days.[23]

Looking at general Surgery, the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at the weekend rather than during the week, where the service is not well organised. Provision of services, particularly of theatre access, critical care and interventional radiology, is often incomplete, and the correct location of patients after surgery is often not given sufficient priority. Furthermore, the clinical response for patients who deteriorate is often poorly thought through and, at times, ad hoc[24].

Dr Foster, a UK provider of comparative health and social care information, also reported that it found a worrying 10% spike in deaths at weekends compared with weekdays across 147 hospital trusts.[25] Too often our services do not respond to 7 day a week working.

PCI (Percutaneous Coronary Intervention) is a treatment to reduce or eliminate the symptoms of coronary artery disease including angina, dyspnea and congestive heart failure. A pilot carried out by the Belfast HSC Trust (Feb10 – Mar11) showed low mortality rates associated with PCI that were largely predictable and could be improved if PCI was better organised.

While significant improvements have been secured, NI continues to spend significantly more per head on prescription medicines than the rest of the UK at £232 per head of population, compared to Wales £194, Scotland £187 and England £165 (2009/10).

All this has informed the Review that the current model does not provide as high quality care as it could.

Reason 8 – The need to meet the expectations of the people of NI

Whilst the Review acknowledges it is difficult methodologically to get a full consensus on a population view, there are however factors which need taken into account.

A structured Omnibus survey to inform the Review was conducted in October 2011 in which 1009 people were surveyed from across Northern Ireland. This was supplemented by the online public survey. The online survey was completed by 673 persons, 91% of whom work for an organisation providing HSC services.

The high level results of the surveys are highlighted within this section with more detail throughout the body of this report and within Appendices 2 and 3.

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[23] RCP National Sentinel Clinical Audit of Stroke 2010

[24] Aylin P, Yunus A, Bottle A *et al*. Weekend mortality for emergency admissions. A large,multicentre study. Qual Saf Health Care 2010; 19: 213–217

[25] Dr Foster – Hospital patients 'more likely to die at weekends', November 2011

There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied.

However, the Omnibus survey results went on to highlight dissatisfaction with:

- accessibility of services;
- the quality of services to older people; and
- the quality of services for people with mental health problems and learning disabilities.

A need for improvement was identified across each of these areas.

Access

- In regard to GP services: 65% felt that improvement is required including 23% who stated that a lot of improvement is required (22% in the online survey).
- Looking at assessment for home nursing or residential care: 79% felt that some improvement is required (including 21% who felt that a lot of improvement is required). This was supported by the online survey findings where 86% felt improvement is required (including 26% who felt that a lot of improvement was required).
- Appointment with a hospital consultant: 82% (and 91% in the online survey) felt some improvement is required, including 36% (30% in the online survey) who felt that a lot of improvement was required.
- Non emergency operations: 88% (91% in the online survey) felt some improvement was required including 36% (and 34% online) who felt that a lot of improvement is required.
- Time waiting in Accident and Emergency (A&E): 91% (96% online) felt improvement was needed, including 56% (and 47% online) who felt a lot of improvement was required.
- Access to Mental Health Services: 93% of people (online survey) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required).

Quality of Care for Specific Groups

- Older People: 89% (98% online) felt that improvement is required in the quality of care for older people, including 35% (35% online) who felt a lot of improvement is required.
- People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required.
- People with learning disability: 70% (91% online) felt that improvement is required, including 30% (32% online) who felt a lot of improvement is required.

The online survey also highlighted the following:

- Quality of hospital services: this was not highlighted as an issue within the omnibus survey, but the online survey results showed that 92% felt there was some improvement required, with 18% feeling a lot of improvement is required; and
- Support for Carers: 97% of the online survey stated that improvement is required, including 45% who felt a lot of improvement is needed.

Further reinforcement of these results is expressed in the Patient and Client Council Priorities for HSC in Northern Ireland, November 2011. Some of the key priorities identified were:

- hospital care;
- care of the elderly (including domiciliary and community care);
- waiting times;
- cancer services;
- mental health and learning disability;
- health and social care staffing levels;
- access to GPs and primary care;
- children's services;
- reducing the costs of administration and management; and
- quality of care.

This evidence indicates strongly that the current system of health and social care is not meeting citizens' expectations.

Reason 9 – Making best use of resources available

This review is not about money per se and any discussion on resources produces strong views. It is, however, entirely valid to look at how we could use resources and the consequent productivity. In that regard it is difficult not to conclude that, with the overall level of resources available, we have the ability to provide a better service. The budget cycle has indicated annual expenditure of £4.65billion by the end of this Assembly period (2014/5). The Review was not asked to reduce this figure but knows that with annual pressure of 4% from residual demand and changing population,[26] change is non-negotiable. The challenge presented to the Review is simply how best to spend the resource to achieve maximum benefits.

Best Use of Estate: we currently have 10 acute hospitals, 5 local hospitals and 30 community hospital facilities, with 4,361 beds in acute and local hospitals, and 1,924 community beds. In addition there are 60 statutory residential and nursing homes for older people, 39 residential homes for children, as well as a range of daycare centres and health centres. There is an over reliance on buildings to

[26] Reshaping the System (2010) McKinsey

provide care rather than support its delivery.

Any future models of care will have to take into consideration the best use of the estate that is currently available. It will not however concentrate on the preservation of the existing building stock but rather present a new service model which delivers care on a 24/7/365 basis.

Best Use of Staff: the HSC currently employs 78,000 people either full-time or part-time, which equates to 53,209[27] whole time equivalents across all specialties comprising:

- 33% nursing staff;
- 7% medical and dental;
- 12% social services;
- 5% Allied Health Professionals;
- 4% home helps;
- 2% ambulance services staff;
- 7% other professional and technical staff; and
- 26% admin and clerical staff (including medical secretaries ward clerks); and
- 4% managers (being Band 7 or above).

Our staff mix is primarily structured to support the existing care model which is institutionally based. For example, Northern Ireland has a higher proportion of qualified nursing staff (across all settings) compared with England, at 77% compared with 73%. Nursing care has 3.5 times the activity per weighted population than England and Wales. The driver appears to be elderly patients, with NI having 3 per 1000 weighted population compared to 0.16 per 1000 population in England.[28]

Appleby[29] stated that indicative data suggests Northern Ireland produces between 17% and 30% less inpatient, outpatient, day case and A&E activity per head of hospital and community staff than England and that hospital activity per member of staff is 19% lower than the UK average. These efficiency figures are very closely aligned to our current hospital model.

Best Use of Money: In the US, currently the care costs for 5% of the population account for 50% of health care spending.[30] This fact can be applied to any western health economy including Northern Ireland. Addressing the reason for this will require changes to be made which ensure resources are focused in the right areas.

If we were to continue providing health and social care in the same way as we do today, some suggest we would need £5.4

[27] DHSSPS NI Health & Social Care Census, March 2011

[28] Reshaping the System, McKinsey 2010
[29] Independent Review of HSC Services in Northern Ireland, 2005
[30] Research in Action, Issue 19, 2006

billion of funding by 2014/15 to cope with this combination of growing demand for care and inflating costs. Given that this is unrealistic, from both an economic and delivery perspective, we need to reshape services. Adopting a new model which is efficient, patient centred and providing high quality evidence based services, would enable a legitimate debate in the future on how much funding health and social care should receive, compared with other public services.

Much of the significant management, administrative and overhead efficiency savings potential in health and social care has already been captured through the Review of Public Administration (RPA), and the potential for further savings is limited. Instead, fundamental change is required in how we deliver care in the future.

Reason 10 – Maximising the Potential of Technology

Technological change is both a driver and enabler for the future. The pace of change is incredible and our current model does not promote its absorption or benefit as it should. For example, NI has now one of the most sophisticated radiological systems anywhere but we need new ways of working to maximise the potential of this technology. The technology that enables 24/7 intervention in the care of strokes and coronary conditions can revolutionise the outcome for patients but to deliver it our current service pattern must change.

There is overwhelming evidence that organising emergency care separate from elective care makes better use of the infrastructure in hospitals. Information is key. As a system we have a huge amount of data but poor data analysis, preventing professionals from having the evidence that is central to their work. For example, information from patient records could be used more effectively to monitor our local health needs and to assess what treatments are working well. Data needs to be used in a more effective way to ensure it is translated into information that we can use to plan our services.

Communication with the public is not as modern as it should be, for example in arranging appointments, in explaining how to use the service and giving timely information. This leads at times to disorganisation in our response to the individual and inefficiency.

The technological infrastructure in NI is good and it can promote more care closer to home but our service has not yet fully embraced the opportunity that exists. Connected health projects exist but have emerged in an ad hoc manner. If the service is to derive maximum benefit in this regard, development of connected health needs to be more coherent. Changes therefore will need to build upon the existing Memorandum of Understanding between Invest NI and DHSSPS in relation to connected health. A clear commitment to maximising the technological potential to service provision will be essential.

Reason 11 – Supporting Our Workforce

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. The most common reason stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%). When the Review team met with staff to discuss the future there was not a single voice which argued for the preservation of the existing model of service.

The Review acknowledged the willingness of staff to make change and heard clearly that they wanted to be closely involved in how change should happen.

CONCLUSION

It is clear that we need to act now both to improve our system's quality and productivity, and to better manage the demand on our services. Fundamental change is required in how we deliver care in the future. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. More simply put, we need a new model of care.

We are not different. Whilst there are unique factors at play in Northern Ireland impacting on the demand for services, a number of the issues with the HSC in NI are common in other areas of the UK.

Healthcare for London, A Framework for Action was a review into the healthcare delivered to the population of London, led by Prof. Lord Ara Darzi. This review set out similar issues in terms of the need to focus on improving the quality of services delivered, meeting the expectations of the public, addressing the inequalities in the system, delivering the right care in the right place at the right time, issues with the configuration of specialist services and making better use of resources available, both in terms of the workforce, the infrastructure and taxpayers' money.

The Scottish Government's Shifting the Balance of Care framework set out a programme of changes across health and care systems intended to: bring about better health outcomes for people; provide services which reduce health inequalities; promote independence; and provide

services that are quicker, more personal and closer to home.

NHS Wales also recently published a report setting out its 5 year vision for the NHS in Wales, Together for Health. This review identified largely common issues, including challenges with a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

Consequently NI cannot insulate itself from the need for change.

The Review presents an opportunity to consider a more integrated model for the HSC system that allows us to deliver an excellent health and social care service to the population of

THE PRINCIPLES FOR CHANGE

5. THE PRINCIPLES FOR CHANGE

The Review team has concluded that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do, they will not meet the needs of our population and will not be sustainable for the years to come. Therefore, changes are needed to meet future health and social care needs.

In looking to recommend a new model, the Review has engaged widely with the public, clinicians, providers and interest groups, and reviewed research evidence to inform the changes that are required. It started with the 'user first' principle rather than considering the structures in our health and social care system. The aim throughout has been to consider what changes would make the greatest difference to outcomes for patients, users and carers.

The Review has developed a set of principles that will underpin the shape of the future model for health and social care. Later, in the document, when the implementation pathway is described, these principles will be important determinants in the change process. They build upon the three core objectives upon which the National Health Service (NHS) was founded:

- to meet the needs of everyone;
- to be free at the point of delivery; and
- to be based on clinical need, not ability to pay.

The Minister, in his statement on 27th September 2011, said that he believed the Assembly was fully committed to those principles, but had to recognise the fact that the rising level of need in health and social care services, the need to focus on outcomes and the constrained financial context made it increasingly difficult to hold onto those principles. The ability to continue to deliver these principles is only possible through the support of a radical programme of service change and reconfiguration.

The Review has concluded that there are twelve major principles that should guide changes to health and social care.

KEY PRINCIPLES

1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence
3. Providing the right care in the right
4. Population-based planning of services.

5. A focus on prevention and tackling
7. Promoting independence and
9. Ensuring sustainability of service
12. Incentivising innovation at a local

WHAT DO THE PRINCIPLES MEAN?

1. Placing the Individual at the Centre of any Model

The individual must be at the centre of the health and social care system. The model must be built around what will produce the best outcomes for individual users, carers and families. Clarity about communicating this principle is essential.

2. Using Outcomes and Quality Evidence to Shape Services

All services should demonstrate that they are able to meet well understood measures of quality. This must include taking account of an evidence base of existing and emerging research on what produces the best outcome, both within Northern Ireland and beyond.

In NI, Service Frameworks[31] have been developed for 4 service areas, and a further 3 are under development. The Frameworks promote and secure better integration of service delivery along the whole pathway of care from prevention, diagnosis, treatment and rehabilitation, and on to end of life care. These include:

- cardiovascular services;
- respiratory services;
- cancer prevention, treatment and care;
- mental health;
- learning disability (under development);
- older people's health and wellbeing (under development); and
- children and young people's health and wellbeing (under development).

This is the best way to ensure that our limited human, financial and physical resources are used in the most effective way to produce the best possible patient and client outcomes.

[31] Service Frameworks, DHSSPS

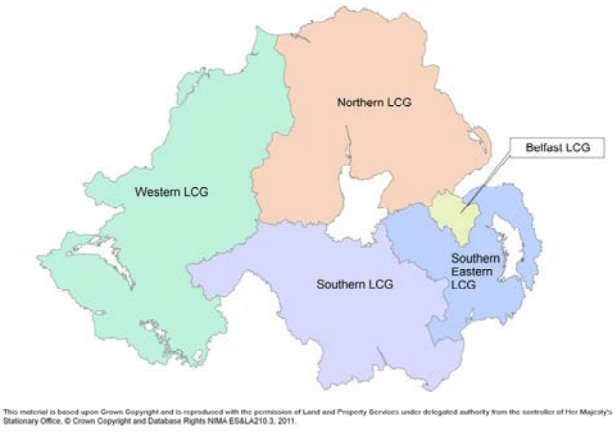
3. The Right Care in the Right Place at the Right Time

Care should be provided at home or as close to home as possible. Many of the services currently provided in an acute hospital or institutional setting should be provided in the community or in people's homes, making them more accessible. Where it is not safe and effective to provide services locally they should be provided more centrally or regionally. More simply put, the health and social care system should provide local services for local people, but safe, sustainable and accessible services for populations.

4. Population-Based Planning of Services

Services should be planned on the basis of the needs of a defined population or 'health and social care economy'. The Review team recognises population boundaries can be artificial but the starting point is to use the existing local health and social care economy populations, which are synonymous with the current Local Commissioning Areas (as in the figure below).

Figure 11: Local Commissioning Areas



When necessary this should incorporate joint planning between these populations to deliver local or more central services. For some services this would require planning to take account of a NI wide perspective. However, with a population of 1.8million it is simply not feasible to provide every health and social care service that may be required, e.g. in these cases planning should be done jointly with other UK countries or the Republic of Ireland. The levels of planning are illustrated in the figure below.

Figure 12: Levels of Planning

5. A focus on Prevention and Tackling Inequalities

Prevention is always better than cure whether primary, that is avoiding the problem occurring, or secondary, that is arresting the problem. Such measures should be embedded into every service area. Services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. The factors impacting on health and wellbeing are diverse but well known and this will require partnership working across government and between the public and voluntary, community and independent sectors. Health economies will need to pay particular attention to achieving these outcomes demonstrating how in practice this approach expresses itself to the individual.

6. Integrated Care – Working Together

Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes. This starts with making it simpler to use the system. It will require clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care, that is doctors talking to doctors, and professionals jointly reaching decisions about patients' and clients' care in partnership with them. Closer working together will be mandatory, illustrated by demonstration of full support of the various constituent parts of the service as to how services are organised. Underpinning this will be the requirement for improved technology and information sharing.

7. Promoting Independence and Personalisation of Care

Greater control by those in receipt of the service is a necessity. Flowing from this, as much diversity as practical should be available. To deliver this there should be a mixed economy of providers. In the majority of instances, this will be provided by statutory services but joint working with the independent sector will be expected. Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements. Patients, service users and their carers should be helped to take the important decisions about their own care, and importantly, enabled and empowered to take ownership of their own health. The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process.

8. Safeguarding the Most Vulnerable

Throughout the health and social care system, appropriate safeguards should be in place to protect the most vulnerable in society.

9. Ensuring Sustainability

Providing services requires significant attention to be spent in ensuring workforce sustainability. More simply put it means service models need to be robust. In this regard endorsement of regulatory and training bodies such as NIMDTA is essential. While locum and agency staff may be used to support a service where necessary and appropriate, they should not be inextricably linked to a service's ability to remain. Services organised this way are quite simply not sustainable.

10. Realising Value for Money

Any service models taken forward as a result of this Review must take cognisance of financial resources available to the HSC and secure value for money. Therefore there is a need for financial realism.

11. Maximising the Use of Technology

Changes should be supported by up to date technology to ensure vital information can be shared quickly among professional staff, duplication eliminated and that the latest diagnostic and treatment tools are available.

Changes should take account and build upon the Memorandum of Understanding between the DHSSPS and Invest NI on "Connected Health and Prosperity".

12. Incentivising Innovation at a Local Level

Making changes on the scale indicated in the following model will require devolved decision making and an incentive culture within health and social care, its workforce and the population. This is a direct response to the question 'why would I do it?'. Changes will need to show how they make things better, starting first with their positive impact on those using the service. The incentives of more local control in decision making, better training and development for the workforce and innovative ways of using resources will all be integral to the change process.

In this regard partnership working will be central, whether between populations in NI or with jurisdictions outwith NI. It will also be essential to explore in this context working with others, for example, the voluntary and independent sectors and the pharmacy industry to fully deliver the new model of care.

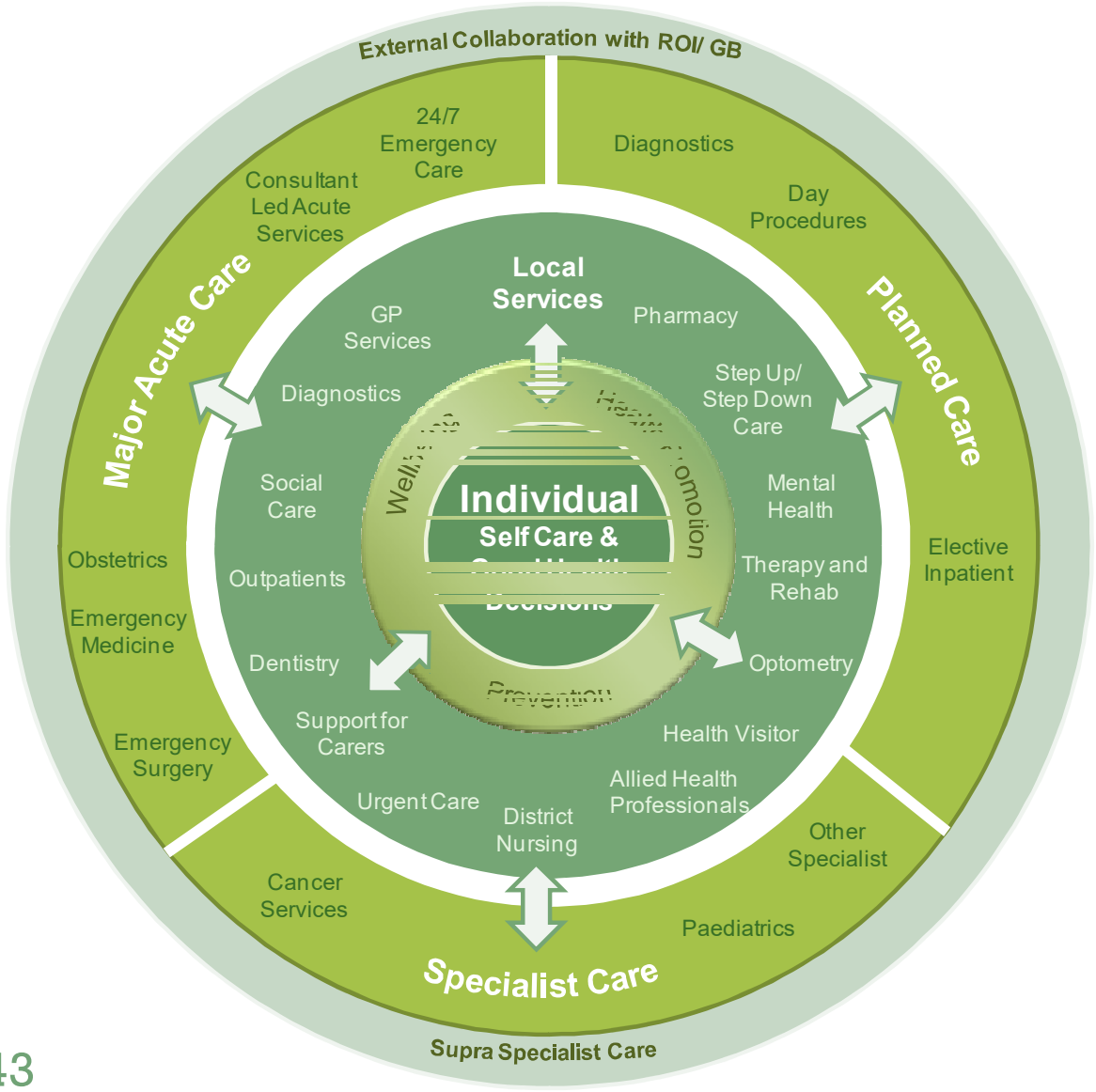
A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

6. A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

Following from the key principles outlined above and the Review's assessment of the opportunities that exist to do things better, a future model for integrated health and social care has been developed. This is illustrated in the figure below.

The future model is designed with the individual at the centre, with health and social care services built around them. Health and social care begins with the individual who is supported to care for themselves and make good health decisions.

Figure 13: Future Model for Integrated Health and Social Care



THE INDIVIDUAL

Every individual has a responsibility to make decisions that help maintain good health and wellbeing, prevent the onset of illness, and minimise deterioration as a result of any existing conditions they may have. People are supported to do this by health and social care professionals, their community, health and social care initiatives and regional health promotion, health protection and prevention initiatives. For example, this may include family support programmes run in community centres, smoking cessation programmes in pharmacies, screening in GP clinics (e.g. for cervical cancer), health visiting for newborns, healthy eating initiatives in community centres, and exercise programmes in local leisure centres. Fundamentally, people need to be supported to take responsibility.

LOCAL SERVICES

Integrated Local Services

For most people, much of what is needed from health and social care services will be increasingly accessible in their local area, either in their own home or in a local facility.

In many ways this may not seem much different to the way services are currently provided. The professionals providing local health and social care services, (for example GPs, district nurses, dentists and social workers) will continue to operate in local surgeries, health centres and high street practices, and to visit people's homes where needed. However, the way that they work with each other will be different.

GP practices will work together as federations of practices, enabling consistently high quality care for their patients. Additionally, Integrated Care Partnerships will be set up to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of local population and planning and delivering integrated services. Seventeen Integrated Care Partnerships will cover Northern Ireland.

For the individual, this will mean that GPs and all the other health and social care providers in an area, including from the voluntary and community sector, will be able to work together to deliver the services needed by their local population. As a consequence people will deal with fewer professionals and be at the centre of the decision making about their care and treatment.

Technology will support this integrated working. Electronic Care Records will allow health and social care teams to see patient records including details of medications, results of tests and any

hospital treatment. This will help ensure that professionals have access to the information they need to treat a patient effectively, including in an urgent care situation. Patients will also have improved information on their personal circumstances.

More Services Provided In the Community

The public told the Review that there should be a greater range of services available in the community. Therefore, under the new model, more of the services that currently require a hospital visit will be available locally. This may include for example, X-rays and other diagnostic tests, and oral surgery. GPs will be enabled to undertake minor procedures in their surgeries. Outpatient appointments in many instances will be provided in the community rather than in hospital. In some specialties, care will be organised directly by the Integrated Care Partnership. New facilities will be developed to support this model, which may be similar to the health and care centres currently in some areas. This model will improve accessibility to health and social care services for the individual.

More specialist care will be provided in the community. Specialist hospital clinicians will support GPs and other community clinicians, working closely with them to plan how services are delivered. More specialists will also be employed in the community, for example, specialist nurses and GPs with a Special Interest. Providing outpatient appointments in the community will become the norm, with some of these being run by GPs and others by hospital specialists. This will reduce the number of follow-up visits to hospital required by patients.

These changes will be very important for people with long-term conditions, for example diabetes, cardiac illness or respiratory problems. For these patients, community-based support programmes will be put in place where multi-disciplinary teams work with patients to help them manage their condition. This will include:

- dedicated community-based clinics where patients can access a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists;
- better use of telehealth equipment to help people monitor their own conditions and alert health professionals when an individual's condition deteriorates;
- a named contact person for patients to call when they need assistance – this may be the GP, a specialist nurse or another member of the integrated care team; and
- direct admission to hospital care when needed as agreed between the GP and hospital specialist, with no need to

pass through the hospital emergency department.

Working in this way will also benefit groups who can face barriers in accessing care. For example, the new model will support the provision of enhanced community health services for people with a learning disability.

There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.

More Support Available at Home

Throughout the Review people expressed their preference for care at home or as close to home as possible. In response to this, the new model will provide more support to help people who are sick or frail to maintain their independence and stay in their own homes for as long as possible. This applies whether that home is the family home, supported housing, a nursing home or residential home. However, there will be much greater emphasis on enabling people to remain in their chosen home. Providing care, treatment and support in this way will change the current model, perhaps most noticeably in terms of the number of residential homes.

As part of this approach, more tailored support will be provided to meet people's needs. People will have access to specialist equipment, nursing care, telehealth and telemonitoring support, and other therapeutic support at home, e.g. physiotherapy, podiatry or occupational therapy.

Social care will also be a central part of the support provided to enable independent living. This will include access to a diverse range of provision to meet people's social and emotional needs and tackle social isolation. Voluntary and community sector organisations will provide this support as well as community health and social care teams.

Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care.

Intermediate care will be an important component of the new model, with greater provision of step-up and step-down beds in the community for people needing extra care for a short period of time. Step-up beds provide locally-based short-term support to avoid the need for individuals to be admitted into an acute hospital. Those leaving hospital may spend time in a step-down bed for rehabilitation before returning home. A reablement model will be introduced to provide people with the support they need to return to their homes following a stay in hospital, an accident or other crisis.

There will be a need to provide more respite care and short breaks in the community, to support individuals and carers. This will include accommodation and other short break options. All of this intervention is designed to respond to the patient's and carer's needs.

How people are cared for at the end of life is a key indicator of the values expressed by the HSC. Under the new model, services for those approaching the end of life will be provided that enable people to die at home, where that is clinically appropriate and consistent with their wishes. GPs and other community health services will provide in-reach to support people at end of life. This will apply in nursing homes as well as family homes.

Urgent Care

An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.

EMERGENCY, SPECIALIST CARE, AND PLANNED CARE

Emergency care, specialist care, and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities.

People needing specialist and acute care will be admitted to hospital. This may be on a planned basis, for example, for a pre-arranged procedure or as a result of an emergency.

The model aims for those admitted to hospital to be discharged to home or a community facility as soon as their health and care needs can be met there. Once individuals are discharged, follow-up care will be provided by the integrated care teams in the community with support from hospital specialists as required. As well as meeting the needs of patients and their families more effectively, this is a more efficient approach which will result in greater productivity.

Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

EXTERNAL COLLABORATION AND SUPRA-SPECIALIST CARE

Some services that are only needed by a very small number of people will be provided outside of Northern Ireland. This is necessary to ensure the quality of provision. Networks will be set up between the HSC in Northern Ireland and health and care providers in the ROI and other parts of the UK.

CONCLUSIONS

The proposed model has been designed to address the challenges presented in the Case for Change and the concerns expressed by those engaged with throughout the Review, both clinicians and the public.

The key differences between the current model of care and that proposed by the Review will be:

- care will be organised around the individual and not the institution;
- greater involvement in decision making will be afforded for the patient / client;
- the model provides a new way to look at the traditional model of GP and community health and social care services;
- home or close to home will be the centre of health and social care provision;
- there will be responsible access to emergency and hospital care; and
- new arrangements will be put in place to support provision outside the jurisdictions.

Overall, the model builds on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future.

CASE STUDIES

The Review team considered it important to describe how it might be different for those using the service and offers the following examples to illustrate the change.

Older People	

Case Study – Long Term Conditions	

Case Study – People with a Physical Disability	

Mental Health

Case Study – Urgent Care	

7. POPULATION HEALTH AND WELLBEING

INTRODUCTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions. Additionally it is an important determinant in optimising health outcomes for the citizen. Investment in prevention also makes economic sense, for example, inequalities have been estimated in England to cost £5.5billion to the NHS alone.[32]

Total annual inpatient costs to health and social services in Northern Ireland as a result of smoking were estimated at £119million in 2008/9.[33]

Loss to the local economy as a result of obesity is estimated at £500million, with 59% of the population being either overweight or obese. This includes, for example, some £24.5million spent on prescribed anti-diabetic medication alone.[34]

The impact of alcohol on the health and social care system is estimated at some £250million. The additional social costs are estimated at almost £900million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and the HSC has a duty to address the health inequalities in our population.

THE CHALLENGES

The starting point is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action across government and partnership working. One area brought to the Review's attention was rural isolation and transport. The Review would suggest this is an area in which joint working could be piloted, including joint sharing and control of resources.

No-one disagrees with the concept of health and wellbeing, the challenge is to deliver a programme of change. Financial pressures will undoubtedly increase within HSC budgets, and often there is

[32] NICE (2009) Using NICE guidance to cut costs in the downturn.
[33] RCP (2000) Nicotine Addition in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.
[34] N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

consequent pressure to defer investment in prevention.

LIFESTYLE CHOICES

Alcohol Consumption in Northern Ireland

Given the link between alcohol consumption and harm, and evidence that affordability is one of the drivers of increased consumption, price has become an important feature of prevention strategies. Alcohol is now 44% less expensive in the UK than it was in 1980. It is possible today to exceed the maximum weekly recommended intake of alcohol for men (21 units) for around £4.

A University of Sheffield report, used by the Scottish Government, suggests that a minimum price of 45p and a complete ban on promotions would save about 50 lives in year one, rising to 225 lives in year ten. Moreover, it has been estimated for Scotland that the 45p per unit minimum price would have a total value to health, crime and employment in year one of more than £50million and over ten years of more than £700million.

The submission to the Review from the Royal College of Psychiatrists in Northern Ireland also highlights its view that alcohol price control could be the single biggest act that Government could undertake to improve health and wellbeing in Northern Ireland.

As NICE states: “There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol".

Over the last ten years, it has become increasingly socially unacceptable to drink and drive. This has been via a mixture of enforcement, education and diversion. In this context, it is proposed that a reduction in hazardous and harmful drinking becomes a priority for Northern Ireland with associated targets such as a reduction in A&E attendances helping to drive performance. This could be supported by focused media campaigns to change behaviours/ culture along with evidence based interventions for reducing harmful and hazardous drinking across Northern Ireland.

Smoking

As detailed in the Case for Change, around 340,000 people aged 16 and over smoke in Northern Ireland. Half of all smokers eventually die from cancer, or other smoking-related illnesses.[35] A quarter of smokers die in middle age, between 35 and 69. These deaths could be avoidable.

Reducing smoking is a high priority for public health and there is an ongoing programme of action to encourage people who smoke to stop and discourage people from starting to smoke. This includes public information campaigns and

[35] Mortality in relation to smoking: 50 years’ observations on male British doctors, Doll et al, 2004

smoking cessation services. The model of care proposed by the Review offers the opportunity to take an integrated, area-based approach to these actions, targeting groups facing particular risks, such as pregnant women, and locations where smoking rates are known to be higher, for example colleges.

Obesity

The Case for Change highlighted the rate of obesity in Northern Ireland and the challenges this presents. An estimated 59% of all adults are either overweight (35%) or obese (24%),[36] which has a very significant impact on our population's health and wellbeing. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

A regional Obesity Prevention Framework is being developed to set out the actions needed to reduce the rate of obesity. These include supporting the individual to take responsible decisions and helping to create an environment that supports healthy decisions about diet and physical activity.

In relation to the lifestyle factors of diet, physical activity, smoking and alcohol consumption, it is important that we provide citizens with good information and that we create environments which make it easier for people to make healthy choices.

To support this, the Review would encourage the Northern Ireland Executive to consider the wider role of the state in taking decisions impacting on health outcomes. In addition to considering the emerging evidence on the potential benefits of minimum pricing for alcohol (for example, taking account of the outcomes of the Scottish alcohol pricing initiative), the Executive may wish to consider the issue of pricing of alcohol and 'junk' food and further controls on tobacco usage.

SCREENING AND PREVENTION

Population screening programmes enable the early detection of disease. They involve testing people who do not have any particular symptoms of a disease to see if they have the disease or are at risk of getting it. Screening allows earlier intervention which contributes to improved outcomes for individuals. The current programmes include screening for breast, cervical and bowel cancers, diabetic retinopathy, antenatal infection screening and a programme of screening for newborns.

Immunisation is the most effective public health intervention for preventing ill health and saving lives. It provides people with vaccinations to protect them against serious infections. Many of these are provided in childhood, for example primary vaccinations for diseases including polio, whooping cough, diphtheria, and the MMR vaccine for measles, mumps and rubella. Uptake rates for childhood vaccination are very

[36] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

high in Northern Ireland and above the UK average. The uptake rates for the flu vaccination, which targets groups at risk of serious harm from the winter flu virus, are also higher than the UK average in Northern Ireland.

The Public Health Agency is responsible for screening and immunisation programmes. Key priorities are to maintain and expand existing programmes and to introduce new programmes where there is good evidence that they can be effective.

SOCIAL WELLBEING

The role of social support in preventing illness and enhancing individuals' quality of life is well recognised. For example, Section 8 which focuses on care for older people, describes how loneliness and social isolation have been proven to have a negative impact on physical health.

The voluntary and community sector plays a significant role in supporting the social needs of vulnerable groups, often working in partnership with health and social care, housing and other statutory services. This role should be expanded.

THE ROLE OF INTEGRATED CARE PARTNERSHIPS IN HEALTH PROMOTION

The Integrated Care Partnerships proposed under the new model, will have a leading role to play in promoting health and wellbeing. They should be incentivised to support evidence-based health and wellbeing promotion and embed prevention into health and social care services.

This should include:

- expansion of screening and immunisation programmes in the community where evidence exists to support them. Where possible, screening and immunisation should be provided in the community;
- an enhanced role for community pharmacists in health promotion, for example, in relation to information and advice around obesity and weight management, alcohol use and minor ailments;
- support for the role of Allied Health Professionals in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation;
- support from clinicians for community-based education programmes; and
- local community and voluntary organisations supporting the social and emotional needs of vulnerable groups.

SUMMARY OF KEY PROPOSALS

1. Renewed focus on health promotion and prevention to materially reduce

2. Production by PHA of an annual report

health and wellbeing to the public.

supported by clinical evidence.

4. Consideration by the Northern Ireland

further controls on tobacco usage.

the community.

transport.

7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.

8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

8. OLDER PEOPLE

INTRODUCTION

As highlighted in the Case for Change, Northern Ireland has the fastest growing population in the UK and it is an ageing population. By 2020, the number of people over 75 years is expected to increase by 40% from that in 2009, and the number of people aged over 85 is expected to increase by 58%.

Longer life expectancy is something to celebrate and many older people enjoy good health. However, among the 'older old', rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70[37], and the rate of disability among those aged over 85 is 67% compared with only 5% among young adults[38]. The health and social care system cares for the most vulnerable when their needs change. Older people are significant users of health and social care services, and almost a fifth of the Health and Social Care budget (19% or £616million) is allocated to services for older people[39].

- Around 60% of acute hospital beds are typically occupied by people over 65.[40] Many arrive at hospital because there is no viable alternative in the community (more specific information on this follows later).
- Approximately 23,389 people receive domiciliary care, equating to some 233,273 hours of care each week.
- 9,677 people aged over 65 live in nursing or residential care.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers. But there is a high level of dependence on institutional and hospital care, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations in terms of quality and consistency. Too often they tend to focus on acute events and crises rather than providing the range of proactive and preventative support that can maintain the health and wellbeing of older people.

[37] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.
[38] DHSSPS (2010) Physical and Sensory Disability Strategy. A Consultation Document 2011-2015.
[39] HSCB Social Care Directorate Submission to the Review (October 2011)

[40] HSCB figures for 7/12/11 identified 60% of emergency and elective admissions excluding obstetrics, sick babies, the Children's Hospital and mental illness.

HOME AS THE HUB OF CARE FOR OLDER PEOPLE

Residential and Nursing Home Care

The proportion of older people in Northern Ireland living in nursing homes is 3.5 times higher than in England and Wales[41] and is increasing. Between 2007/8 and 2009/10, the number of nursing home places increased from 6,392 to 6,694. This reflects the growing complexity of needs and high dependency levels among some of the older population – for example the growth in cases of dementia where currently there are an estimated 19,000 cases. [42]

Meanwhile, the number of residential care places is slowly declining, reflecting the growth in supported housing schemes provided by Housing Associations which have replaced residential homes. Over the same period 2007/8 to 2009/10, the number of residential places fell from 3,096 to 2,983. Many of those using residential care are no longer permanent residents.

The policy aim for some time has been to shift care from institutional settings to home and community settings. The current Health and Social Care Board (HSCB) target (from April 2011) is for at least 48% of care management assessments to recommend a domiciliary care package rather than a nursing home or residential care. However, the majority of expenditure still relates to institutional care. In 2009/10 residential and nursing home provision accounted for £190million, with domiciliary care accounting for £138million and hospital care for £115million. Suggestions on how to improve care, from the online survey, included more community services, person centred care and in-reach services.

Following from the key principle that home should be the hub of care, the Review recommends that steps are taken to support greater provision of services for older people at home and in the community.

The Review supports the trend towards independent living – at home or in supported accommodation – and expects to see a very significant reduction in provision of long-term residential places in the next five years. This will inevitably

[41] Reshaping the System, McKinsey 2010
[42] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

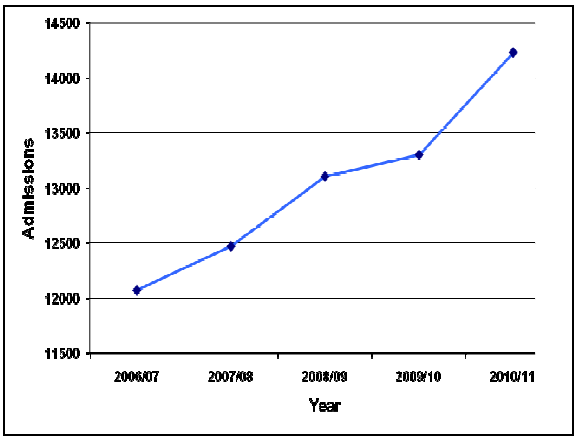
lead to the closure of existing facilities in a planned manner with resources transferred to home care or where appropriate to new models such as respite care.

Hospital Care

Increasing numbers of older people are being admitted to hospital on an unplanned basis and when they are admitted, older people tend to have longer stays and are more likely to face delays in waiting for discharge.

Over the five years to 2010/11, the number of admissions of older people into hospital increased by 18%, as shown below.

Figure 14: Total Admissions to HSC Hospitals in NI under the Elderly Care Programme of Care (2006/07 - 2010/11)



Source: NI Hospital Statistics: Inpatient Activity 2010/11

Many older people arrive at hospital because there is no viable alternative in the community, for example, due to lack of appropriate nursing and medical interventions available in nursing homes or at home.

Once admitted, older people tend to have longer stays in hospital. During 2010/11, the longest average length of stay across all specialties in Northern Ireland was under the rehabilitation specialty where admissions lasted for an average of 30.9 days. Longer lengths of stay for older people can be associated with cases involving a complex range of physical and mental health issues and therefore a requirement for a robust package of care to be agreed before discharge into the community.

Since April 2010, a target has been in place stating that the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours of the decision to discharge, with no discharge taking longer than seven days. As at the end of 2010/11, 86% (13,009) of complex discharges were within 48 hours regionally. The most common reasons for delay recorded were:

- no domiciliary package available;
- essential equipment / adaptations not available or assessment not completed; and
- no nursing home bed available in the chosen facility.

Research by the Alzheimer's Society found that people with dementia stay longer in hospital than other people undergoing the same procedure, and stays in an acute hospital environment

can have a detrimental effect on the symptoms of dementia.[43] Admissions to hospital can also result in reduced confidence of older people and their families to live independently, and can lead to a move into residential and nursing care[44].

The Health and Social Care Board will begin to introduce a reablement model of care across Northern Ireland from 2012. This approach involves providing older people with intensive, time limited support with everyday tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. It has been shown to be an effective means by which to keep people independent for longer. The Southern HSC Trust has already begun implementing a streamlined assessment and care planning approach built around the reablement model.

It is also known that older people are often admitted to hospital at the end of life. A recent report by DHSSPS showed that 82% of people dying in hospital were over 65 years of age. Of these people, 18% (2010/11) had a length of stay of less than 2 days. The report also looked at the number of people dying in hospital within 2 days of admission who were admitted from a nursing home. In 2009/10, 28% of the deaths of people admitted from a nursing home occurred within 2 days of admission into hospital.[45]

Suggestions for improved care for people nearing the end of life, from the online survey, included more home support to allow people to die in their preferred location.

To help avoid unnecessary admissions of older people into hospital and encourage independence, the Review endorses the plan to introduce a reablement model across Northern Ireland. The Review also recommends that there should be better integration of hospital and community services. With the establishment of the 17 Integrated Care Partnerships there is a tremendous opportunity to:

- improve communication between GPs providing out of hours care and hospital specialists;
- provide in-reach into nursing homes by specialists and GPs;
- have clear specification of the care and interventions to be provided in a nursing home environment including, for example, administration of intravenous therapy and catheterisation;
- provide the management of end of life care in nursing homes – being transferred to hospital at the end of life can be distressing and the Review recommends that other than for sound

[43] DHSSPS Dementia Strategy
[44] Stilwell and Kerslake (2003) What makes older people choose residential care, and are there alternatives?

[45] DHSSPS Hospital Information Branch (2011)

clinical reasons or family preference, nursing homes should manage end of life care;

- create greater provision of intermediate care, increasingly using the independent sector to provide:
    - step-down beds for short-term rehabilitation following a stay in hospital;
    - step-up beds that provide short-term support to prevent an admission into hospital; and
    - short-term reablement support to enable people to learn or relearn the skills necessary for independent living.

The Review suggests that whilst some intermediate care beds will be statutory, there will be an increased role for the independent sector in providing beds.

Patient and User Experience

The public place a high priority on the availability of good care for older people. In November 2011, the Patient and Client Council (PCC) engaged with its members on the future priorities for HSC in Northern Ireland. Of the top ten priorities identified, Care of the Elderly, including domiciliary care was second. Those consulted raised concerns about both the quality and quantity of social care provided, and the need for appropriate care in the community to help people live in their own homes. The need for better support for older people living in rural areas was identified.

Those consulted with by the PCC raised concerns with the PCC about the length of time that is allocated to those delivering domiciliary care.

Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process.

The quality and availability of respite care was highlighted as an issue, in particular for people with dementia. Consultees emphasised the importance of respite to support individuals and their families and carers.

The public survey conducted for this Review also found evidence of concerns with the quality and accessibility of care for older people:

- 35% of respondents felt that there was a 'lot of improvement' required in the health and social care services provided to older people overall;
- 24% of respondents stated that a 'lot of improvement' was needed in the quality of residential care for older people;
- 36% of respondents stated that 'a fair amount of improvement' or a 'lot of

improvement' was required in home help or home nursing care; and

- strong concerns were expressed about the waiting time for an assessment for home help, nursing or residential care - 33% felt that a 'little improvement' was needed, with 24% and 21% respectively, stating that a 'fair amount' or a 'lot of improvement' was required.

Workshops with clinicians confirmed public concerns in relation to care for older people. Clinicians highlighted the increasing demand for nursing and residential care due to the ageing population. They expressed the view that the capacity and capability of staff within nursing and residential care settings to provide care to the increasing numbers of patients with complex care requirements needs to be addressed. Quality issues were identified including poor nutrition of older people in hospital, nursing and residential care.

A 2008 UK-wide nutrition screening survey in hospitals, nursing homes and mental health units found that people in these care settings had a higher risk of malnutrition on admission and that the risk was much higher again for older people being admitted to care. For example, it estimated the rate of malnutrition for those aged 65 in the community at 14% compared with 32% for those being admitted to hospital and 42% for those being admitted to care homes[46].

Clinicians also highlighted a perceived lack of continuity and integration between hospital care and community based care. The limitations of IT and communications systems to support sharing of information between hospitals, primary care settings and residential and nursing homes was noted.

They expressed the view that greater rehabilitation and intermediate care is needed to prevent hospital admissions and support timely discharge.

The Review was persuaded of the need for, and its new model supports, a shift in services from hospital settings to closer to home. This will require more personalised care and diversity of service provision. Advocacy will be important in providing safeguards to vulnerable individuals. Telecare support will enable the greater management of risk and improving personal confidence.

PROMOTING HEALTHY AGEING

Throughout the Review, the public and clinicians expressed a desire for a more preventative model of care and one which enables better quality of life for older people. This is supported by research that suggests that preventative approaches can deliver better outcomes

[46] DHSSPS - Promoting Good Nutrition A strategy for good nutritional care for adults in all care settings in Northern Ireland.

for older people, with fewer hospital admissions, shorter lengths of stay and greater satisfaction with service provision.

Preventative approaches aim to take a more holistic view of older people's needs, by addressing issues other than health which impact on wellbeing but require intervention from other areas of public service. The Joseph Rowntree Foundation's Older People's Inquiry[47] identified the areas that are valued by and thus important for the wellbeing of older people as:

- comfortable and secure homes;
- an adequate income;
- safe neighbourhoods;
- getting out and about;
- friendships and opportunities for learning and leisure;
- keeping active and healthy; and
- access to good, relevant information.

This emphasises the need for a more joined-up approach to assessing the care needs of older people, recognising the role of multiple providers of health and other services across the public, voluntary and community, and private sectors. The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas.

The Partnerships for Older People Projects (2009) in England tested more integrated approaches to supporting older people. Its evaluation suggests that low intensity practical support services that

[47] Raynes, N et al (2006) Evidence submitted to the Older People's Inquiry into 'That Bit of Help.' York, Joseph Rowntree Foundation.

help older people to live well in their own homes (e.g. cleaning, care of pets, gardening, befriending, help with managing bills and DIY) had by far the greatest impact on health-related quality of life[48].

There is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing. Social exclusion is associated with poor physical and mental health outcomes for older people, and social isolation has been identified as a particular risk for older people in rural areas.[49] A review of a rural intervention to address social isolation among older people in Northern Ireland concluded that health and wellbeing of older people can be profoundly influenced by geographical location and that interventions informed by local needs are likely to be more successful.[50]

A recent report by the Social Care Institute for Excellence (SCIE) illustrates the emerging evidence that one to one interventions such as befriending and outreach can reduce loneliness and depression, and are cost effective[51]. Such initiatives are often provided by community organisations. In this regard care services are more important than health services.

Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.

Personalised budgets refer to the greater involvement of those qualifying for health and social care services in how they are provided. Needs assessment identifies the amount of care funding available for each individual and a joint decision is taken between the service user and the provider on how that funding will be used.

This includes the option to access a Direct Payment which involves the provision of funding directly to patients and clients who then purchase directly the services they feel best meet their needs. Direct Payments are available to older people who need support, individuals with physical disabilities, learning disabilities or mental health issues.

[48] Windle, K et al (2009) National evaluation of Partnerships for Older People Projects: final report. Canterbury, Personal Social Services Research Unit.

49 Commission for Rural Communities (2008) The Personalisation of Adult Social Care in Rural Areas.

[50] Heenan (2009) How Local Interventions Can Build Capacity to Address Social Isolation in Dispersed Rural Communities: A Case Study from Northern Ireland. Aging International, vol 36, no 4, 475-491

[51] Windle, Francis and Coomber (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence.

When people are provided with information and advice on the services that are available to them, they are in a position to make an informed choice as to the most appropriate care delivery for their particular needs. Those choosing to take a Direct Payments are able to choose who provides their care, when they deliver it and what they do to meet their particular needs. This may mean reduced uptake of core social care services provided directly by the HSC Trusts and uptake of a more diverse range of provision including that of the voluntary sector. Direct Payments users may also employer support workers directly.

Promotion of personalised approaches and the uptake of Direct Payments has been Government policy across the UK for some time. However, research has shown that there may be variation in the benefits experienced by patients and clients receiving direct payments, especially for older people and those with mental health problems. The most recent figures indicate that a total of 687 older people are in receipt of Direct Payments and 34 carers receive Direct Payments on behalf of an older person[52].

During the Review, the Direct Payments process was highlighted as being bureaucratic and of limited appeal to older people and their families. The need for independent provision of advocacy and coordination was identified as a method to facilitate and support service users in using personalised budgets.

Where individuals do not wish to take financial control, they should be given the option of advocacy to act on their behalf or a financial statement of the cost of their assessed support to enable greater choice on their part.

The Review concludes that there should be a focus on promoting healthy ageing, individual resilience and independence among older people.

Care for older people should be underpinned by a consistent assessment process, and a more holistic approach to planning and delivering support taking account of physical, social and emotional needs. Budgets within health and social care should be pooled, with joined up assessment and planning of needs using NISAT. The Review would also recommend pilots to explore budgetary integration beyond health and social care so as over time, the support funding managed by other parts of the public sector e.g. for housing support, could be integrated into a single care budget.

Support planning should take account of a diverse range of health, social and other support services appropriate to the needs of the individual, whether provided by statutory health and social care providers, the independent sector or voluntary and community sector providers. Service user involvement models for adult social care are being developed in other parts of the

[52] HSCB Statutory Monitoring Returns May 2011

UK as a basis for more collaborative 'co-production' of services.[53]

The role of care users and their families as partners in care should be recognised, and support should be personalised to deliver the outcomes care users and their families want to achieve. This should include control over and clear information about budgets, whether through Direct Payments or involvement in personalised budgets where HSC procures services on behalf of and as directed by the individual. Advocacy and support should be available if needed to help make this a reality.

A diverse choice of provision should be available to meet the individual health and social care needs of older people, with appropriate regulation and safeguards in place to protect the vulnerable. The Review recommends overhauling the current financial model to drive this objective within the statutory, voluntary and private sector.

SUPPORTING CARERS

Informal care from family and friends is vital to enabling a large number of older people to continue to live in the community. Across the UK, this informal care is estimated to equate to £87billion per year[54]. Carers UK estimate that there are 207,000 carers in Northern Ireland (a substantial increase from the DHSSPS figure of 185,000 quoted in 2006) and that the value of the care they provide is more than £4.4billion per year.

Carers can suffer poor physical and emotional health themselves, either directly because of the strains of their caring role or because their caring role restricts their ability to access health care. Carers UK report that carers are twice as likely to be permanently sick or disabled than the average person. The Princess Royal Trust for Carers research 'Always on Call, Always Concerned' found that 69% of carers surveyed reported a negative impact on their physical health from their caring role, and the same percentage reported that caring had a detrimental effect on their mental or emotional health.

Frequently the Review heard from carers the centrality of their role and their sense of being taken for granted.

The Caring for Carers Strategy (DHSSPS 2006) was designed to recognise, value and support the role of carers. Each HSC Trust has a nominated carer co-ordinator and is developing new ways of supporting the needs of carers. An assessment of carer needs is an integral part of the NISAT approach which is beginning to be rolled out across all HSC Trust areas.

[53] Needham and Carr (2009) Queen Mary University of London, SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation Social Care Institute for Excellence.

[54] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007.

Different carers are likely to need different types of support and their needs will change over time. Carer support interventions may include:

- programmes designed to educate carers about the care-recipient's condition and treatment;
- peer or professionally led carer support groups;
- respite services to provide carers with 'time away' from their caring responsibilities, including within the home, daycare or residential / inpatient provision;
- psychological therapy for carers; and
- care recipient training to promote confidence, self management and empowerment.

Evidence indicates that carer interventions such as these are effective in reducing carer depression and in some cases can have a positive impact on the condition of the care-recipient. Interventions which exist over a longer period of time have been found to be more successful than short-term initiatives[55]

The Review recommends a policy review to improve the outworkings of the carer assessment to better respond to their needs. There should be better recognition of carers' roles as partners in planning and delivering care for older people, and more practical support including, in particular, improved access to respite provision.

THE COSTS OF CARE FOR OLDER PEOPLE

Those engaging with the Review raised the issue of funding for adult social care and the potential future mix of funding sources including health and social care funding, social security benefits, and the patient or user's income. Current legislation in Northern Ireland enables charging of those being admitted to institutional care or receiving home care, but at present charging is not enforced for home care. The Review's role is not one of recommending charging but suggests it is a debate in which Northern Ireland society must fully engage.

The Review acknowledges that the independent sector is a major local resource in providing care for older people. It recognises that the relationship with government, particularly over pricing can be difficult. Consequently, the Review recommends the DHSSPS undertakes a policy review to consider:

- the benefits or otherwise of independent price regulation within the sector;
- the feasibility of the introduction of a certificate of need scheme ahead of

[55] Tommis, Zinovieff, Robinson and Morgan (2009) Carer Interventions Assessed Final Report. All Wales Alliance for Research and Development in Health and Social Care

the development of new premises with upper size limits;

- much more due diligence checking on any organisation entering the market, including exploring the concept of a financial bond for new entrants to minimise risk on all sides; and
- ongoing financial appraisal to ensure the robustness of facilities in the sector.

SUMMARY OF KEY PROPOSALS

9. Home as the hub of care for older people, with more services provided
10. A major reduction in residential accommodation for older people, over
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of
12. A greater role for nursing home care
13. More community-based step-up/step-down and respite care, provided
14. A focus on promoting healthy ageing, individual resilience and
15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond
16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an
17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and
18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to
19. A policy review of carers' assessments and more practical support for carers including improved
20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for

9. LONG TERM CONDITIONS

INTRODUCTION

Long-term conditions (LTCs) refer to patients who have a condition that cannot, at present, be cured but can be controlled by medication and/or therapy for example diabetes, asthma or hypertension. These conditions affect both adults and children.

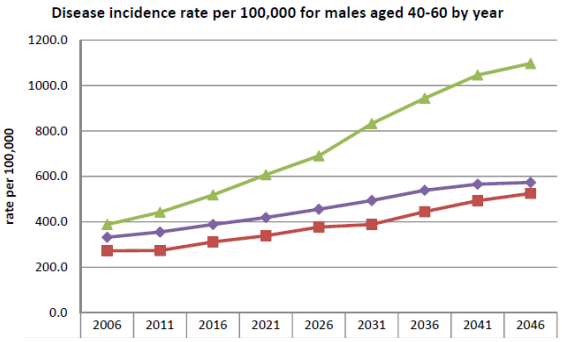
International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget.[56] The majority of the 5% are made up of the elderly and people with long term conditions. Incidence of long-term conditions are on the rise.

A report[57] by the Royal College of GPs has identified that individuals with long term conditions account for more than 50% of all GP appointments, 65% of outpatient appointments and over 70% of in-patient beds in England. It also advocates that GPs are better placed to help individuals manage the issues associated with their condition.

It is clear that people with LTCs require high levels of care. It naturally follows that the health and social care system needs to focus its efforts on how to deliver high quality care to these individuals. The objective is to ensure better outcomes for patients. It is also important to understand that better organisation of care pathways will improve quality and value for money. The recent policy framework Living with Long-term Conditions[58] set out a number of principles and actions for the overall approach to the treatment and care of adults with LTCs.

The figure below illustrates the disease incidence rates for adult males.

Figure 15: Disease Incidence Rates



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The Review recognises and celebrates advances made in modern treatments, but is also cognisant of the implications to future well-being. Major advancements in treatments for illnesses such as cancer have improved the life expectancy of sufferers. Increasingly cancers are becoming LTCs. Health and Social Care needs to ensure that it is ready to manage

[56] Research In Action, Issue 19, 2006
[57] Care Planning: Improving the Lives of People with Long Term Conditions, 2011

[58] DHSSPS (2011) Living with Long-Term Conditions A Policy Framework Consultation Document

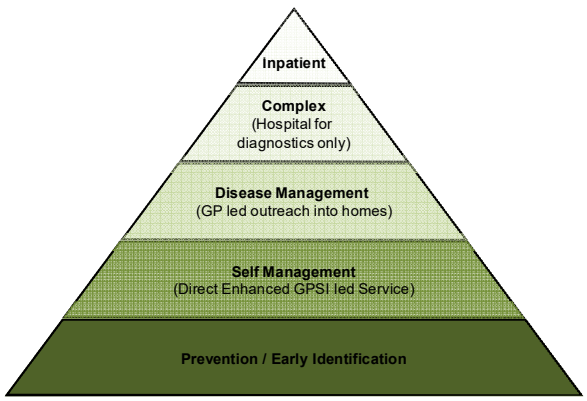
the LTCs that often develop as a result of progress in treatment.

The reality of the current system is that on many occasions individuals with a LTC are admitted to hospital after completing a complicated journey through A&E because there is no alternative.

In recent years, an emphasis has been placed on increasing the role of primary care and the community supporting LTCs. It is the Review's view that this current role can be expanded and based around the principle of 'home as the hub of care'.

The approach to the management of long term conditions should be based on the theory that the majority of effort is in prevention, early identification and self management with as little as possible care delivered within an inpatient setting, as shown in the following diagram.

Figure 16: Approach to management of Long Term Conditions



FOCUS ON PRIMARY AND SECONDARY PREVENTION

Whilst not all conditions are preventable, evidence indicates prevention has a key role in tackling:

- the increase in the percentage of children and adults who are overweight or obese;
- the increase in the number of people with long term conditions, such as diabetes;
- the higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities; and
- the higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in our society, particularly in more disadvantaged communities.

Although not all long term conditions are preventable, steps can be taken by individuals to decrease their chances of developing a condition. These include:

- promoting healthy lifestyles;
- reducing alcohol related problems;
- reducing overweight/ obesity levels;
- increasing a focus on psychological well-being; and
- decreasing incidences of falls among older people.

For many conditions, early case identification can be the key to limiting the effects of an illness.

There is a link between the prevalence of some conditions and deprivation, in particular for Chronic Obstructive Pulmonary Disease and asthma where rates are highest in the most deprived wards.[59]

The first focus is therefore to enable much greater self care to avoid chronicity. Integrated partnership working between clinicians in primary and secondary settings can produce real benefits for patients, for example in the treatment of diabetes. Support therefore begins with the GP, integrated community teams and community pharmacy.

The online survey included early intervention and use of community pharmacists as suggestions for better care for people with long term conditions and the Review supports this approach.

The Review considers Integrated Care Partnerships, that is professionals working together providing services for a population, as the way forward. In this regard the GP list acts as a building block for creating populations to enable this to happen. The data already known has the potential to be warehoused to inform best practice and intervention methods.

PERSONALISATION OF CARE PLANNING

At present personalised care planning is not practised in every area of NI. Consequently, care provision for people with a long term condition often lacks cohesion and consistency. This is a real source of frustration for the individual as they are managed simultaneously by a series of health professionals. This system results in the duplication of information reporting, which impedes analysis and treatment of the problem. All too frequently this results in overuse of hospitals.

Evidence shows that where information is readily available and accessible to all parties concerned with the treatment of LTCs, including the individual, patient experience outcomes are through a better managed system of delivery. This is enhanced even further if the individual has been involved in the planning of their care. Working in a more integrated system enables a more easily understood and straightforward care contract with individuals and their family to be created.

[59] PHA Health Intelligence Briefing, QOF, 2011

Flexible care packages should make arrangements more responsive for individuals, particularly those with changing circumstances.

Evidence suggests that with the correct support, individuals suffering from a long term condition can have an important role in the management of their condition.[60]

Self management enables individuals to take control of their own care plan, acquiring the skills required to manage them through the education they have received.

The Stanford University Model designed by Professor Lorig, recognised that issues faced by individuals with chronic conditions were often exacerbated by a number of factors including pain management, stress, low self esteem and depression.

To tackle this, better planning of self-care management will need to be introduced and replicated across the region.

Social and emotional issues can be supported within the community by establishing links between the individual and clubs, societies, transport and other amenities which will have a direct impact to the overall well-being of the person.

The Expert Patient programme[61], led by fellow sufferers aims to empower people to:

- feel confident and in control of their life;
- manage their condition and its treatment in partnership with healthcare professionals;
- communicate effectively with professionals and be willing to share responsibility for treatment;
- understand how their condition affects them and their family; and
- use their skills and knowledge to lead a full life.

An important part of the individual's ability to manage their LTC will be the strength of the support they receive from family and friends. Carers should be respected as partners in care in regard to the overall provision of services.

Working within Integrated Care Partnerships, community pharmacies have an important role in the support of individuals with a LTC, particularly in medicines management as discussed below.

Predominately referring to diabetes care, but applicable to the management of all long term conditions, a 2007 report described how organised and proactive

[60] Patient and family participation – What difference should it make to the quality of care?

[61] NHS England

services in partnership with engaged, empowered patients would ultimately provide better outcomes.[62]

One example of this in action has been the introduction of insulin pumps. The Public Health Agency reports the case of a 14 year old girl who was previously admitted to hospital 99 times from 2001-2010, but since the introduction of an insulin pump has had no diabetic related admissions. As a result her attendance at school and level of academic achievement has increased.[63]

The North West London Integrated Care pilot introduced greater use of multidisciplinary teams working within the community as well as having a direct link into secondary care.[64]

In the new model of care recommended by the Review, multidisciplinary teams will form the essential nucleus of health care professionals supporting patients in their own homes and community.

The integrated team is likely to include:

- General Practitioner;
- General Practitioner with a Special Interest (GPSI);
- Specialist Nurse;
- Occupational Therapist;
- Physiotherapist;
- Dietician;
- Social Worker; and
- Support Care Workers.

The composition of these teams should reflect the needs of the local population and be flexible to adapt to the nature of individual cases. All GP surgeries should indicate the lead professional for that practice. It may not always be that individual who treats or supports but they should be the first point of reference for patient and colleague professionals.

MEDICINES MANAGEMENT

People with LTCs often have multiple medicines to help manage their symptoms. Pharmacy errors are a very common risk factor for these patients. Compliance with the directions for use is key to the successful use of the medicines. The community pharmacy plays a key role is assisting people with LTCs.

The community pharmacist will form part of the multi-disciplinary approach to the management of LTCs. Pharmacies are ideally placed within local communities to provide advice without appointment. [65]

[62] Roberts S, Working together for better diabetes care: Clinical case for change, Department of Health, 2007
[63] PHA, 2011
[64] North West London Integrated Care Pilot : Business Case, 2010

[65] Supporting people with long term conditions to self care: A guide to PCTs in developing local

This new model seeks to keep the focus on the patient, providing alternative options to being admitted to hospital, and providing opportunity to prevent such occurrences wherever possible.

In the new model General Practitioners with a Special Interest (GPSI), will assess the individual to determine the correct treatment needed and where the most appropriate setting is. Where an individual requires secondary care, the GPSI will contact a specialist directly for admittance to hospital. Case records will be fully available to the hospital which will improve efficiency and reduce length of stay.

Making the home the hub of care, multi-disciplinary teams would provide the primary source of intervention. These health care professionals will be known to the individual, and likewise to each member of the team, allowing quick response and effective treatment delivered locally.

Community led teams should also be responsible for helping individuals to prevent their condition worsening. Regular contact with the individual is essential, along with practical support and education.

DIRECT ADMISSIONS TO HOSPITAL FOR PEOPLE WITH LTCS

Early prevention and self managed care supported by multidisciplinary teams will help stem the demand for hospital care. However, there is still a real need for high quality, responsible acute care for those who need hospital care.

In the event of an individual requiring emergency treatment, there should be greater integration between community teams and secondary care clinicians.

The GPSI will be able to contact the hospital directly once it has been determined that acute care is required. Direct admission will ensure a better experience for the patient and ultimately a better outcome.

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strategies and good practice, Department of Health, 2006

TECHNOLOGY

A key enabler in the introduction of the new model is technology. Greater support can be given to individuals and health care professional through telehealth monitoring.

An individual will have the ability to better manage their own condition through a combination of assistive technology and access to information.

The current duplication along with poor patient records slows down the system and causes frustration to the individual when forced to continually relay their particular situation and treatment. A solution to this would be the creation of a single Electronic Care Record (ECR) which follows the individual through different care settings and Trust boundaries.

SUMMARY OF KEY PROPOSALS

21. Partnership working with patients to enable greater self care and

22. Personalised care pathways enabling home based management of the LTC with expanded support from the

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided

10.PEOPLE WITH A PHYSICAL DISABILIITY

INTRODUCTION

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability[66]. While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors. At March 2010 there were 7,527 people with a physical or sensory disability (aged up to 65 years) in contact with HSC Trust disability services. In budgetary terms, adult disability services account for a small proportion of health and social care spend - 2.8% of the HSCB budget or £91million.

PERSONALISATION AND PROMOTING INDEPENDENCE

Personalisation, independence and control are at the heart of the Review and for those with a physical disability. A Physical and Sensory Disability Strategy for Northern Ireland is in the final stages of development. It will formalise in policy terms the changes to the model of support for disabled people. Traditionally, a limited range of support services such as daycare and residential care have been provided for people with a disability.

The current service-led approach should be replaced by a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with the disabled person and their family / carers to help people access the support that meets their individual needs. This may include some of the traditional residential and daycare services, but will increasingly reflect a wider range of needs. For example, a personalised support package might include:

- personal care support at home;
- specialist equipment such as a wheelchair or adaptations to the home;
- occupational therapy, speech and language therapy and physiotherapy;
- assistive technology; and
- assistance with day to day activities such as cooking, travel or work.

Voluntary and community sector organisations play a vital role in providing this much wider range of support and in acting as advocates for disabled people, promoting the control and independence agenda. Other parts of government have an important role to play in promoting independence for people with a disability,

[66] NISRA 2007, referenced in DHSSPS Physical and Sensory Disability Strategy A Consultation Document 2011-2015. December 2010.

notably housing, education, employment, and culture, arts and leisure.

This approach is supported by the findings of the online survey conducted by the Review which recommended a multi-disciplinary and person centred approach.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

As independent living options become more readily available there has been a gradual decline in the number of people with a disability living in long-term residential care (from 92 in 2005 to 80 in 2010) and there are only three statutory residential homes solely for people with a disability. However, the number of disabled people living in nursing homes has increased over the same period, from 284 in 2005 to 319 in 2010, reflecting the complex support needed by some which is not currently being met in the community.

There continues to be around 400 people with a disability living in long-term care settings. Care could be provided closer to home with more intensive treatment and rehabilitation when needed. Despite the drive to provide more home-based support, the number of people receiving a home-help service actually decreased by 30% between 2004/5 and 2008/9. This may reflect higher thresholds to access services and a focus on providing services for those with the highest level of need or the increase in uptake of Direct Payments which allow individuals to purchase their own support.

There is an increasing population of young disabled people with complex needs who are surviving into adulthood because of improvements in therapies and medical care and who require more intricate and costly packages of care, particularly during the transition to adulthood.

Provision of equipment is vital to allow people with a disability to live well at home. A third of the respondents to the Review's omnibus survey reported that 'a lot of improvement' was required to reduce waiting times for equipment such as wheelchairs and hoists. This issue was also raised at the clinical workshops where clinicians noted concerns surrounding the provision of adequate

resources and equipment for patients and clients with physical disabilities. Clinicians also highlighted the need for inter-departmental working to address matters which patients and clients with physical disabilities experience, such as ensuring that housing is suitable for individual needs.

While it will be challenging to balance the increasing complexity of needs and requirement for significant nursing and personal care support, with more independent living, this is essential to promoting the rights of people with disabilities.

New service models will be needed to meet this challenge including continued development of respite and short break care to support disabled people and their families/carers. At present much of this continues to be provided in the traditional residential and daycare settings, but home-based respite services are beginning to be developed and should be further developed.

PERSONALISATION AND INDEPENDENCE

There has been little change in the number of people using statutory daycare facilities, although their role has changed somewhat, for example, provision of short-term respite support. Results from the omnibus survey indicated that 24% of respondents felt that 'a fair amount of improvement' was required with regard to the range of day provision for people with a disability, and a further 22% of respondents stated that 'a lot of improvement' was needed.

Participants at the clinical and voluntary sector workshops and many individuals engaging with the Review focused on the need to shift from a medical model of care and treatment for individuals with physical disabilities, towards a more user-centred care model, which delivers the right care to meet that patient or client's needs. The potential of personalised budgets to improve choice and control was highlighted by many as a means to ensure that the care patients and clients receive meets their particular needs i.e. addresses the question "what would make my life better?"

Direct Payments have been embraced by many people with a physical disability who welcome the greater control they allow. Between September 2007 and September 2010 the number of Direct Payment recipients within the Physical Disability programme of care increased from 312 to 587. Encouraging uptake of Direct Payments has been a target for several years and mechanisms have been put in place to promote uptake and support people with managing their own budgets to purchase services or employ support directly.

While the uptake of Direct Payments is growing, in particular among people with a physical disability, there is potential to grow this and other self-directed support approaches considerably within this group. Feedback from some indicates that bureaucracy is a barrier to uptake of

Direct Payments and a regional approach is needed to tackle this issue and encourage greater uptake.

Set against the endorsement of the forthcoming Physical and Sensory Disability Strategy, the Review proposes the following:

SUMMARY OF KEY PROPOSALS

28. Promoting independence and control for people with a disability, enabling

29. A shift in the role of the health and social care organisations towards being an enabler and information

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support

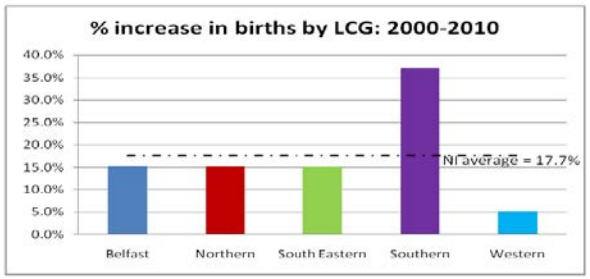
33. More respite and short breaks

11.MATERNITY AND CHILD HEALTH

MATERNITY

The Review is cognisant of the current consultation on Maternity Services[67] and has factored that work into its thinking. In 2010 there were over 25,000 live births registered in Northern Ireland. During the last decade (2000-2010) the birth rate in Northern Ireland has increased by almost 18%. There are significant differences in birth rates across the province, as illustrated in the figure below.

Figure 17: Increase in births by LCG: 2000-2010[68]



Almost all births (99%) took place in hospital, and most mothers (91%) gave birth in their nearest consultant led unit.[69] Less than 1% of mothers are choosing to give birth at home. In recent years the proportion of births to teenage mothers has decreased (5.0% in 2010). Projections indicate that birth rates are likely to decrease over the next decade to approximately 23,500 by 2022/23.

There are a range of consultant led, co-located midwifery led, and freestanding midwifery units in NI. The capacity of the service to provide the recommended level of staffing cover for intra-partum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units.[70]

Maternity care is of a high standard and according to recent surveys, women are happy with the standard of care they receive[71]. However there is increasing potential for variation in the provision of maternity care across Northern Ireland. In addition there are significant inequalities in maternal and infant outcomes, particularly amongst women from socio-economically deprived backgrounds.

The level of caesarean sections is generally higher than in the rest of the UK. There is increasing complexity arising from lifestyle for expectant mothers, most notably the increased rate of obesity, which provide both challenge and risk, across the population. Additionally many

[67] Maternity Strategy for Northern Ireland, September 2011. DHSSPSNI, 2011
[68] NISRA in Health Intelligence briefing Trends in Northern Ireland Births and future projections, Public Health Agency 2011
[69] Births in Northern Ireland (2010), A Statistical Bulletin, Northern Ireland Statistics and Research Agency, March 2011
[70] Draft Commissioning Plan (Health and Social Care Board and the Public Health Agency – June 2011)
[71] Parental Views on Maternity Services. Parents' views on the Review of Maternity Services for Northern Ireland. Patient and Client Council, 2010.

women now choose to start their families later in life.

Challenges for maternity services into the future include:

- give a realistic choice of birth location for women;
- need for more continuity of care throughout pregnancy;
- reducing unnecessary interventions;
- dealing with the public health issues facing women of child bearing age to reduce ill-health and disability of mother and child; and
- supporting the expectant mother in her ante-natal care and connecting that support to the early years of parenthood.

The Review therefore expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, birth and the post-natal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

CHILD HEALTH

Child health problems are often diverse in nature, severity and duration. The causes are often multi factorial and sometimes poorly understood. Effective interventions are often complex and time consuming, requiring a range of skills to be tailored to the needs of individual children.

Following the principle of care at or close to home, the Integrated Care Partnerships will be vital. However it was also clear to the Review that communities and the independent sector should be enabled to support families with ill children where appropriate.

When children need hospital care they need prompt access to skilled staff. There are challenges in providing a full range of paediatric sub specialties to a population of 1.8 million. Given this, there is a need to have clear pathways and consequent consistency of treatment.

In this field workforce issues and multiple service locations have the potential to threaten service resilience. Single handed specialties are difficult to sustain unless networked with other centres, whilst scarce skilled resources need carefully managed in the hospital setting. Notwithstanding this, community paediatrics should become a key resource working alongside integrated care partnerships enabling most care to be provided at or closer to home. The Review also saw potential for more formal links to larger centres in the UK or Republic of Ireland for this service area.

During its deliberations the Review team received a strong plea to examine, as a specific task, the nature, function and shape of in-patient paediatric services. The Review was persuaded this merited a separate piece of work. In this regard it also had drawn to its attention the very specific issue of palliative care for children.

Although there is a Children's Strategy for Northern Ireland there is no strategy for child health and no specific arrangements for palliative and end of life care for children. One of the Review proposals is that palliative and end of life care for children should be considered as part of the proposed review of Paediatric Services.

SUMMARY OF KEY PROPOSALS

Maternity

34. Written and oral information for women to enable an informed choice about

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of

38. Continuity of care for women

39. A regional plan for supporting mothers

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

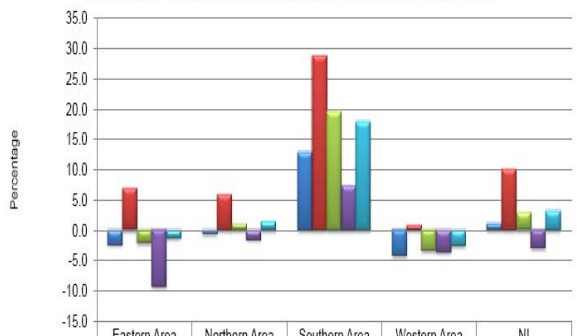
12.FAMILY AND CHILD CARE

INTRODUCTION

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020.[72]

As the figure below illustrates, percentage increases between geographical areas is variable but the overall increase will bring increasing demands on family support services.

Figure 18: Percentage population change 2008-2023 by Area and Age Band



	Eastern Area	Northern Area	Southern Area	Western Area	NI
0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
5 to 9 Years	6.8	5.8	28.7	0.8	10.0
10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

Source: NISRA 2008 Population Projections

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales. Overall, the number of children on the child protection register has increased between 2006 and 2010 in all regions of the UK.

In 2010 there were 2,606 Looked After Children in Northern Ireland, up by 6% from 2009. The greatest proportion (65%) was in foster care. Between 2005 and 2008 the number of children in foster care decreased. Since then, this figure has increased by almost a quarter (23%) to 1,687. The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010.[73]

EARLY INTERVENTION

As discussed in Section 7, early intervention is an important focus in addressing population health and wellbeing.

It has been recognised by a number of independent reviews that, compared to other parts of the UK, there is a significant under investment in children's services

[72] NISRA (2011) Population projections

[73] Social Briefing, Research and Information Service Briefing Paper, Northern Ireland Assembly, 83/11 NIAR 217/11, July 2011.

within Northern Ireland. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skill of young children. There is a major incentive in getting this right. On a practical level, early engagement pays a very high rate of return. The dividend is 12%-16% per year for every £1 of investment – a payback of four or five times the original investment by the time the young person reaches their early twenties and the gains continue to flow throughout their life[74].

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

Children's services are heavily prescribed by legislation and associated guidance and regulations. These services operate within an infrastructure premised on the growth of partnerships which promote inclusivity and collaboration. These partnerships have enabled an increase in capacity and facilitated the improvement of outcomes.

The overarching principle set out within the Childrens (NI) Order 1995[75] that children are best cared for within the family of origin will continue to shape interventions and service delivery. The Review supports the development of advocacy, information services and training in the support of kinship care.

International best practice demonstrates that the health and social care needs of children and young people cannot be addressed by any single agency. A key example of this is the Children and Young People's Strategic partnership, which is a multi agency partnership whose purpose is to put in place integrated planning and commissioning aimed at improving the wellbeing of children in Northern Ireland.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of Families Matter[76], Healthy Child-Healthy Future[77] and the Family Nurse Partnership Initiative. The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Child and Adolescent Mental Health Services (CAMHS)

The overall direction of Child and Adolescent Mental Health Services (CAHMS) will continue to be shaped by the Bamford Review of Mental Health and

[74] (0-5): How small children make a big difference –The Work Foundation 2007
[75] The Children NI Order 1995, Legislation.gov.uk

[76] Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy March 2009, DHSSPSNI
[77] Healthy Child, Healthy Future, A framework for the Universal Child Health Promotion Programme in Northern Ireland Pregnancy to 19 Years. DHSSPSNI, May 2010

Learning Disability. The needs of children with a disability remain a priority for commissioners and providers alike.

A Review of CAMHS in Northern Ireland was published in 2011 by the Regulation and Quality Improvement Authority[78]. A number of work streams are underway which will address many of that report's recommendations:

- progressing the Bamford Action Plan 2009;
- a review of Tier 4 services; and
- the appointment of a Commissioner for CAMHS.

Overall it is clear that child and adolescent services are continually improving and developing. However there is much work to do to develop and improve services further. It is estimated that to fully implement the RQIA recommendations may cost around £2million per annum. In the current financial climate this will require a prioritised approach.

Residential care

Approximately 11% of Looked After Children are in residential care. A number of issues have been identified:

- there is an increasing complexity of needs being presented by young people particularly in relation to mental health, drug and alcohol abuse, sexually harmful/vulnerable behaviours and criminality;
- it is difficult to provide flexible residential accommodation to meet the needs of a small number of young people; and
- young people aged 16+ are being excluded from their homes/ community as result of difficult behaviours.

Families

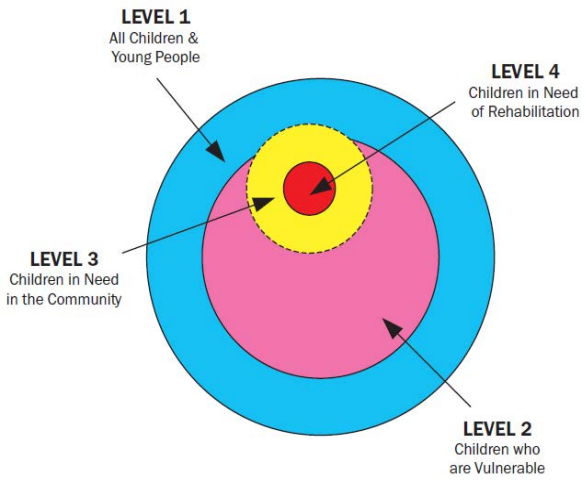
Families Matter: Supporting Families in Northern Ireland (Regional Family and Parenting Strategy 2009) moves parents into a central position in policy terms and strives to provide strategic direction on how best to assist parents in Northern Ireland to be confident and responsible in helping their children to reach their potential.

The wider vision of family support has been articulated in the Northern Ireland Family Support Model, which enables a 'whole system' approach to service planning. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need.

This model details four levels of need: all children and young people; children who are vulnerable; children who are in need and looked after children, illustrated in the figure below.

[78] RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland February 2011.

Figure 19: Northern Ireland Family Support Model[79]



It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experience from the Sure Start model which targets "children who will benefit most" and other similar initiatives here and elsewhere needs to be understood and extended where benefit can be demonstrated.

[79] Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy. DHSSPS 2009

The Review acknowledges and endorses the streamlining and improving processes in regard to Children's Services as being taken forward through the Children's Services Improvement Board and Review on Co-operating to Safeguard Children. In addition the Review also makes the recommendations below.

SUMMARY OF KEY PROPOSALS

46. Re-structuring of existing services to develop a new 'Headstart' programme

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young

48. Completion of a review of residential

49. Promotion of foster care both within

50. Development of a professional foster

51. Implementation of the RQIA recommendations in relation to

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS

13.PEOPLE USING MENTAL HEALTH SERVICES

INTRODUCTION

Northern Ireland has higher mental health needs than other parts of the United Kingdom.[80] Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[81]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services. The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.

Although there is frustration there is also progress with actions that lay the foundations for modernising and improving services, for example the development of new strategies and agreeing new models of care for particular conditions. However, it remains the case that tangible services on the ground are the touchstone by which those using the service judge its success.

[80] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.
[81] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

PROMOTION AND EARLY INTERVENTION

Raising awareness of mental health issues and reducing the stigma associated with mental ill-health continues to be a key objective of the reform and modernisation programme. In terms of primary prevention, a suicide prevention strategy Protect Life[82] was launched in 2006 and is currently being refreshed. A new five-year Mental Health and Wellbeing Strategy is being developed to support the whole population to maintain good mental health. The Review endorses these actions.

The Royal College of Psychiatrists' submission to the Review highlights that early intervention in psychoses can be effective and emerging evidence supports a similar approach for depression and anxiety. It therefore encourages development of a system capable of early intervention. The Stepped Care model (see figure below) promotes early intervention at the first stages of mental illness and the Psychological Therapies Strategy made recommendations as to how people with mild to moderate mental health problems could access psychological support. However, lack of investment has constrained the implementation of this strategy and feedback during the review suggested concern with the level of provision at Tiers 1 and 2.

Access to information about mental health services was raised by several of those with whom the Review engaged, including the Bamford Monitoring Group and registered social care workers. The Bamford Action Plan included plans to map available services and provide this information to service users, but progress has been slow in this regard. Users and carers told the Review how important it is to be able to easily access information on services that meet their particular needs.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 20: Stepped Care Model

[82] Protect Life, A Shared Vision – The NI Suicide Prevention Strategy and Action Plan 2006-2011, DHSSPS

Each of the HSC Trusts has developed Crisis Response and Home Treatment models that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing and Trusts are developing streamlined pathways for urgent mental health care.

However, these services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. Whilst the Review acknowledges that there will be solutions for local areas, there is now a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services are still to be developed for particular client groups including children and young people, people with a learning disability and older people.

Despite the shift underway in care provision from the hospital to community setting, the Review noted that the objective to shift expenditure to a ratio of 60% community and 40% hospital has not yet been achieved.

PROMOTING INDEPENDENCE AND PERSONALISATION OF CARE

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. The Review strongly endorses this approach.

The voluntary and community sector plays a crucial role in providing the diverse range of support that may be needed. Recognising this, the Review recommends greater involvement of these organisations in planning provision for local populations. It also acknowledges this will be a challenge in some parts of the independent sector.

Provision of Direct Payments is one approach to support personalisation of care. However, among people with mental health issues, the uptake of Direct Payments has been lower than among other groups. At May 2011, a total of 81 people were in receipt of Direct Payments. The Review was told that perceived bureaucracy and inconsistent promotion of Direct Payments have been constraining factors.

A regional approach should be implemented to promote the uptake of Direct Payments among mental health service users including involvement of current recipients to share their experiences, and the provision of

advocacy and support where needed should be considered. As a minimum, clear information on the financial package available should be given to those using the service.

INSTITUTIONAL CARE

A critical element in changing how things are done for this client group is to end long-term residency of people in mental health and learning disability hospitals. To date, 181 long-stay mental health patients have been discharged to the community. There are currently 150 long stay psychiatric inpatients who should be resettled into the community.

The model designed by the Review makes it clear that care should be provided at home or as close to home as possible. Fresh impetus into delivering the closure of long stay institutional care is required.

The Review urges an absolute commitment to completing the resettlement process by 2015 as planned, and ensuring that the required community services are in place to prevent the emergence of a new long-stay population. This should include developing models of treatment for children and young people, and those with specialist mental health needs, for example in the areas of learning disability and psychiatry of old age.

Attempts to shift the balance of spend between hospital and community expenditure should continue with reinvestment of any savings achieved in the hospital setting into community services.

The proposals below are set in the context of making tangible changes for mental health service users and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and

14.PEOPLE WITH A LEARNING DISABILITY

INTRODUCTION

A learning disability is a lifelong condition and requires long-term support. Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

In regards to this care programme the Review heard nothing which challenged Bamford, but as with mental health services, did hear frustration at the speed of implementation. Despite this frustration there is progress, with actions being completed that lay the foundations for further change, for example, the development of new strategies and agreeing new models of care. Ultimately though, those who are supported judge it by changes to services on the ground. In this regard the Review heard of the need for more rapid progress.

EARLY INTERVENTION AND PROMOTION

The importance of early years intervention to support positive life outcomes was highlighted throughout the Review's engagements with the public, clinicians and others. While children with a learning disability and their families may be able to avail of early years support this is variable across the region. Consistent with the proposals set out in Section 12 on Family and Childcare, the Review considers that early years support for children with a learning disability should be part of a coherent and consistent programme of support for 0-5 year olds.

Many learning disabilities have associated physical health conditions, for example complex mobility or personal care needs, whilst the rates of early onset dementia are much higher among those with Down's Syndrome than among the general population. Evidence was presented to the Review on the challenges for people with a learning disability in accessing the full range of healthcare provision enjoyed by the general population. In particular, accessing health services such as occupational therapy, physiotherapy and speech and language therapy was highlighted as being important. People with a learning disability also identified a need for disability awareness training for clinical staff in the community who do not always deal appropriately with them, for example, not providing enough time and not speaking directly to the disabled person. The Review considered improvement in this area as fundamental.

Programmes are in place in each population area to enhance access to

primary healthcare services for people with a disability including annual healthchecks and employment of health facilitators in the community. The Review endorsed this approach but was clear that a consistent outcome for all is important. In this regard it was made aware of particular problems in accessing Dentistry.

As services are planned Integrated Care Partnerships should be asked to ensure that clinicians are facilitated to respond more appropriately to the needs of people with a learning disability.

PROMOTING INDEPENDENCE AND PERSONALISATION

Promoting independence and personalisation is a key principle underpinning the model proposed by the Review. Feedback provided to the Review indicates that achieving this objective for people with a learning disability will require particular focus on the following areas:

- Day services - the diversity and age-appropriate nature of day services remains an issue for people with a learning disability. While there has been progress made in reforming the day centre-based model and providing more community based options, there is further work to be done in this regard. A one size fits all service will be less relevant in the future;
- Respite and short breaks - provision has increased but service users and carers indicate that much remains to be done to meet current needs. Services are frequently accommodation based. While these are important more flexibility in the home or local day placement should be explored. Respite care is not always age appropriate, for example, respite provision in nursing homes primarily for older people has limits. New models need to be created;
- Direct Payments – the number of people with a learning disability taking up Direct Payments has increased from 218 in June 2008 to 561 at May 2011 but the Review heard that service users and carers need more information and support with Direct Payments. Sharing the experiences of current recipients is recommended, along with provision of advocacy and support where needed. As a minimum clarity about the financial commitment should be available;
- Information – in general, users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue. Many carers are also unaware of their right to a carer's assessment and access to support to meet their physical and emotional needs; and
- Advocacy – people with a learning disability expressed the need for peer and independent advocacy to support

them in making decisions and protecting their rights.

The Review considered voluntary and community sector organisations have a crucial role in providing support to people with a learning disability. In some instances these are organised and run by parent groups. This should be supported.

INSTITUTIONAL CARE

A critical element in changing the model of care and support for people with a learning disability is to end long-term residency in hospitals. Since 2008, 642 long-stay learning disability patients have been discharged to the community. There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community.

The majority of learning disability services are already provided in the community as opposed to hospitals. The ratio of spend is 82% in the community to 18% in hospital. New community facilities are being developed for assessment and treatment for people with a learning disability which will support the resettlement programme. The Northern Ireland Housing Executive's Supporting People Programme also plays an essential role in developing a range of supported living options in the community for people with a learning disability. Supporting People has enabled 23,000 people (including both mental health and learning disability service users) to live independently.

The proposals below are set in the context of making tangible changes for people with a learning disability and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and

71. Commitment to closing long stay institutions and to completing the

15.ACUTE CARE

Acute care is often perceived as synonymous with hospitals. However it also includes elements of primary care such as Out of Hours. This part of the report comments upon:

- unscheduled care;
- planned care;
- ambulatory care and diagnostics; and
- regional services.

UNSCHEDULED CARE

Unscheduled care includes such services as accident and emergency, emergency surgery, intensive care, coronary care, stroke services, urgent care and medical admissions. Trauma and orthopaedic services are integral to emergency care.

Ambulatory care, where patients can walk in and walk out on the same day can also be unscheduled care.

The Review does not propose to extensively define each component of service but considers it prudent to share its thinking about urgent care, emergency departments or A&E services. Three broad levels exist:

- Major trauma, which is dealt with regionally;
- Emergency intervention most commonly associated with the 999 ambulance service; and
- Urgent care/ Out of Hours care where a difficulty exists but it does not initially present as life threatening and includes minor injuries.

Unscheduled care is currently delivered via 10 Accident and Emergency Departments (9 of which are 24/7 consultant led), 8 Minor Injuries Units and 19 GP Out of Hours facilities and supported by the NI Ambulance Service.

Evidence suggests the system is increasingly not fit for purpose in the 21st century.

For example the HSC is failing to deliver acceptable A&E waiting times of 95% of patients waiting no more than 4 hours and no patients waiting for more than 12 hours. Overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 7,386 breaches of the 12-hour standard in 2010/11 (compared to 3,883 during 2009/10) and cumulatively only 82% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2010/11.

As discussed in the Case for Change, the Royal College of Surgeons' evidence is that better organised care equals better outcomes for the patient.

New treatments and associated technology for stroke and coronary care are a challenge to deliver in the existing model. Maintaining the supporting infrastructure necessary for high dependency or intensive care in our current model also presents a challenge. Additionally difficulties in retaining appropriately trained staff creates sustainability issues and remains a frequent challenge.

Organisational resilience is a recurrent problem. Each year the current model cannot appropriately staff its A&E service with all of the quality and financial issues that flow from this.

The public in a different way expresses similar problems:

- 91% of the people involved in the omnibus survey felt that improvement was needed to the time spent waiting in A&E, of which 56% stated that a lot of improvement is needed.
- 68% of people surveyed in the Omnibus survey agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they don't have to wait as long. There was no significant difference in the response from people from an urban area (67%) compared to those in a rural area (70%).

EMERGENCY SERVICES

Proximity to acute facilities is often perceived as the determining factor as to whether the local health and social care service will adequately provide for their needs. Increasingly, however, it is not only the distance to the appropriate facility that may determine outcome for the patient, but also the timeliness of the initial intervention.

For example, a person with a stroke needs to get access to the staff and technology to diagnose the stroke as quickly as possible, as explained:

Best Practice Guidance - Stroke Care

Evidence shows that people with an ischaemic stroke who receive thrombolytic treatment within 3 hours of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months.[83] However, this treatment would harm people with haemorrhagic stroke. Therefore, it is essential that suspected stroke patients are transferred directly to an acute setting with the staff with appropriate skills and access to diagnostics which will allow accurate diagnosis (and therefore appropriate treatment) as quickly as possible.

[83] Best Practice in Stroke Care 2007, Buchan, A (sourced from Healthcare for London: A Framework for Action report

The Omnibus survey showed that 70% of people surveyed agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they get the best treatment and 71% agreed or strongly agreed that ambulance staff should take seriously ill people to a hospital with the specialist services they need even if it is not the closest hospital.

The Rural Trauma Outcome Study in Scotland[84] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The omnibus survey also highlighted the fact that the majority of the public are aware of where to attend in a number of circumstances, for example 74% of people said that they would attend the GP Out of Hours service if they had a child with a high temperature after 10pm.

However, it appears that the public do not actually attend the most appropriate setting for their needs. Of the activity recorded within the accident and emergency departments across NI, 50% of these are for conditions rated as standard cases without immediate danger or distress (Category 4 based on the Manchester Triage Categories). It can be assumed that a large proportion of these cases could be cared for in an urgent care setting without the need to attend an accident and emergency department.

Furthermore, for less common emergencies it is essential to maintain the required skills to enable the best patient outcome.

A model of care has been set out which delivers best outcomes to patients with major trauma and ensures a resilient service for the population of NI.

Regional Trauma Service

Major Trauma is the single biggest potential cause of death of people under 35 years of age. Due to the relatively small population of Northern Ireland (circa 1.8m) and the low incidence of major trauma cases (approximately 0.02% of the total population per annum), it is impractical to equip and staff all hospitals to the required level to provide optimal care for patients with major trauma.

The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre acting as the hub of the NI trauma network. Protocol dictates that patients should be transferred to the Royal Victoria Hospital directly, provided they are able to withstand the journey. If a patient is not able, they will be taken to the nearest major acute hospital within the network with the intention of transferring them to the Royal Victoria Hospital when they are able. Staff employed at the acute hospitals within the network receive

This Review concluded that a similar model could be considered for other

[84] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

emergency conditions which do not present in sufficient numbers for services to be maintained at all acute sites.

The result of networking services will be a model which includes a major acute hospital supported by a network of hospitals providing services to meet the needs of the local population. There are ten acute hospitals in Northern Ireland. In Great Britain populations of 1.8million are supported by maybe only four large hospitals. The Review accepted that by 2016/7 the model of major acute hospitals for Northern Ireland's more dispersed population will reconfigure to a more appropriate scale.

This will mean change at several of the current acute hospital sites, and the Review recommends that the key test for any future service configuration must be that it is sustainable and resilient in clinical terms. We recommend that each Local Commissioning Group should draw up specific proposals, taking account of the potential to provide service to the ROI. The Review's view is that it is only likely to be possible to provide resilient sustainable major acute services on five to seven sites, assuming that the Belfast Trust hospitals are regarded as one network of major acute services.

The Role of the Northern Ireland Ambulance Service

The role of the NIAS will be key in ensuring that people are treated in the right place at the right time. Patients should be transferred to the correct location first time where possible, to avoid further transfers at a later stage. It will be important that the NIAS can transfer people not only to Accident and Emergency Departments but also to Urgent Care Centres, Minor Injuries Units or GP Out of Hours. Bypass protocols will be required which clearly define which location patients should be transferred to for each type of condition.

Better management of unscheduled care in partnership between the HSC Trusts and the NIAS offers potential for improving care, patient flows efficiency and patient satisfaction.

Alongside all of this, it will be essential that the public are provided with information about the correct procedures in an emergency.

Quality of Outcome

Quality of outcomes requires that senior clinical decision makers are available at all accident and emergency departments 24/7/365. The model will be capable of delivering this outcome.

For the model to be successful it will need the support of urgent care centres, minor injuries units and GP in and Out of Hours services.

Delivering this model will require clinicians to be networked as one workforce pool for its population to ensure that training and good organisational opportunities are available to deliver a safe, high quality service.

URGENT CARE SERVICES

The clinical advances that result in a more specialised workforce create tension between local accessibility of urgent care services and the need to provide high quality services in acute hospital settings.

The current model includes a small number of Minor Injuries Units and GP Out of Hours to support Accident and Emergency Departments. Given the high volume of attendances at A&E which are Category 4[85] and below, there is potential to do things differently and achieve consistent outcomes. Accident and Emergency Departments can and should be supported more locally through an integrated urgent care model.

The urgent care model is not a 'one size fits all' approach. It is an approach which looks at the needs of the local people and tailors the provision to meet their urgent care needs. This model could, for example, look very different for an urban area compared to a remote rural area. Urgent care should be available on a 24/7/365 basis, including some on-call arrangements where necessary. The services to be provided to a population would be minor injuries, specialist nurses trained in urgent care, urgent care GPs, specialist teams such as mental health crisis response teams and urgent care social workers. The key is that these services are delivered in an integrated fashion.

These services will be supported by diagnostics available in the local community and the ability for GPs to directly admit patients into beds where necessary. Many of these services, other than beds, could all be available within a health and care centre setting, like the Health and Care Centre at Holywood Arches for example.

GP Out of Hours services are currently available for urgent care outside of the normal GP practice opening hours.

GP Out of Hours services should work as an integrated model of care with other urgent care services. A good local example of this working in practice is Downpatrick Hospital. In the UK the Shropshire approach has merit, as outlined below.

[85] Cases without immediate danger or distress, Manchester Triage

Good Practice Example

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays.

The service also supported Out of Hours nursing arrangements. Shropdoc doctors carried 'Rapid Response Boxes' for palliative care, catheterisation, resuscitation, syringe drivers and controlled drugs and therefore undertook much of the night-time care that might otherwise have been referred to district nurses or resulted in patients being admitted.

Shropdoc also ran the Care Coordination Centre. This provided a single point of access for GPs to other services between 8am and 6pm and included physiotherapy triage for some referrals.

This model has been working well and has the potential further to develop.

CLEAR PROTOCOLS FOR THE POINT OF CONTACT FOR EMERGENCY AND URGENT CARE

There is evidence that the options available to the public in dealing with emergency and urgent cases are limited or not well known. As outlined above, it is important that people are referred to the place that is best suited to meet their medical needs. This will require clear communication with the public as to the types of facilities available, where they are located and under what circumstances they should be used.

To allow this, it will be important that the public can get access to the right advice at the right time. At present this is through the 999 emergency telephone number. The introduction of an urgent number to work alongside the emergency 999 number would allow people to talk to a trained professional who will be able to advise them on the best route for them, be that to an Accident and Emergency Department, an Urgent Care Centre, Minor Injuries Unit, GP Out of Hours service or to wait for a GP appointment the following day. The NIAS will play a pivotal role in managing unscheduled care into the future.

Dedicated Care pathways should be developed for children and people with long term conditions that will allow direct contact with a trained team available to support them in an emergency or when requiring urgent care. This should involve the ability to directly admit these patients to beds hospitals.

PLANNED CARE

INTRODUCTION

Planned or Elective care includes inpatient admissions which happen with prior planning, sometimes at relatively short notice. Often these services cover major treatments or interventions, for example cancer surgery, diagnostics, testing to assist diagnosis, for example blood tests or X-ray and planned ambulatory care, where patients can walk in and walk out on the same day.

Planned care is currently delivered largely from our 10 acute hospitals, 5 local hospitals and a number of community hospitals. There are approximately 6,646 (average 2010/11) hospital inpatient beds in NI (3,683 acute beds and 2,963 non acute beds).

Increasing demand has evidenced itself through rising numbers of inpatient Finished Consultant Episodes. This reflects the increasing subspecialisation as well as absolute demand.

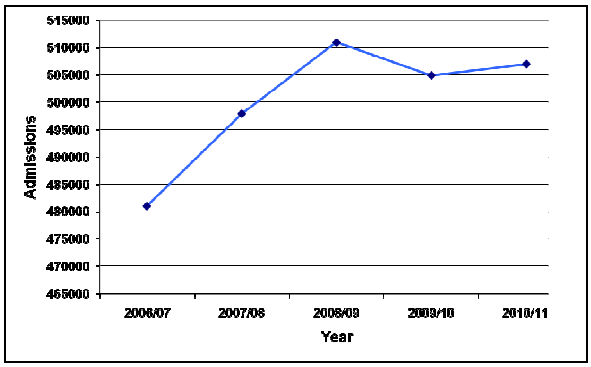
Some changes to service patterns have occurred, for example in cancer and urology, to improve outcomes. Whilst the role of some hospitals has also changed, more is required. However such change cannot happen without recognition of the impact on our current model. Partial change simply pressurises the existing system.

As stated in the Case for Change for both planned and emergency inpatient stays the length of stay is above UK levels.

During 2010/11, a total of 1,502,611 patients were seen at consultant led outpatient services within HSC hospitals in Northern Ireland.

The Total Admissions to HSC Hospitals in Northern Ireland under the Acute Programme of Care are shown in the figure below.

Figure 21: Acute Admissions



Source: DHSSPS Hospital Statistics

Our daycase rates are lower than they should be at 64% (2010/11) compared to the target of 75%. This means that the service is over reliant on inpatient beds when carrying out the procedures which could be carried out as a daycase.

The current target determines that at least 50% of inpatients and daycases are treated within 13 weeks and that all cases are treated within 36 weeks. At present, the current system is failing to meet these targets. Concern about increasing waiting times was highlighted as one of the

People's Priorities by the Patient and Client Council.

In the future planned care will be treating more older people. Planned care needs to be organised separately from emergency care. It gives better patient outcomes and enhances productivity. The Review therefore wishes to see better organisation of planned care.

Where there are planned specialist treatments, which are highly specialised, they will need to continue to be provided in one centre in Northern Ireland or via an agreement with a tertiary centre elsewhere (e.g. GB or ROI).

Diagnostics is an integral part of planned care. It assists the diagnosis of illness, for example blood tests, X-ray, MRI scans etc. These services are currently delivered within major acute hospitals and health and care centres. The review of Pathology Services in NI recommended there should be a managed clinical network for pathology. The Review strongly reinforces the expeditious implementation of this recommendation.

The current target determines that no patient waits longer than 9 weeks for a diagnostic test. In 2010/11 there were 23,518 breaches of this target.

Given all of this, it is impossible not to come to the conclusion that change needs to happen to improve outcomes for patients.

CARE CLOSER TO HOME

Evidence[86] shows that separating emergency and planned care improves outcomes in terms of continuity of care for patients, improved training for staff and faster access to senior opinion. The organisation of planned care should be clinically led and supported by the appropriate infrastructure.

Inpatient Activity

Key to the delivery of effective services is to ensure that people are given the right care in the right place at the right time. For planned care this means ensuring that people who need to be seen urgently are done so, that people who can wait do and that they are seen within a reasonable period of time.

Better organisation of planned services was supported by the Omnibus Survey which highlighted the following:

- waiting times for an appointment with hospital consultant: 82% felt some improvement is required, including 36% who felt that a lot of improvement was required; and

[86] Separating Emergency and Elective Care: Recommendations for Practice, The Royal College of Surgeons of England, March 2007.

Delivering surgical services: Options for maximising resources. The Royal College of Surgeons of England, March 2007.

- waiting times for on emergency operations: 88% felt some improvement was required including 36% who felt that a lot of improvement is required.

In supporting the principle that care should be closer to home it will be important to ensure that referrals to acute hospitals and inpatient beds are for sound medical reasons.

Similarly when people are admitted as an inpatient, appropriate discharge protocols must be in place to ensure timely discharge.

This can be supported by multi-disciplinary teams in the community and the availability of intermediate care (care between home and hospital), including step-up and step-down facilities.

Outpatient and Diagnostics

Evidence suggests that GPs and nurses could carry out a proportion of outpatient appointments without the need for a consultant appointment. The location of these types of appointments does not need to be in an acute setting.

The National Primary Care Research and Development Centre[87] identified a number of approaches which resulted in effectively reducing demand for specialist outpatient treatment without impacting on quality or safety. These included primary care clinics for chronic diseases; discharging hospital outpatients to no follow up (patient initiated follow up only); and direct access by GPs to hospital-based diagnostic tests, investigations and treatments.

Case Study

In NHS Stracathro hospital in Scotland acute medical services are being concentrated in larger hospitals that have a full range of support services and technology. Smaller hospitals were reconfigured to provide a wider range of other services including: the management of chronic illness, community rehabilitation, provision of diagnostics and therapy and more local outpatient clinics delivered more locally than ever. The relatively small number of patients who require specialist inpatient treatment are managed in acute hospitals capable of

A large proportion of diagnostics could be carried out within facilities closer to people's home. Diagnostics should be available alongside GP practices with the ability for GPs to directly refer patients.

Day cases where possible

Advances in surgical and medical techniques have meant that more procedures can be done as day cases. The Review recommends a better organised response to making sure the individual is referred to the most appropriate location for the best outcome.

[87] Can Primary Care reform reduce demand on hospital outpatient departments? (March 2007)

The HSC should continue to work towards the 75% rates of day cases for surgical procedures for the basket of 24 procedures. This will assist the move away from inpatient care unless medically necessary.

While there is a strong argument for locally accessible services and care closer to home, this cannot be at the cost of quality and safety. There is recognition than any transfer of services must maintain the levels of both quality and safety.

HOSPITAL NETWORKS

To ensure good patient outcomes no hospital in the future can work other than as part of a network.

In order to provide complex healthcare safely and allow professionals to keep their skills and knowledge up to date they need to treat sufficient volumes of patients with particular conditions. Safe treatments are therefore difficult to deliver at every hospital because there are not enough patients to maintain the skills of the professionals.

Networks should be established to ensure that accessible and safe services are available to all citizens. For common conditions there will be sufficient demand to allow those services to be delivered as locally as possible, either through local hospitals or community facilities. For less common conditions, there will be a need to centralise services on major acute sites to ensure that a resilient workforce is available to support that service.

Planned services provided in hospitals should be organised to meet the needs of that population.

No facility or department should operate as a standalone unit. Professionals should work in networks across hospitals and Trusts to deliver the best care to the patient by working together. This can also help to sustain local services with staff in local hospitals networking with larger acute hospitals, or through provision of nurse-led facilities supported by appropriate medical backup and working with effective transfer protocols for patients requiring acute medical care.

Care Pathways

Care pathways are an important route map for how people will experience treatment and are clinically led.

While there has been some progress in developing tailored care pathways for specific conditions and to address the issue of resilience in the service, there needs to be more consistency of approach across the region to ensure the best quality care is provided, the service is resilient and sustainable and that people are treated in the right place at the right time.

Specialist Provision

The Review has already offered its thinking on the implications of the overall population size of 1.8million for sustaining

the viability of specialist hospital services. Consequently this leads to vulnerable services which are difficult to attract staff to work in and if not effectively networked have the potential for poorer outcomes.

The sustainability of these services will best be delivered through networking with other tertiary centres, either in GB or ROI. This allows for consultants to gain the sufficient experience required and allows for multi-disciplinary team discussions on patients. Networks already exist for paediatric cardiac surgery (with the ROI), adult intensive care, cancer and pathology services.

The HSC sent 336 patients to hospitals in GB and ROI in the 6 months to September 2011 to be treated. Where services are so specialist the HSC cannot deliver these in NI, either in isolation or within a network. These types of specialist services will continue to be sent to specialist tertiary centres either in GB and ROI.

The Review recommends the development of joint planning arrangements with colleagues in the Republic of Ireland. In the first instance this would look at:

- shared opportunities in tertiary and specialist care,
- procurement,
- services in the New Hospital in the South West, and
- services which straddle the Border areas.

This would include a regular planning interface between the two jurisdictions to ensure areas of mutual interest are explored. These arrangements would be in addition to Co-operation and Working Together (CAWT), the existing partnership between the Health and Social Care Services in Northern Ireland and ROI, which facilitates cross border collaborative working in health and social care.

TECHNOLOGY

Technology will be a major enabler of networked working and care closer to home.

Investigations and treatment have become much more sophisticated requiring 24-hour access to increasingly complex technology – CT (Computerised Tomography) and MRI (Magnetic Resonance Imagery), sophisticated blood tests etc.

Technology will be required to support the changes in delivery of unscheduled care. Technology will allow all parts of the HSC to be linked in, allowing them to share live information on patients regardless of their location.

There is emerging evidence of the potential for telemedicine to support timely and appropriate inter-hospital transfer as well as better networking between hospitals. Some examples are shown below.

Example of Technology Working in the HSC

The Southern Trust currently operates a tele-dermatology service in which a specialist nurse sees the patient in an outreach clinic with a consultant remotely verifying the skin condition (via a high resolution photograph of the skin condition electronically sent to their location) and providing guidance on the most appropriate nurse or doctor-led

The opportunities for technology to support the new model of care are explored further in the Implications section of this report.

CONCLUSION

All of this leads to a conclusion doing nothing is not an option and that planned and organised change is essential to achieve the following objectives:

- Right Care, Right Place, Right Time, Right Outcome;
- Organising Sustainable Inpatient Care;
- Improving Diagnostics;
- Engaging Primary Care;
- Creating a Sustainable Service;
- Being responsive to the public;
- Balancing local and central demand with quality and safety; and
- Providing clear information to the public about how to access services.

SUMMARY OF KEY PROPOSALS

73. Over time, move to a likely position of five to seven major acute hospital

16.PALLIATIVE AND END OF LIFE CARE

INTRODUCTION

Palliative and end of life care is an important service in our system, expressing the essence of the values of the NHS. Palliative Care is defined as: "the active, holistic care of patients with advanced progressive illness". End of life care is a component of palliative care.

The Review heard no reason to challenge the Northern Ireland Palliative Care Strategy 'Living Matters, Dying Matters'[88], outlines an approach to improve the quality of palliative and end of life care for adults in Northern Ireland, irrespective of condition.

Approximately 15,000 people die in Northern Ireland each year. The main causes of death are circulatory diseases (35%), cancer related deaths (26%) and respiratory diseases (14%). Over two thirds of deaths occur in hospitals and nursing homes. The death rates in NI are falling and improving life expectancy means that the population of Northern Ireland is becoming 'older'. The profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses. Recent predictions suggest that one third of people over the age of 65 will be living alone by 2020.

Given that the prevalence of chronic conditions and dementia increases with age, demand for palliative and end of life care services is likely to increase.

As a society we need to have open and honest discussions with all age groups about the processes of dying, death and bereavement. We also need to understand the significance of planning ahead to avoid having to react in a crisis as well as planning for a death with dignity. Using some of the questions outlined in models such as in the Gold Standards model[89] can enable increased awareness and preparedness. We need to increase our understanding of when the palliative care phase ends and the end of life phase begins. These phases can move backwards and forwards and it may be difficult to determine when someone is dying. This can assist people in coming to terms with death and dying including the aspiration of planning for a good death.

Although the Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis, it is applicable to other causes of death. The Review heard of a recognised inequity of access to palliative care for non cancer patients. General palliative care is delivered by a range of professional staff in primary, hospital and community settings.

[88] Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland - DHSSPS March 2010

[89] Gold Standards Framework

Specialist palliative care including complex psychosocial, end of life and bereavement issues is provided within HSC and by voluntary sector organisations that make a valuable contribution in this area of care.

It is estimated that two thirds of all deaths in Northern Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. 20,000 bed days are used in NI for people dying in hospital from cancer conditions alone. There is currently no strategy that directly addresses the palliative and end of life needs of children.

We correctly invest a large volume of resource in the last year of life, but often provide poor quality which does not meet patient and carer wishes. The Review concluded it can be improved with greater coordination of care in order to ensure that people die with dignity.

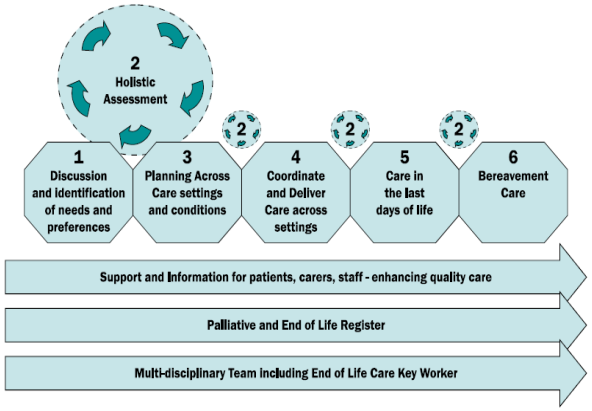
We also know that many more people than currently do would prefer to die at home. At the same time there are too many unnecessary, unwanted and costly end of life hospital admissions. We need to shift more care to the community where it can be more appropriately delivered.

Nursing homes are increasingly becoming the place where older people live and die with shorter average lengths of stay between 18-24 months. Complexity and higher dependency levels within nursing homes have implications for staff development to meet residents' end of life needs.

Frontline staff in general often lack training in delivering end of life care. There is a need to improve education and training for those providing palliative and end of life care.

The Review supports the model[90] below illustrating a continuous, holistic assessment of palliative and end of life care, co-ordinated by a key worker.

Figure 22: Palliative and End of Life Model



[90] Living Matters, Dying Matters, An End of Life Care Strategy for Adults in Northern Ireland, DHSSPSNI, March 2010.

SUMMARY OF KEY PROPOSALS

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

17.IMPLICATIONS FOR THE SERVICE

The changing model of care which moves care as close to home as possible, will only work if the way in which we deliver services also changes.

With a change in the model of care delivered by hospitals, the support required to deliver services in the community and at home, there will be a shift of services that will impact on the type of facilities which we require and the workforce that will deliver the service.

This section sets out an overview of the guiding criteria to be used when considering the new model of service delivery:

- infrastructure;
- technology;
- workforce; and
- resources.

INFRASTRUCTURE

CARE AT HOME

As has been outlined in the sections above, there will be a major shift to care delivered within people's homes, throughout people's lives, whether it be management of long term conditions, support to people with mental health or learning disabilities or end of life care.

In some cases people's homes are nursing homes or residential facilities.

The care delivered to individuals in these facilities should enable residents to remain in the facility provided their needs can be met there. The package of care will be based on personal needs, not based on location.

Personalised budgets will encourage diversity of service. Where there is reluctance to take charge through personalised budgets, advocacy and clear information on the financial implications of any assessment will promote this outcome.

An overview of the services that will be delivered in the home, through Integrated Care Partnerships, is as follows.

Services in your home
Access to specialist teams for long term conditions will be developed
Support for Specialist care for cancer
Rehabilitation services
Domiciliary Care, including home nursing
End of Life Care
Access to a range of support services for example daycare or respite
Health and Wellbeing support for vulnerable groups
Enabling good outcomes for those using the service - for older people this is best described as the reablement model. In mental health, the recovery model and in child care, the rescue model.

CARE IN THE LOCAL COMMUNITY

People will have access to a greater package of services within the community.

Services will be focused on the needs of the local population. Local planning will ensure that services are delivered that meet their needs and work towards tackling health inequalities, for example multidisciplinary teams to deliver a package of care to someone with a long term condition or more than one condition.

The types of services that will be delivered within the community, through Integrated Care Partnerships, will include:

Services in your local community
GPs with enhanced services
Pharmacy
24/7 Urgent Care including GP, mental health crisis response and minor procedures
Outpatients
Diagnostics
Access to therapy and rehabilitation
Social support
Links to Voluntary and community organisations to support care
Advocacy services
Antenatal and postnatal care
Health and Wellbeing Advice
Optometry
Dentistry
Cross Departmental working groups to support social needs
Beds used for step-up/ step-down from hospital managed by GPs
Support to carers
Re-ablement

Our 353 GP practices will work within networks based on the already established 17 Primary Care Partnerships. These should be on a formal basis as 'federations of practices'. This should result in GPs working together in a consistent manner.

The GPs currently within Primary Care Partnerships will form part of the Integrated Care Partnership along with representatives from other HSC bodies, as outlined above. Consideration should be given to the potential for these ICPs to form the basis for a multidisciplinary mutual organisation or to have social firm status.

Pharmacy will deliver an enhanced role in medicines management and health promotion to the local community and will be part of the multidisciplinary team supporting individuals with complex needs.

The ambulance service will have the ability to transfer patients to urgent care settings rather than defaulting to a major acute hospital if this is the most appropriate type of care required for the

patient. The ambulance service will also be able to refer patients back to their GPs if they do not see the need to transfer the patient to other services such as urgent care or emergency care.

The focus of care will be reablement where possible. Support at home will be: increased availability of respite care; step up and step down beds between home and hospital; and rehabilitation beds. This will be supported by outpatients services, diagnostics and minor interventions being available closer to home.

The current decline in the demand for residential care homes will continue. In NI, we also have a higher use of supported accommodation than the rest of the UK. This trend is also likely to continue leading to a major reshape of this service.

People who require 24 hour nursing will be cared for within nursing homes.

The move away from residential care provision towards care at home will require a joined up approach to service delivery between the Department for Social Development and DHSSPS.

There will also be a move of dental services closer to home. For example, oral surgery can be carried out within the community at dental practices rather than within a hospital setting as is often the case.

The pathway for referral to hospital optometry services from practices has led to unintended high volumes of referrals. Clinical protocols for direct referral should be considered.

HOSPITAL SERVICES

Introduction

In the future hospitals will work as a system with each facility contributing to the provision of a total service to its population.

The Review is aware that there will be a considerable interest in the current hospital sites and their future role. However, as has been indicated early in the report, the final functionality of each of the facilities will be based on population need and the principles set out above.

The Review recommends that the commissioning system using its local communities should bring forward proposals for hospital services for each of the five populations by June 2012.

Evidence presented to the Review persuaded it that local populations and in particular professionals should design the way forward rather than impose a top down approach of specifying a function for each hospital.

In accepting this approach it wishes to make clear that there will be, as a consequence, change on all sites over a five year period. With change of this magnitude, the system and those working within it must enable, not disable, the change process. The following clearly articulates **what** should be provided. The **how** is for those working in the system.

Hospital Services

All current hospitals will have an integral role in the delivery of services to their localities. They will be essential in contributing to what a local population requires from a hospital service.

The Review is not prescriptive about the service configuration in these facilities but it is expected to include the following profile of services.

Services in your hospital
Urgent Care – doctor led assessment
Out of Hours – GP led
Elective Surgery – daycase and selective inpatient
Inpatient medical care on the basis of agreed pathways designed between primary and secondary doctors
Rehabilitation
Diagnostics
Midwife Led Obstetrics, where feasible based on demand

Hospitals will be networked with the GPs/ GPSIs and staff from the major acute centres. The preferred route for treatment is at home or within the community. Where people cannot be cared for in their own homes or within their community, they will be referred to hospital. Decisions on where to admit will be determined by clinical protocols and designed to ensure the best outcome for the patient.

Hospitals will be expected to separate elective surgical procedures from emergency procedures so that the system of care leads to better clinical outcomes and productivity, without one detrimentally affecting the other.

Patients may also be transferred within the network depending upon clinical need.

Major Acute Hospitals Services

Major acute hospitals provide care and treatment that requires centralisation to ensure that services are delivered by senior staff and that those services are resilient to demand pressures and provide the best outcomes for patients.

Each major acute hospital service must be capable of delivering and sustaining the following profile of services.

Services
24/7 Emergency Department
Emergency Surgery available 24/7
Complex Elective Surgery
Some non-complex elective surgery
Undifferentiated inpatient Medicine, e.g. coronary care and stroke
Paediatrics (Inpatient) available 24/7
Critical care available 24/7
Specialist Diagnostics available 24/7
Outpatients
Consultant led obstetrics
Midwife Led Unit, where appropriate

Since resilience is essential to the provision of hospital services, critical clinical staff will be employed to work in the hospital system and be a resource for

each population working as necessary across hospital services and facilities.

Where inpatient provision is currently regional, such as cardiac surgery or sub regional, such as urology, clear clinical pathways which ensure equal access to populations will be required.

Specialist Services

Specialist hospitals will continue to deliver specialist services to the population of Northern Ireland including complex medicine, complex surgery and the associated outpatients service.

These services will be networked as necessary with ROI and GB to ensure that the highest quality services are delivered and that the staff are well trained and experienced.

Supra-Regional Services

Services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland. These include for example transplantations and rare disease management.

The Northern Ireland Perspective

The Review recognises that the future model must take into consideration the Northern Ireland dynamic. Given the rural nature of the West, and its close links to the ROI, the new model will require two major acute facilities in the West. The ROI has expressly indicated it wishes to maximise the opportunity for its population in the new hospital in the West.

Altnagelvin and Belfast hospitals have already well established working arrangements with ROI around some of its services which will continue.

There is currently a level of use of Daisy Hill Hospital by residents of the north east region of ROI. The future configuration of major acute services in Newry will be impacted upon by the potential demand for services from the ROI.

Conclusion

As a consequence of re-profiling services in this way there will be change on all existing sites.

The Review anticipates a major restructuring of how services are

delivered by our current hospitals. As previously described, for NI this is likely to mean between five and seven major acute hospital facilities or networks.

The Review also wishes to make clear that maintaining an 'as is' model cannot be successful in delivering against the key principles or the guidelines already described. Furthermore, systems which are overly reliant on locum and agency staff are not acceptable.

Impact on the Northern Ireland Ambulance Service

The role of the NIAS is of central importance to the ability to deliver the new model of care. The NIAS has been going through some major changes in modernising its service to meet the needs of the HSC in the 21st century. This modernisation is planned to continue. The plans of the NIAS will support the implementation of the Review, in particular:

- supporting the new care pathways for unscheduled, in particular urgent care;
- training of NIAS paramedic staff to support the model;
- provision of an alternative to the 999 emergency number and availability of medically trained staff to triage patients to the most appropriate service;
- supporting the focus on prevention and wellbeing through information and advice; and
- continuing to support the move of care closer to home through diagnosis and treatment of minor illnesses and injuries in the community.

The NIAS will be involved in the planning and implementation process following the Review, alongside the representatives from across health and social care.

TECHNOLOGY

Technology is a key enabler of the delivery of the new model of care, in particular in supporting care closer to home and the ability of staff to work as an effective integrated multi-disciplinary team.

A forum should be established to take forward how technology will support the new model of care linking the service to industry and academia to ensure the optimum and best value for money solutions are taken forward and opportunities are identified and considered. Where appropriate, development of technological support will be through a collaboration approach with the Department of Enterprise, Trade and Investment (DETI) in line with the Memorandum of Understanding agreed between the Minister for Health, Social Services and Public Safety and the Minister for Enterprise, Trade and Investment.

The plans for technology to support the new model will come in the form of regional projects as well as technology solutions that will support the delivery of

services to meet the specific needs of patients in a certain area. The population based planning approach will include plans for the use of technology to support how the model of care is delivered for that population.

Availability of Information at the Point of Care Delivery

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

By making more health records electronic, there will be quicker ways to get important information to HSC healthcare staff treating patients, including in an emergency

Electronic Care Records (ECR) can be used to allow the sharing of information between the many systems currently used to store information across the HSC. This would result in all information held on each patient being available together through the use of the ECR platform.

An ECR pilot is currently underway. This has involved sharing of information within a Trust (i.e. acute, community and primary care information). The Review endorses the roll out of ECR across Northern Ireland with the ultimate aim of sharing information, not just within a Trust, but also across Trusts such that the service will provide an individual electronic care record for every patient in NI. Any patient could then attend any facility across NI and the health records and information will be available.

Information sources will include:

- GP records;
- Community Information Systems (also see below);
- pharmacy records (medicines management); and
- hospital records, including results of diagnostic tests.

Mobility of Staff

Mobile working by community staff allows for better use of resources.

With the shift of care into the community, consideration should be given to the merits of mobile technology to support staff working in the community.

The National Mobile Health Worker Project findings were that mobile devices loaded with office and clinical software allowed clinicians working within the community to make nearly 9% fewer referrals and avoid 21% of admissions.

GP Records

The Review also endorses the approach of developing a data warehouse for GP records in order to deliver information which is of a high quality and consistent across practices resulting in reduced variation and a safe and secure method of storing and sharing patient information.

The data warehouse will protect the confidentiality of patients and will provide timely, anonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;
- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data would be routinely extracted from GP systems and loaded into the data warehouse. The data warehouse would be used by staff at Trust, HSCB and DHSSPS levels. Access to the data would be strictly controlled and where necessary the data would be anonymised. Each "type" of user would have access only to the data for which they have authorised access.

Supporting People to Self-Manage their Care

Technology should be harnessed to support patients in managing their own care through, for example:

- supporting patient education;
- direct patient monitoring and support (telemedicine);
- clinical information and management systems; and
- promoting healthy living and disease prevention.

Telemedicine can be used to provide care closer to home such that the patient does not need to be in a hospital to receive care.

Connected Health

Connected Health is used to describe a model for healthcare delivery that uses technology to provide healthcare remotely. It provides a strategic opportunity for a different business model of procuring and delivering care around the needs of the patient. Through the use of technology patients are able to monitor their own condition, within the parameters set by their GP, thereby enabling them to take greater responsibility for managing their own health and well being. This should lead to a reduced need for patients to visit their GP Practices for monitoring of their condition. Variations to their clinical condition will be monitored remotely and they can be triaged to the relevant area of the health service as appropriate to their need at that time. This will result in patients visiting their GPs about their condition only when they need to and will lead to more appropriate and timely referrals to secondary care.

Connected Health sits well with government health strategies at many levels. It supports patient choice by allowing patients to remain within their own homes with effective self-management. It also supports the move of services from secondary to primary care settings and the ability to deliver a more cost effective, better quality service.

Supporting the principle of Right Care, Right Place, Right Time

One contact number for urgent care will allow triage of patients and ensure that they are directed to the best place of care as discussed in the NIAS section below.

A single robust community information system is required to support the increase in care to be delivered within the community.

WORKFORCE

The new model of service delivery requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and at home or close to home.

New care model – Workforce implications

Some of the key implications include:

- more people will receive care in their own home, or close to home; which is more integrated with hospital clinicians working closely with GPs and other community staff to plan care delivery, along with increased clinical support provided in the home;
- multi professional community integrated teams will form the essential nucleus of health and social care professionals supporting patients in their own homes;
- increasing use of networks to coordinate care and share good practice and greater emphasis on partnership working within and across sectors; and
- the need to accelerate the pace of change.

The proposed changes will require staff to develop different skills and capacities. For example, GPs with Special Interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is likely that there will be more overlap and networking between services, and it is proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses. Furthermore there is potential to explore new and extended roles as part of future care provision including the potential to introduce further multi-skilling alongside the use of assistive technologies to maintain older people in their homes.

Role change

Our expectations for what it means to be a health and social care professional are changing. They go beyond clinical practice itself, precisely because high quality care is delivered by a team in a system, not alone in a vacuum. To reach its full potential health and social care needs to harness the skills of professionals working together in making decisions in the clinical arena and bringing that expert judgement to bear on difficult resource and management

decisions that impact on patients. Patients, the public and staff expect to see visible leaders making the case for those changes to services which evidence shows will improve patient care.

We need to be clear about what HSC organisations expect and need from tomorrow's clinicians and managers. Workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their roles. In light of the range of external factors likely to impact on health and social care our workforce planning needs to focus on demand signals from the local health economy and patients/ clients rather than just supply side inputs; linked to service planning and needs and underpinned by financial plans making it more robust and linked to patient needs. There needs to be close working between all education and training providers and the HSC to ensure continued high quality of education and training, based on service needs.

Extending GP leadership: Using the building block of Clinical Leads recently appointed to lead the recently formed PCPs, we need to identify and develop GPs will assume a critical leadership role in the new Integrated Care Partnerships. Clarity around roles and expectations will be critical to ensure they are able to engage with twin challenges of professional and management responsibilities.

Resilience

The ability to deliver good outcomes to patients is inextricably linked to workforce and in particular the medical workforce. In recent years the allocation of junior doctors has been problematic. Two matters are pertinent, access to good training and individual choice about workplace. Both will remain into the future. Failure to take full account of this has created many problems for the current model. It is likely that workforce availability over the next 3 years will be numerically less than required for the existing model but much more importantly the training experience that the current model provides, and ultimately the quality of outcome for patients, means that continuation of the current model is unsustainable. Any attempt to sustain the current model would simply flounder.

Engagement with staff organisations

Within the HSC a process of active engagement has been developed over a period of time, incorporating not only regular consultation on matters of concern to both HSC organisations and the staff representatives, but also partnership working on issues of joint concern to the service and the members they represent. It is vital that we remain committed to ongoing, close working with staff organisations and their representatives going forward.

NIAS

The Ambulance Service is a key part of the new service delivery model. Training

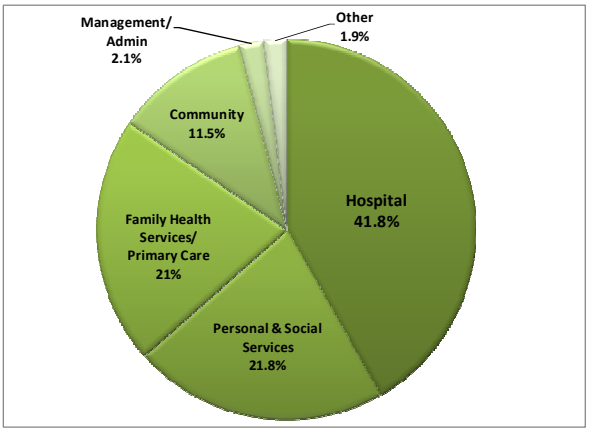
of ambulance staff in the new model and best location of care will be required as well as ensuring that bypass protocols are in place.

RESOURCES

Revenue Budget

The current revenue budget for DHSSPS in 2011/12 is £4,383million. The Health and Social Care element is £3,904million and is split as follows:

Figure 23: Current HSC Revenue Budget, 2011/12

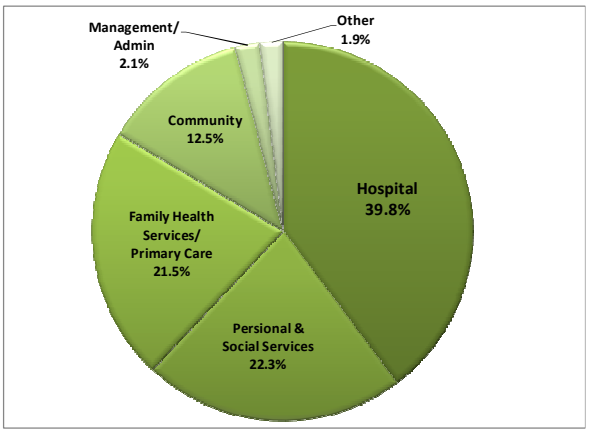


To allow the implementation of the new model of care the funding available for HSC services will be re-allocated. There will be a shift of care from hospital settings into the community. Some of the key changes that will be seen in the community will be:

- more care delivered in the home;
- changing care packages for people in nursing homes;
- increased role of the GP;
- increased role of Pharmacy in medicines management and prevention;
- a strong focus on prevention;
- increased use of community and social care services to meet people's needs; and
- outreach of acute services into the community.

The revenue budget for DHSSPS in 2014/15 is £4,659million. The Health and Social Care element is £4,150million. The projected allocation, applying the new model, is illustrated in the figure below.

Figure 24: Projected Allocation of HSC Revenue Budget, 2014/15



The impact on investment of the potential redistribution of the budget is illustrated in the figure overleaf and is as follows:

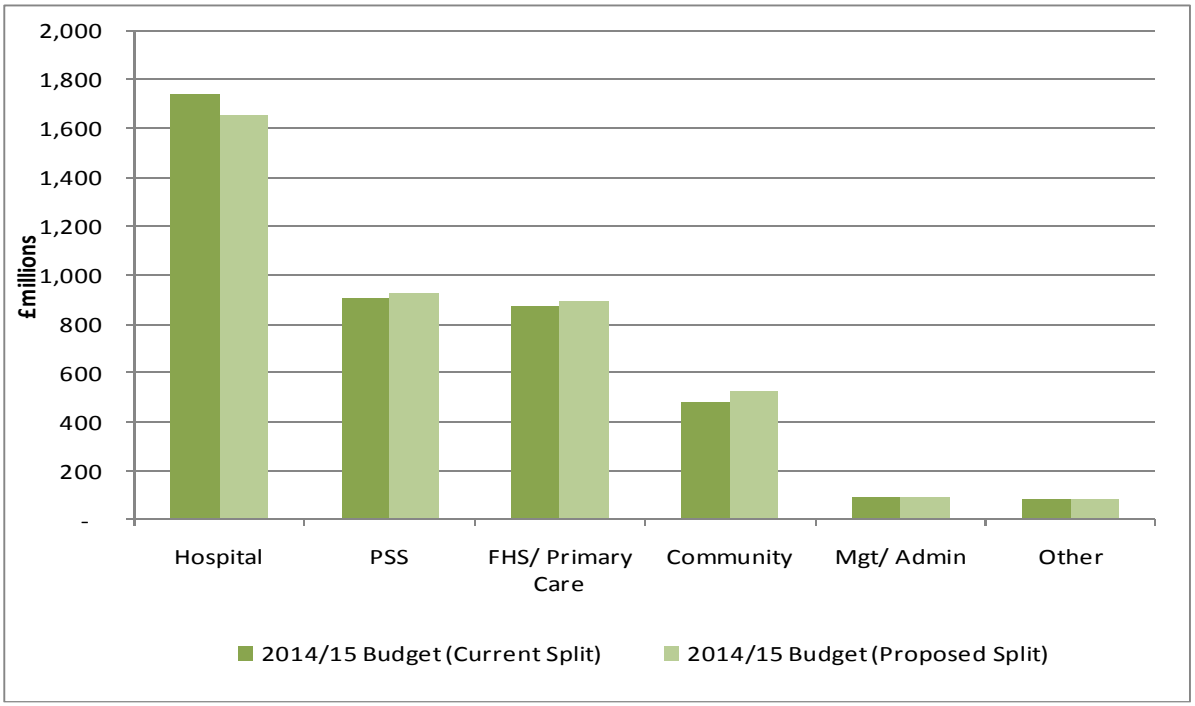
- reduction of the budget in hospital services, from £1,733million to £1,650million. This represents a £83million reduction, equating to 5% of the hospital services budget;

- increase in Personal and Social Services (PSS), from £903million to £924million. This represents a £21million increase, equating to a 2% increase in the PSS budget;
- increase in Family Health Services and Primary Care Services, from £871million to £892million. This represents a £21million increase, equating to a 3% increase in the FHS budget; and
- increase in Community Services, from £477million to £518million. This represents a £41million increase, equating to a 9% in the Community Services budget.

A shift of care from hospital settings into the community reflects the principles, as outline in section 5, by which the Local Commissioning Groups will develop their population plans. The re-allocation of resource, illustrated in figures 23 and 24 is indicative; however it does reflect the anticipated level of change required to effect the change.

Consideration will also need to be given to the capital investment required to enable the change process to occur.

Figure 25: Projected Allocation of HSC Revenue Budget, 2014/15



TRANSITION AND IMPLEMENTATION

This change will not be straight forward. It will require fundamental changes to the way we deliver services and will require substantial re-training of staff.

In addition it is estimated that transitional funding of approximately £25million in the first year; £25million in the second year; and £20 million in the third year will be required to enable the new model of service to be implemented.

We recommend this should be invested in:

- Integrated Care Partnerships, with a focus on older people and long term conditions;
- service changes; and
- voluntary early release scheme.

It is anticipated that after 2014/15 the model would be self-financing.

The principles for implementation are set out in section 18 overleaf. Detailed implementation plans will be developed following this review to reflect the complexity of changes required.

Income Generation

Often a parallel is drawn with other UK regions in regards to NI. Citizens contrast availability of services elsewhere with those that they have access to. This is sharply focused when there is discussion about income generation. Other regions have access to resources from charging which is not available in NI. The Review does not offer an opinion on how this should be addressed but would state there are no neutral decisions.

While income generation was not a matter for the Review, there needs to be a sensible debate about growing income within the spirit of the NHS principles. The Review recommends that this debate commences in NI in 4 areas:

- Non-emergency transport – for example car parking for visitors and staff and travel to day centres;
- Domiciliary care – DHSSPS has never applied the ability to charge for domiciliary care in the home;
- Prescriptions – consideration of a contribution towards the cost of prescriptions; and
- Social Bonds and their ability to support more diversity in community service provision.

The Review would wish to restate that it is not supportive of any move away from core NHS principles.

SUMMARY OF KEY PROPOSALS

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital

87. Development of population plans for each of the five LCG populations by

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs,

89. Development of clear patient pathways

90. Establishment of a forum to take forward how technology will support the new model of care linking the

91. Full rollout of the Electronic Care

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

ROADMAP FOR THE FUTURE

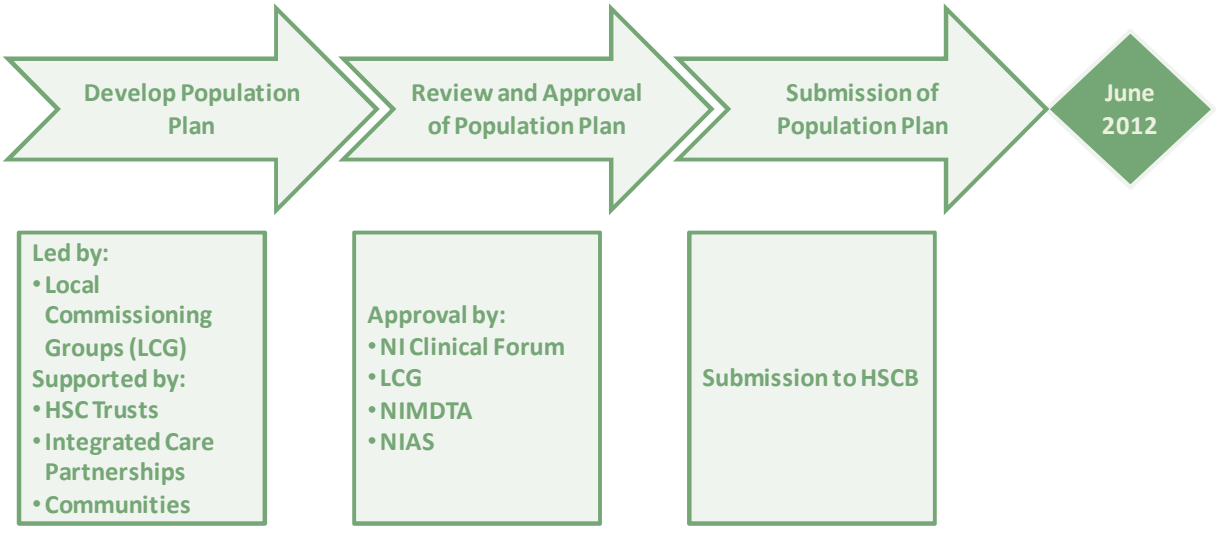
18.ROADMAP FOR THE FUTURE

Key to the successful delivery of the new model is a clearly defined roadmap for the future which sets out the steps needed to move from the current model of care to the new model of care. It is essential that a clear direction of travel is set out. This should be in the form of a clear implementation and engagement plan. The engagement plan will be an essential tool in setting out how the changes will affect users, families and staff. To support the implementation clear governance and reporting arrangements must be established. An answer to the 'who's in charge' question must be clear and accountabilities easily understood by all.

This section sets out a proposed response to this challenge. It comments upon governance arrangements for the programme, presents an approach to create an implementation plan and identifies the key actions and milestones for implementation of the recommendations of the Review. Additionally it describes a plan for engagement with staff and users. The Review recommends that detailed implementation and engagement plans are developed and published by June 2012 following this Review, as illustrated below.

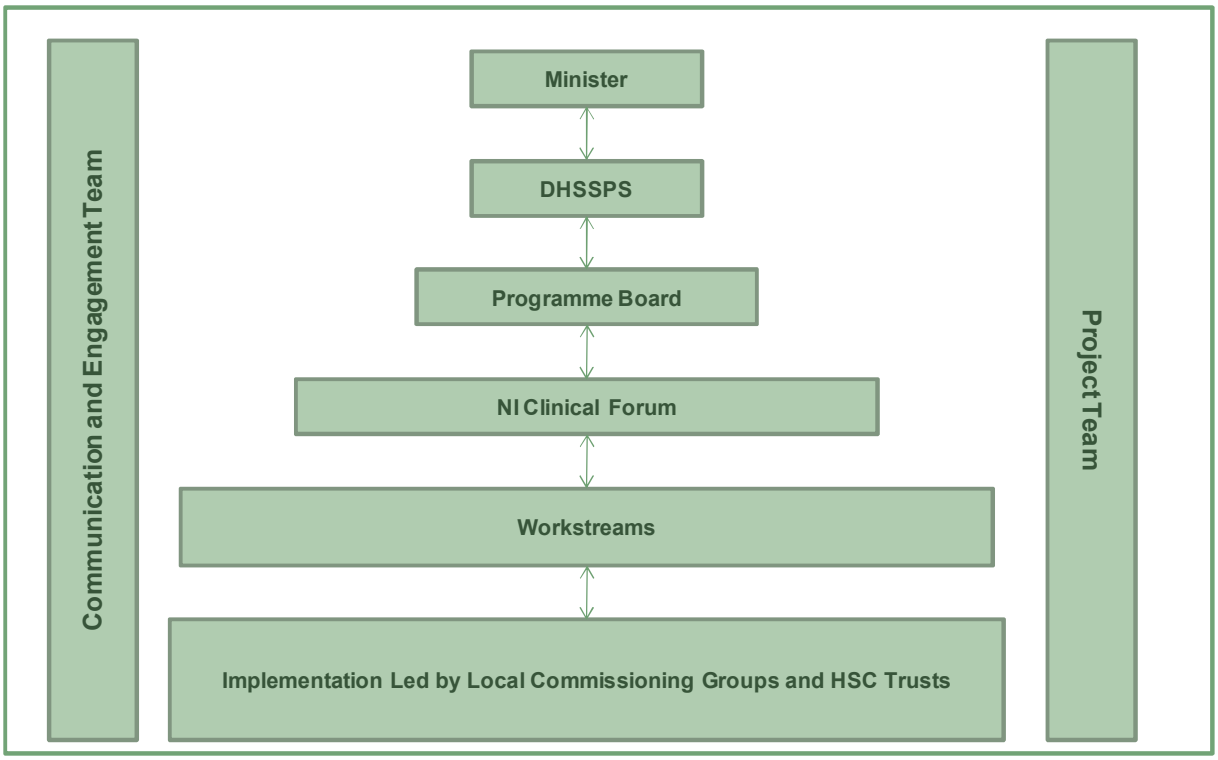
In addition, the Review recommends paying particular attention to achieving sign off from the 17 Integrated Care Partnerships, NIMDTA and the NI Ambulance Service when the Local Commissioning Groups put forward the models for their population.

Figure 26: Population Planning Process



PROGRAMME GOVERNANCE

Figure 27: Programme Structure



The programme of change will be led by the Minister for Health, Social Services and Public Safety. A Programme Board will be set up to report to the DHSSPS and Minister on the implementation of the Review. The Programme Board will be supported by the Northern Ireland Clinical Forum, a project team and workstream leads. The roles of each of the bodies included in the programme will be as follows.

Minister for Health, Social Services and Public Safety

The Minister is responsible for the roll out of the programme of change. The Minister will approve all major decisions about service changes, policy or legislation. The Programme Board will report to the Minister on progress of the implementation through the DHSSPS.

DHSSPS

The DHSSPS will advise the Minister on extant policy or new policy and will support the Minister in making decisions relating to the programme of change. In addition, the DHSSPS will ensure close collaboration with the Programme Board as it discharges its responsibilities.

Programme Board

The Programme Board will be chaired by the HSCB and made up of representatives from the HSCB and HSC Trusts. The Programme Board will be responsible for steering the implementation using the commissioning process. It will also be responsible for reporting to DHSSPS and the Minister on progress.

NI Clinical Forum

A NI Clinical Forum will be established in 2012 to provide strong professional advice to the Programme Board and give robust clinical advice in taking forward the changes. Additionally the Patient and Client Council will be invited to describe how best to ensure users and carers are engaged.

Workstreams

A number of workstreams will be set up for each area that is seen as key to leading the implementation. These workstreams will lead the implementation of the agreed plans for each population. They will report to the Programme Board on the progress under each workstream.

Delivery

The actual implementation of the changes agreed will be taken forward as a joint approach between commissioners and providers. The Local Commissioning Groups will work with the HSC Trusts and other providers in taking forward the plans. The LCGs will report to the Programme Board on the progress of the implementation.

Project Support

The Programme Board will be supported by a Project Team. The Project Team will use Project and Programme Management principles to monitor the progress of the implementation of the programme of change based on the plans approved by the Programme Board, the DHSSPS and the Minister. The Project Team will report directly to the Programme Board on the progress. The tools used to monitor progress will include:

- detailed Project Plan;
- key responsibilities for taking forward actions and associated timescales;
- actions and milestones;
- targets for measuring success; and
- development and management of project risks.

Communication and Engagement

The delivery of the programme will rely greatly on the ability to successfully communicate changes to the public and

staff working in the HSC as well as successfully engaging with these groups and achieving their buy-in to the process. This will require communication and engagement support from a team with experience in taking forward major change programmes.

The suggested structure of the programme is shown in Figure 18 overleaf.

These arrangements should be in fully place by June 2012 to support the roll out of the population plans submitted at that time.

IMPLEMENTATION PLAN

A detailed implementation plan overleaf will be required to take forward the project. This will be based on population plans. Each of the population areas, led by Local Commissioning Groups, will be expected to produce population plans by the end of June 2012.

The figure overleaf sets out the high level actions associated with the recommendations of this Review.

The Review team acknowledge that many of the recommendations require policy change, as well as necessary equality, human rights and rurality impact assessments. In addition a number may also require legislative change to enable implementation. These will be taken forward in the implementation process.

ENGAGEMENT PLAN

The implementation of this programme of change is much more likely to deliver sustained transformational change through commitment than through compliance.

An engagement plan will be a key tool in taking forward the programme. The engagement plan will include:

- identification of the key stakeholders to be consulted with;
- how the stakeholders will be engaged with; and
- plan for engaging with stakeholders.

Stakeholders to be engaged with will include representatives from DHSSPS, HSC Board, HSC Trusts, Voluntary and Community Sector organisations, users and carers.

Stakeholders are expected to be engaged through a number of approaches, both targeted to specific stakeholders and those which are stakeholder wide. This will be via a number of methods which may include already established forums, workshops or one to one meetings.

Regular updates on engagement should be reported to the Programme Board.

COMMUNICATION PLAN

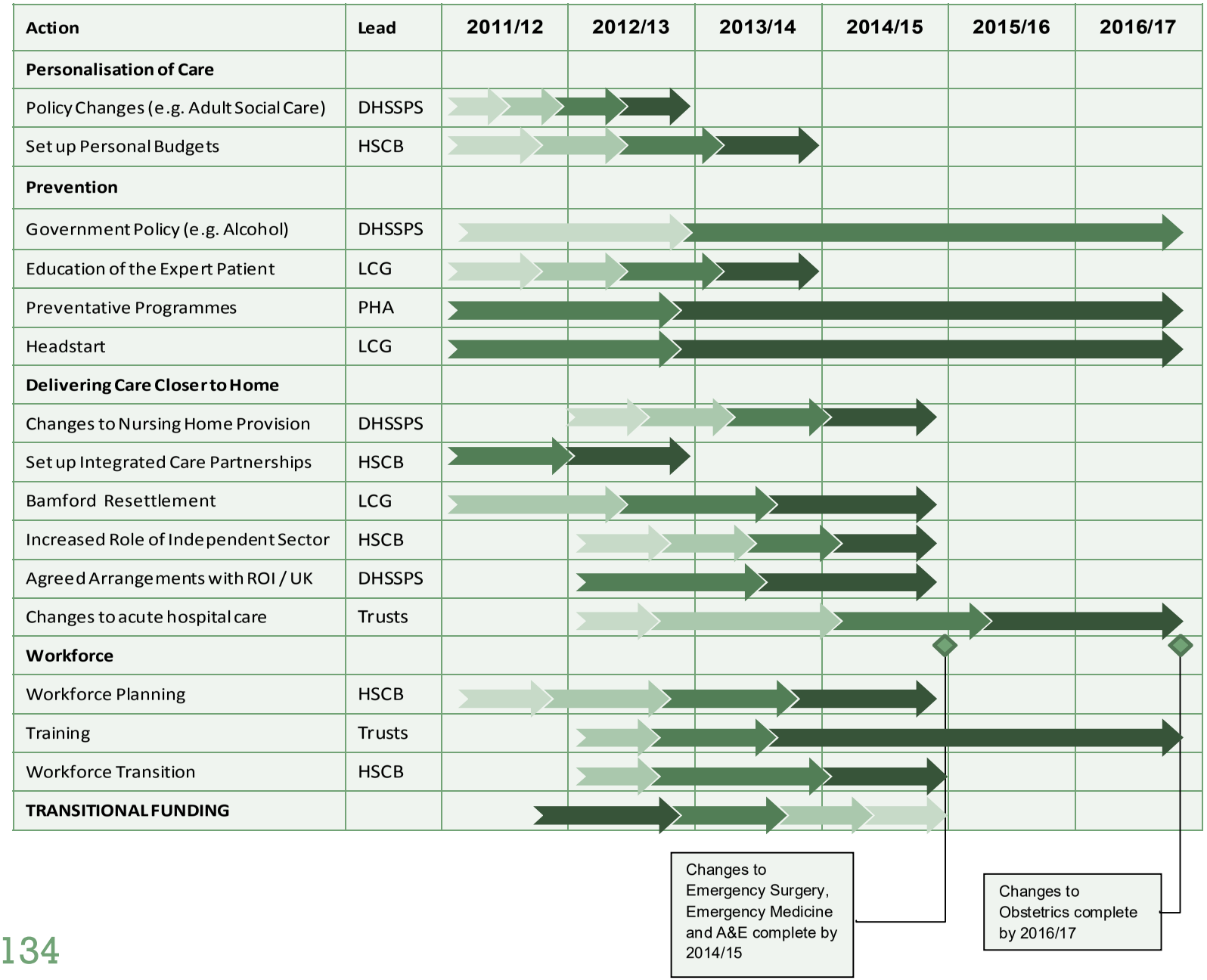
The major changes envisaged by this Review will impact on all residents of NI both those using the HSC service and those working in it.

To manage the effective implementation of the programme it will be essential that the changes are communicated effectively to those who will be affected, both from the perspective of understanding how the changes will affect care, changes in how to access care and a clear understanding of what is expected from the public in delivering the programme of change.

The communication plan should include details of:

- the key messages to be communicated;
- the target audience for communication;
- the approach to communication; and
- the forum and tools to be used when communicating with the groups identified.

Figure 28: Timeline for Completing Key Actions



19.SUMMARY OF PROPOSALS

POPULATION HEALTH AND WELLBEING

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

OLDER PEOPLE

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.

15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.

16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.

17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.

19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.

20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

LONG-TERM CONDITIONS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

PHYSICAL DISABILITY

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

33. More respite and short breaks provision.

MATERNITY AND CHILD HEALTH

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

FAMILY AND CHILD CARE

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

MENTAL HEALTH

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

LEARNING DISABILITY

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

ACUTE CARE

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

PALLIATIVE AND END OF LIFE CARE

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

20.CONCLUSION

The Review team was impressed and enthused by the opportunity offered by the Minister to bring forward coherent changes for HSC in NI. Change is always difficult, but in looking at change the Review was determined to keep the individual, their family and the evidence of what works at the fore-front of its deliberations.

Looking towards the next 5 years there is real potential with the implementation of the Review to see a service much improved and fit for the future. The Review cannot be impervious to the present wider economic climate and how that might impact on HSC. However the Review Team was firmly of the view that the best defence to such an eventuality was to be clear about the direction of travel, namely:

- starting with the individual;
- looking to a greater focus on prevention;
- maintaining care close to home;
- re-designing primary care; and
- re-shaping hospitals.

Planning for taking decisions and creating a new model for the future is at the core of the Review. The Review is convinced failure to plan will cause detriment to the health and wellbeing of the population

21.APPENDIX

1. Terms of Reference
2. Online survey summary of results
3. Household survey summary of results
4. Questions raised at public meetings
5. List of attendees at clinician workshops and areas covered at each event
6. List of attendees at sector workshops
7. List of stakeholders engaged with at small group meetings
8. List of written submissions
9. Glossary

Appendix 1
Terms of Reference

Review of the Provision of Health and Social Care services in Northern Ireland

1. The Review should take account of:

- the Minister's statement of vision and strategy for the HSC;
- the statutory duties on the HSC to improve the quality of services provided to individuals, and to seek to improve the health and social well-being of the population, and to reduce health inequalities;
- all extant statements of policy and strategy approved by the Minister, and in particular the aims of improving **public health**, the **prevention** of illness, and of improving **outcomes** for patients and clients. Other major themes of policy and strategy are the quest for better early intervention and chronic condition management, and the strategic shift of all suitable services towards a primary and community context;
- the organisational structure of the HSC as established in the 2009 Reform Act, and in particular the responsibility to secure a clear focus on public health, and increasingly effective local commissioning of services and to exercise good governance and provide clear accountability – the Review will need to ensure that its analysis and recommendations are practical and applicable within this statutory framework;
- the resources available in the Budget settlement for 2011-12 to 201415 approved by the Executive and the Assembly in March 2011, given the overriding obligation on all HSC bodies to manage services within the level of resources approved by the Assembly;
- best practice guidance of regulatory and advisory bodies affecting the provision of safe and effective services, notably the National Institute for Health and Clinical Excellence, the Social Care Institute for Excellence and the Royal Colleges;
- evidence of how arrangements for the delivery of health and social care in the Republic of Ireland and Great Britain and cooperation for mutual benefit with service providers there, might contribute to the objectives of the Review;
- the established framework of terms and conditions for HSC staff including Agenda for Change and the Consultants' Contract, and the contractual arrangements in respect of primary care;
- recent previous studies and analysis of the HSC including the Appleby Reports of 2005 and 2011, the McKinsey Report of 2010 and the forthcoming PEDU Review; and
- evidence-based good practice on the delivery of services from within Northern Ireland from elsewhere.

2. On that basis, the Review is asked to:

- Provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and

communities are being met by existing arrangements, taking account of the issues of outcomes, accessibility, safety, standards , quality of services and Value For Money;

- Undertake appropriate consultation and engagement on the way ahead with the public, political representatives (primarily through the Assembly Health Committee), HSC organisations, clinical and professional leaders within the HSC, staff representatives (through the Partnership Forum), and stakeholders in the voluntary, community, independent, private and local government sectors;
- Make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community or other settings. The essential task of the Review is to set out a specific implementation plan for the changes that need to be made in the HSC in the context set out above, including proposals in relation to major sites and specialties;
- To identify, at an early stage, potential areas of concern, specific priorities for Ministerial focus and potential issues of public/political/media concern;
- To prepare a Report incorporating its analysis, findings and recommendations.

3. The new organisational structures within Health and Social Care have delivered major efficiencies already. They are currently the subject of a further review as part of a wide ranging review by the Executive of all Arm's Length Bodies and are outside the scope of this Review.

4. The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

5. Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that the Minister can be advised of the issue and give a specific steer as to how the Review should proceed.

6. The Review should complete its Report by 30 November 2011.

Appendix 2
Online Survey Summary of Results

Online Survey Results

In total there were 1107 responses.

However many of the responses were incomplete and in many cases only demographic information was captured.

The final sample was **673** responses although for some of the 'Quality' questions the sample was reduced further.

Summary of findings:

Demographic Profile

- **91%** of respondents said they work for an organisation providing health or social care services in NI
- **81%** said they work for an HSC Trust
- **95%** were providing the response on their own behalf

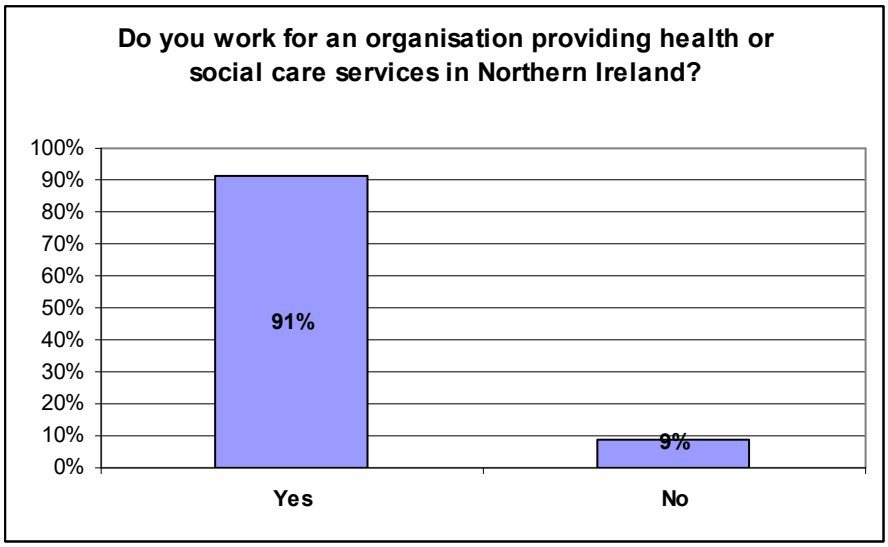
Service Usage in the last Year

Top 3 services reported by most respondents

- **94%** of respondents (or their families) have used GP services
- **54%** of respondents (or their families) have had an appointment with a hospital consultant
- **40%** of respondents (or their families) have used A&E services

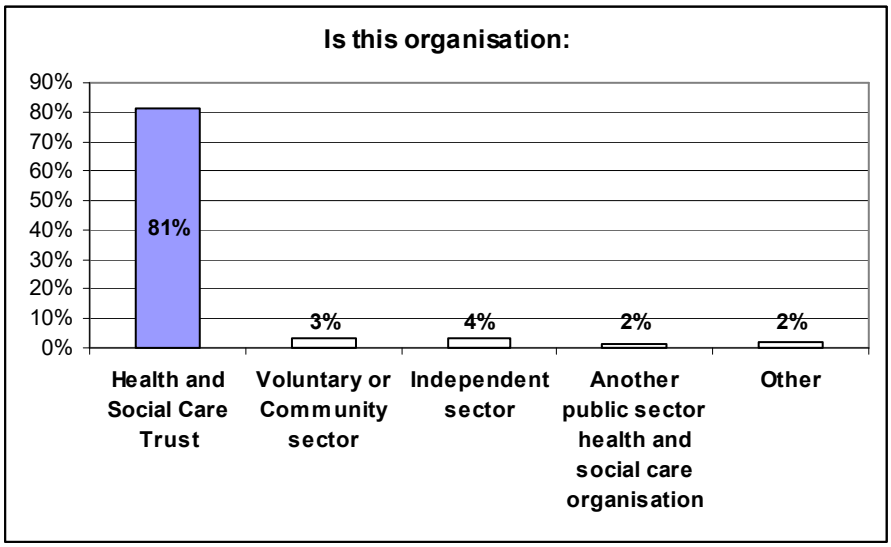
Profile

Do you work for an organisation providing health or social care services in Northern Ireland?

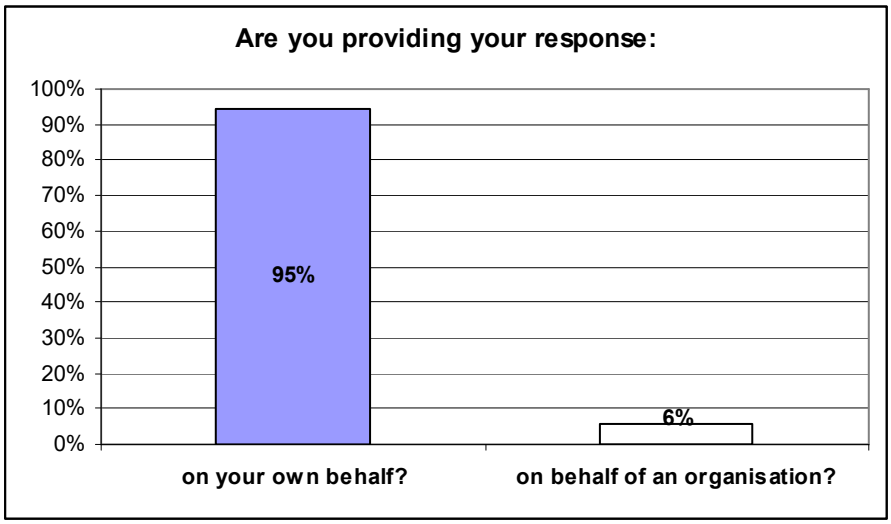


Is this organisation:

-A Health and Social Care Trust
-Another public sector health and social care organisation
-A voluntary or community sector organisation
-An independent sector organisation
-Other

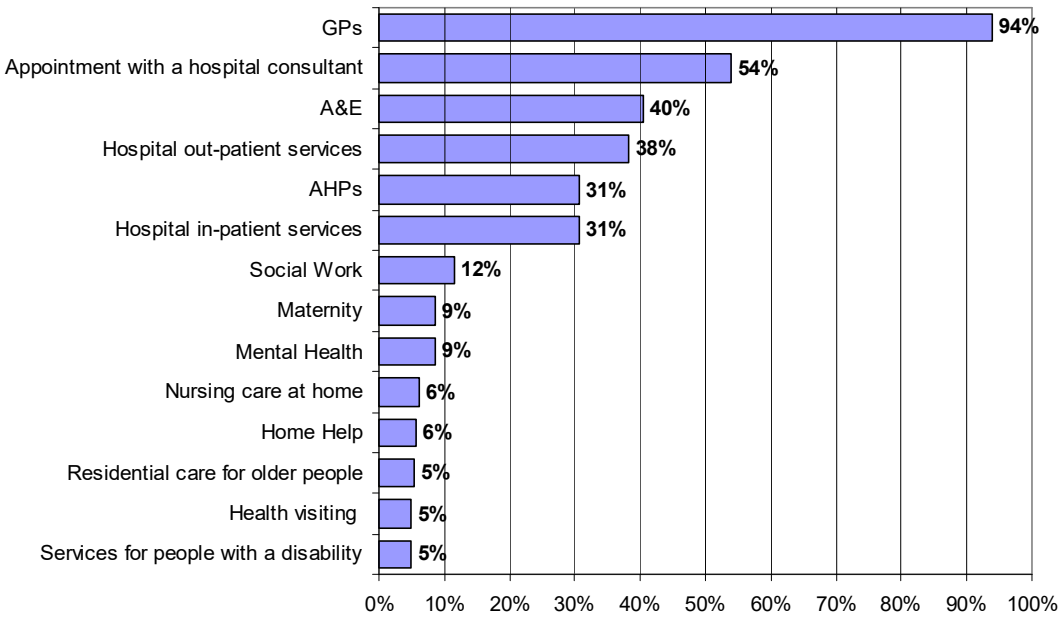


Are you providing your response
- On behalf of an organisation or
- On your own behalf?

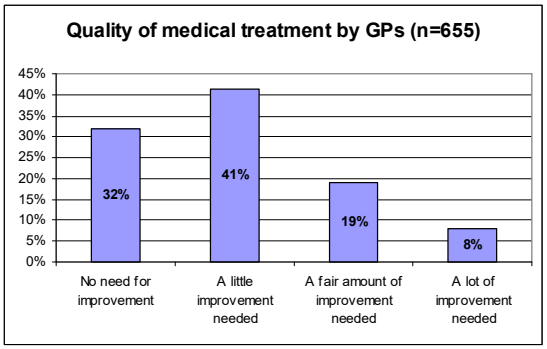


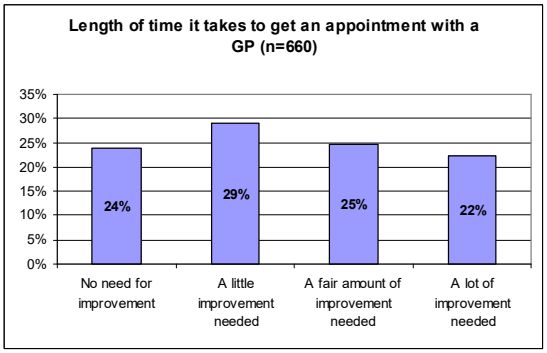
What is the name of the organisation you are sending your response on behalf of?
Action Mental Health
Autism NI (PAPA)
Bradleys Pharmacy
Castleview Private Nursing Home, Carrickfergus
Community Organisations of South Tyrone & Areas Ltd (COSTA)
Contact a Family
Dundela Pharmacy Ltd
FAITH HOUSE
Fermanagh Cardiac Support Group
Fold Housing Association
Foyle Parents and Friends Association
Home-Start Craigavon
Home-Start East Belfast
Home-Start In Northern Ireland
Kennedy's Pharmacy (Rasharkin and Dunloy)
Maria Mallaband Care Group Ltd
Mencap in Northern Ireland
MindWise New Vision for Mental Health
Newry & Mourne Carers Limited
Orchard House Private Nursing Home
Phoenix Healthcare
Shalom Care
Strandburn Pharmacy
The Dry Arch Children's Centre
The Stroke Association Northern Ireland
Wilson Group (Nursing Homes)

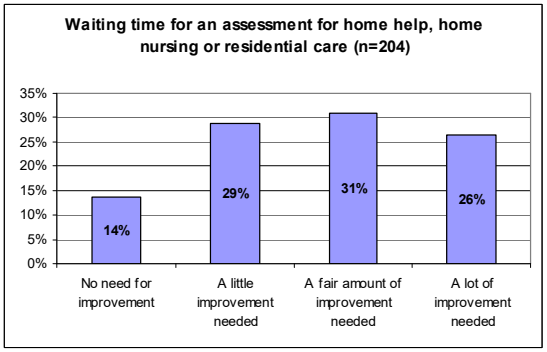
Have you or your family used any of these health and social care services in the last year?

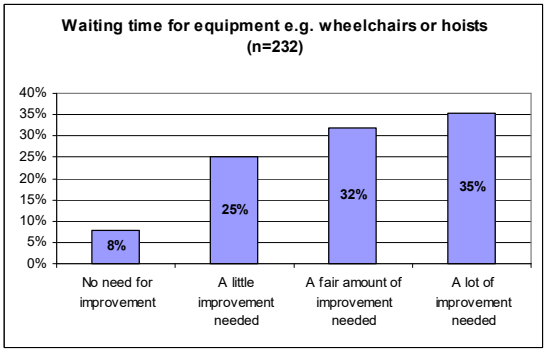


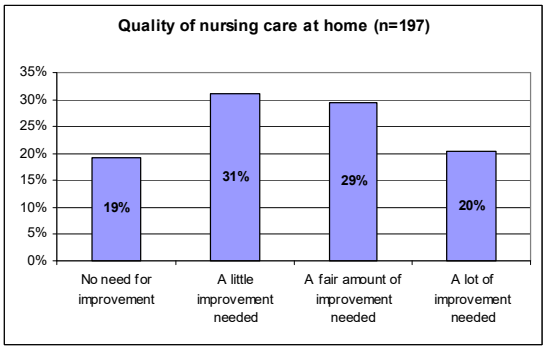
How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?:

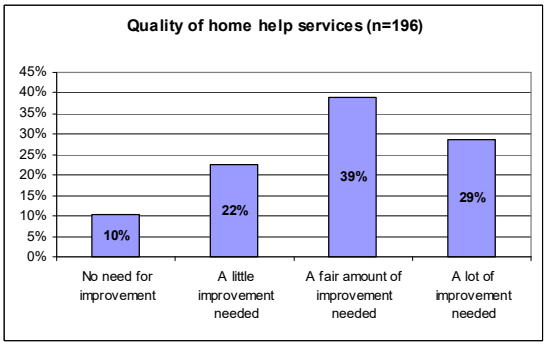


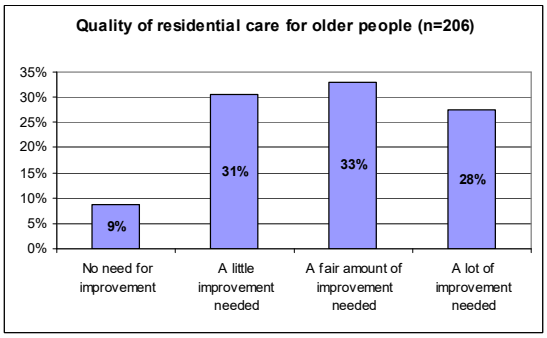


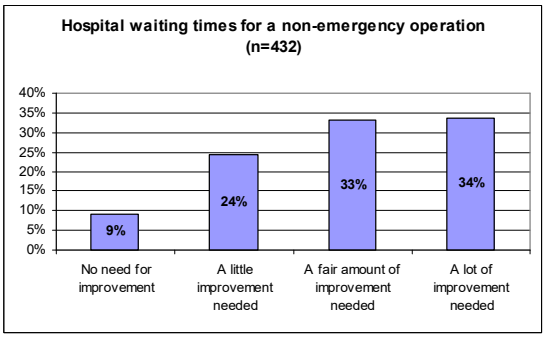


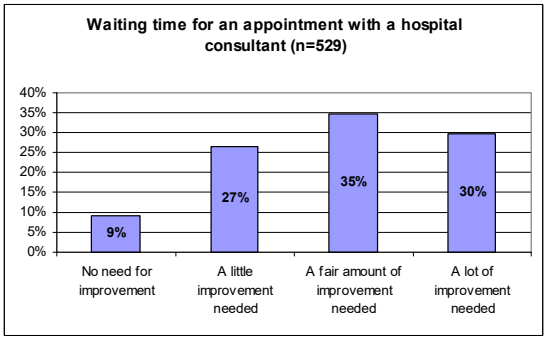


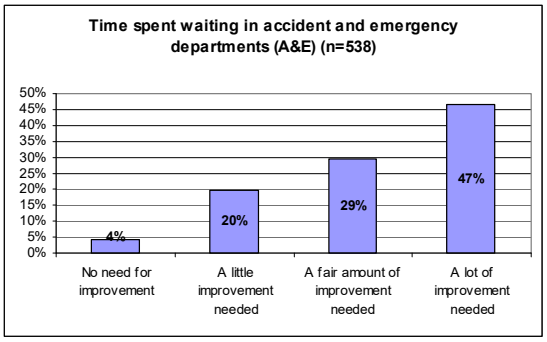


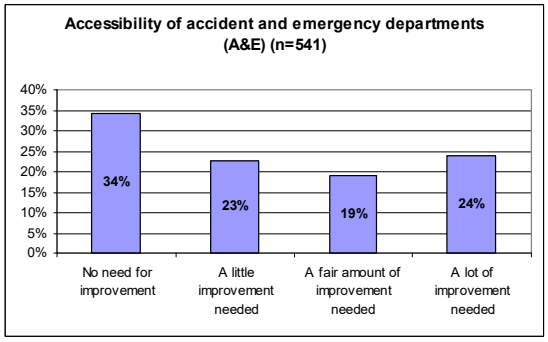


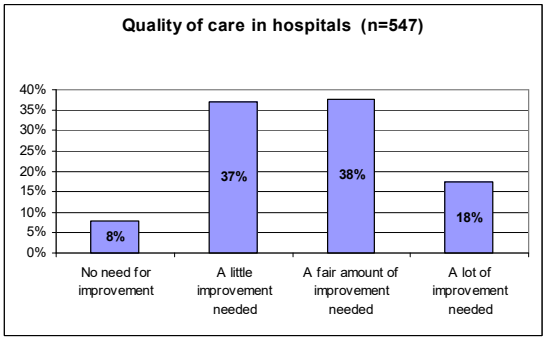


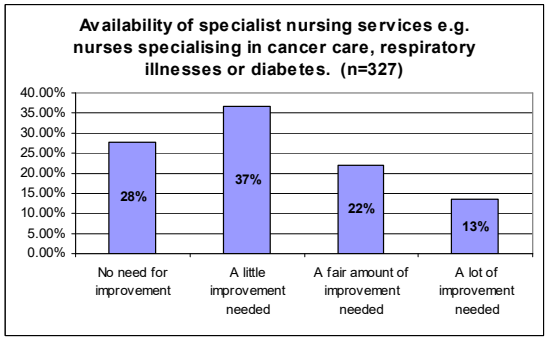


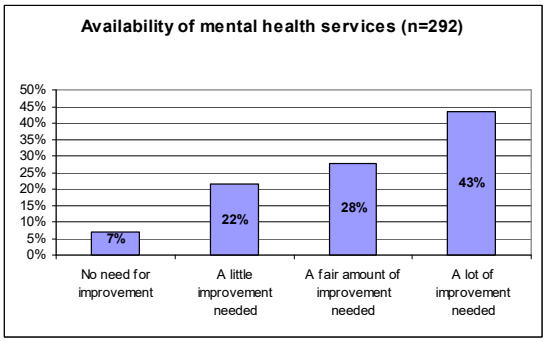


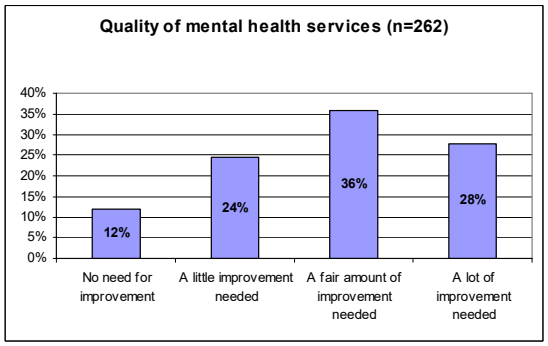

Time spent waiting in accident and emergency departments (A&E) (n=538)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
4%
20%
29%
47%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

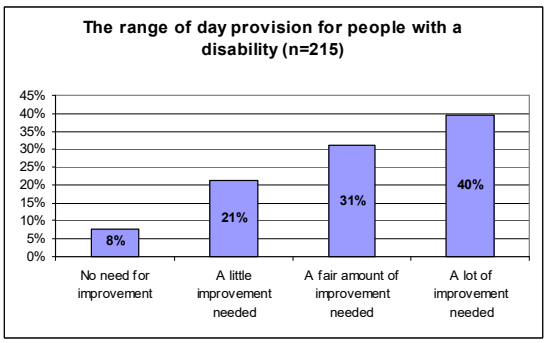

Accessibility of accident and emergency departments (A&E) (n=541)
40%
35%
30%
25%
20%
15%
10%
5%
0%
34%
23%
19%
24%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

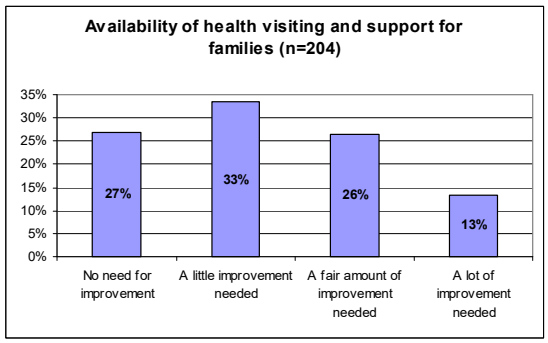

Quality of care in hospitals (n=547)
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
37%
38%
18%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

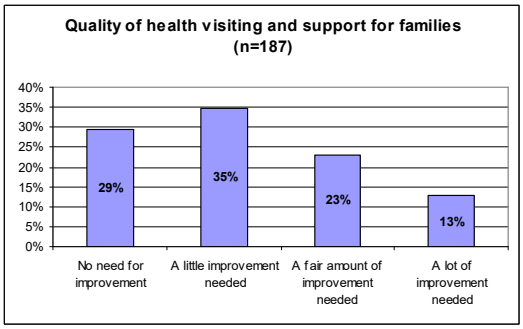

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illnesses or diabetes. (n=327)
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
28%
37%
22%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

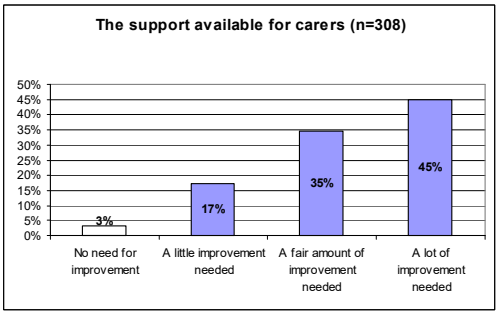

Availability of mental health services (n=292)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
22%
28%
43%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

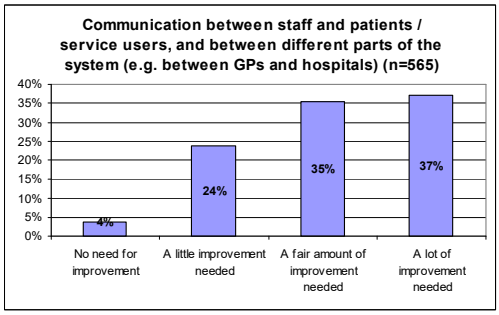

Quality of mental health services (n=262)
40%
35%
30%
25%
20%
15%
10%
5%
0%
12%
24%
36%
28%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

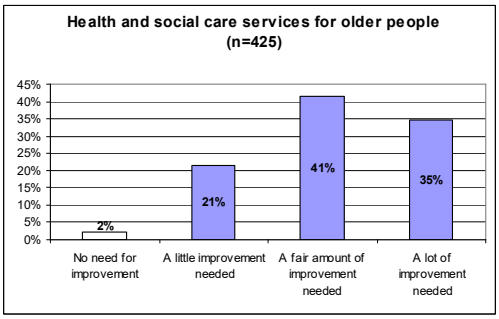

The range of day provision for people with a disability (n=215)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
21%
31%
40%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

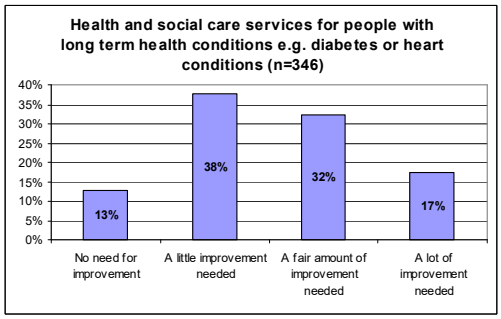

Availability of health visiting and support for families (n=204)
35%
30%
25%
20%
15%
10%
5%
0%
27%
33%
26%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

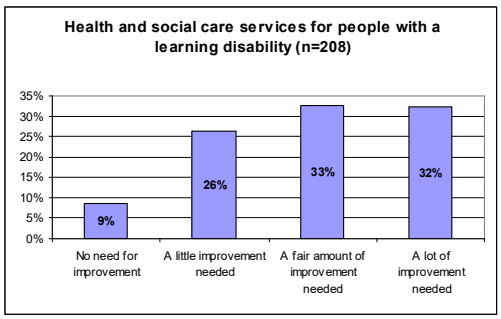

Quality of health visiting and support for families (n=187)
40%
35%
30%
25%
20%
15%
10%
5%
0%
29%
35%
23%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

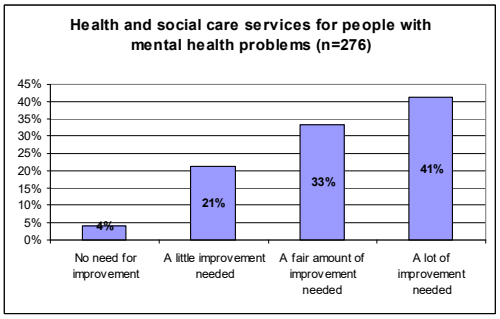


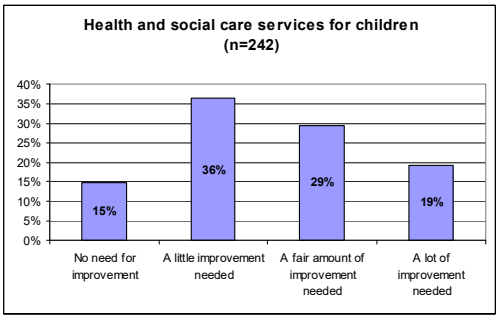


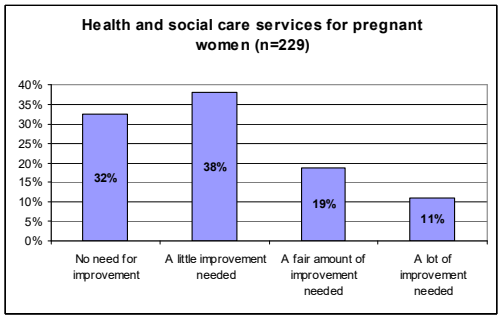


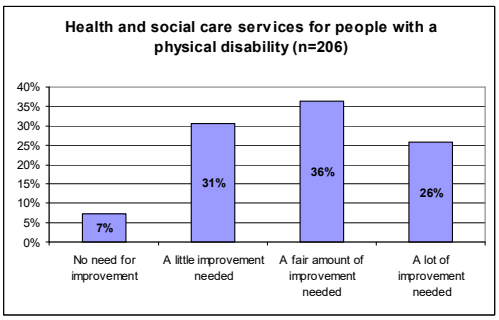


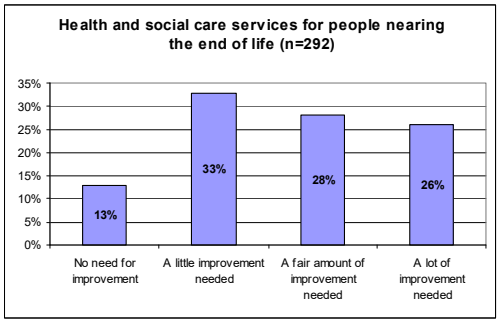












Suggestions for Improvement

Quality of Medical Treatment by GPs

- Promote use of IT / access of information from other systems / electronic records for better decision making
- Improve communication across primary and secondary care / GP to GP / with patients & families
- Increase accessibility (extend opening hours) - evening and weekend clinics
- Training - skilling up especially in relation to Mental Health & Learning Disability, depression; keep skills up to date
- Improve interpersonal / customer care skills – especially listening skills, empathy
- More time for each appointment
- Continuity of GP
- More GPs
- Provide advice service - Use of other systems to provide advice e.g. telephone system, emails
- Use of Nurse to triage

Length of Time to get an appointment with a GP

- Increase accessibility (extend opening hours) - evening and weekend clinics
- Walk in Clinics (no appointments required)
- More GPs (and more Female GPs)
- Penalties for patients who 'Did Not Attend' (DNA) – use of reminder system
- Use of Community Pharmacist for minor ailments (German / Austrian Model)
- Provide help lines (may reduce demand for appointments)
- Increase role of the Practice Nurse / Triage Nurse / Triage service
- Improved system for making appointments (EMIS / online systems)
- Train receptionists re customer care skills
- Better sharing of information

Waiting time for assessment of home help home nursing or residential care

- Increase staff / resources / fill vacant posts
- More efficient use of resources
- Better process for assessment and implementation of services
- More funding
- Review 'need' – this may change / decrease
- Less bureaucracy
- Person centred / holistic approach

Waiting time for equipment

- Better procedures required for tracking and return of equipment e.g. central register of equipment; Trusts set target for return / recycling; patients pay deposit or application of financial sanctions for damage / non return (seems to be big issues with respect to trying to return equipment)
- More staff required particularly Occupational Therapists (OTs) and improved management of teams
- More resources for equipment purchase
- Faster appointment process

Quality of nursing care at home

- More time allocated per call
- More staff / resources
- Training of staff
- Increased use of Community Pharmacy
- Continuity
- Random audits / inspections and better regulation required
- Sign posting

Quality of home help services

- More time allocated per call – 15 minutes is not enough
- Training – a wider skills remit by staff and care plans to be held at home to indicate what carer has to do
- Increased use of Community Pharmacy
- Continuity
- More staff/ more resources / better pay = better service
- Increased funding – possibility of patient contribution
- Regulation
- Implement a register of carers - Trust service better than private.

Quality of Residential Care for Older People

- Improve regional standards of care especially for Dementia
- More staff
- Person-centred / holistic approach to provision including assessment on admission
- Random inspections
- More space / activities including crafts, stimulation to keep minds active etc
- Staff training especially re stroke
- More homes
- More money
- Better facilities including hygiene
- Direct payments – enable patient to make own decisions re care

Hospital waiting times for a non emergency operation

- Increased use of Community Pharmacy
- More staff (= more appointments) / more investment in staff to do scans etc
- Increased funding / use of Integrated Clinical Assessment and Treatment Services (ICATS)
- Prioritise waiting list using emergency and non emergency
- Up-skill staff
- Use/make better use of cancellation lists; deposit system (fines for DNAs)
- Improve, maximise theatre efficiency (including number of slots / evening and weekend appointments)
- NHS do NHS work - stop NHS consultants doing private work
- Employ Cardiac Paediatrician and stop sending to Birmingham and Dublin
- Improve communication
- Implement IEAP properly
- Bigger A&E departments and less of them
- St Thomas's

Waiting times for an appointment with a hospital consultant

- More consultants / specialists/ clear backlogs / increased training for these; more staff generally
- No private work
- More appointments (evening and weekends)
- Improved coding on new/review system / clarity on partial booking system
- Use of ICATS
- Expand Nurse led appointments /clinics
- Penalties for DNAs
- Improve communication
- Training for community specialists
- Telemedicine

Time spent waiting in A&E departments

- Reduce inappropriate referrals / attendances - educate public re appropriate use of A&E
- Use of specialist teams for improved triage – redirect to community as appropriate
- More staff and resources
- Improve communication re how long can expect to wait
- Long waiting times may be ameliorated through use of walk in centres / extended GP hours
- Use of a nurse led helpline to signpost public to correct department

Accessibility of A&E departments

- Improve local accessibility - stop closing local A&E Departments
- Address car parking including for disabled
- 24/7 opening hours including for Minor Injury Units
- Delivery of X-rays etc in other settings

Quality of care in Hospitals

- Improve hygiene
- Person centred care – more assistance with basic care e.g. eating, drinking, (dieticians), toileting
- Bring back matrons, senior nursing staff
- Address staffing shortages / more frontline staff doing the 'nursing'
- Ensure all are treated with dignity and compassion – improve staff attitudes and morale
- Improve communication
- No mixed wards
- Look at OASIS system in South Australia for IT

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illness or diabetes

- More specialist nurse are required – more training
- Ensure equity of access geographically and for conditions – same as for cancer, and 24/7
- Roll out concept of Expert patient

Availability of Mental health Services

- Implement Bamford
- Investment needed for respite services
- Home treatment teams
- Improve access (for all age groups; 24/7; Learning Disabled) and signposting
- More resources (in the community) & staff
- Increased co-ordination
- Targeted resources
- Enhance understanding by GP

Quality of mental health services

- More investment & staff (Community Psychiatric Nurses (CPN), Cognitive Behavioural Therapists, Psychologists etc))
- Bamford
- Continued emphasis on recovery
- Holistic, multidisciplinary approach must be adopted
- Increased role of Community Pharmacy

- Improve Child and Adolescent Mental Health Services (CAMHS) and Older People's services
- More community initiatives
- Early intervention
- Reduce waiting times

The range of day provision for people with a disability

- Improve the range of activities including daily living skills / increased provision and more choice / appropriate activities
- Remove the age link with this service / increase the opportunity for younger people / for those aged over 65yrs
- Increase capacity provision and choice
- Person-centred
- More availability for brain injury
- Alternatives to daycare e.g. employment schemes; day therapy sessions / community development approaches
- Personalised budgets

Availability of health visiting and support for families

- Need for more health visitors
- Need for more resources
- Increase support provided by health visitors especially in first few weeks for new mums
- More links with Surestart
- Targeted approach for those in need (or at risk) of the service
- Health visitors directly employed by GPs

Quality of health visiting and support for families

- More staff, resources, training
- Provision of more support for families with young children and families, families with disabled children
- Improve communication

The support available for Carers

- More respite opportunities (more respite, regularly) / more funding for respite that is adequate and suited to needs
- Implement carers strategy
- Training for Carers
- Befriending schemes
- Financial reward
- Use of a key worker / advocate
- Use of voluntary sector to provide support
- Bank staff to cover illness
- Increase the awareness of support available to carers

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals)

- Greater use of Technology and electronic methods for communication, prescribing etc
- Use of central information systems (1 system) / files / online patient notes
- Use of patient passports for some conditions
- Electronic Care Record
- Timely communication / openness and honesty
- System link up
- Proactive sharing of information
- User forums

Health and social care services for older people

- Increased use of private sector
- More community services
- Proactive in reach services
- More Nursing homes (to cope with changing demographics); more home help / care packages
- Explore cross border models
- More staff / more resources / more funding
- Person-centred care
- Community development / healthy lifestyles
- Right service, right time, right place

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions

- Self management
- Education on risk management / healthy lifestyles and choices
- Early intervention
- Use of Community Pharmacists (for blood tests/fasting glucose etc)
- Specialist clinics, management by GPs, patients and Nurses in community / 24/7 availability
- Incentives such as paid gym memberships, slimming world etc
- Use of / explore alternative drugs
- Same level of services as for Cancer
- More community based rehab teams
- Rapid access to tests, treatments and surgery to prevent co-morbidities

Health and social care services for people with a learning disability

- Forward planning for individuals with a Learning Disability
- Use of Community Pharmacy

- Review of services for Learning Disability required including those provided by private sector
- More resources including rehabilitation, OT, and respite
- Improve communication and listening
- Multi-disciplinary and person-centred approach
- Implement Bamford
- Training for staff
- More community based services, including day care opportunities, befriending schemes, domiciliary care, training schemes and workshops.
- More support for families and carers
- Improved provision of supported housing for independent living

Health and social care services for people with mental health problems

- Improved access to services generally (24/7) and with respect to Clinical Psychology services
- Involve family
- Involve community services including Pharmacy and CPN
- Better training for mental health nurses
- More resources and staff (including specialists and CBT therapists), to aid early diagnosis and prevention, and continuity of care
- Better acute care provision
- Improved communication
- Implement Bamford – more funding
- More support for 18-25 year olds

Health and social care services for children

- Education / accessibility
- OT in CAMHS services
- Early intervention / prevention
- Inclusive policies /services
- Acknowledge extra support needed for disabled children /more services for Autistic children
- Listen to children and families / Involve parents
- More money/staff
- More school nurses
- More support through Allied Health Professionals (AHPs)
- Locally available services

Health and social care services for pregnant women

- Provide more comprehensive advice e.g. risk behaviour / health improvement / healthy choices – smoking cessation campaigns / alcohol / breast feeding etc
- Continuity of care for individual; consistency across region

- Support for women in general, and for those with mental illness
- More Midwives /direct access in community
- Targeted services for young expectant mothers
- Tailored accessible services for women with a learning disability
- Customer care training for Midwives
- Regular timely access to scanning throughout pregnancy – women should not be allowed to go over due dates
- Patient choice – but safety comes first.
- A little negativity re Midwife led units

Health and social care services for people with physical disability

- Multi-disciplinary and client-centred approach
- Care / Care teams should cater for individuals not age groups / consider children aged 14-18 who sits between paediatrics and adults
- Improved access to AHPS
- More resources / more respite services
- More accessible appointments
- Look at good practice / models e.g. Cedar Model

Health and social care services for people nearing the end of life

- More home support e.g. care packages to die at home or preferred place
- Open honest debate / listening to needs / wishes of patients / choice / allow patients to be part of the end of life plan
- More resources including hospice beds, District Nurses
- Use of Pharmacists
- Provision of Palliative Care teams to all people and allow to die with dignity
- Multidisciplinary approach /Specialist Nurses
- Palliative care for Learning disability
- Training for all involved
- More support for families / bereavement
- Same level of services as is for cancer
- Signposting – who to contact
- More staff –e.g. Palliative nurses
- More co-ordination –palliative nurses used as key workers

If you could make 3 changes to improve health and social care in Northern Ireland, what would they be?

Main themes

- More staff generally, more nurses and AHPs
- Reduce waiting times
- Improve communication
- Improve access to GPs
- Focus on health promotion / prevention; address alcohol as a public health issue
- Improve communication
- Increase local accessibility of services
- Improve hospital and community services for older people
- Reduce the number of managers and reduce paperwork
- Introduce charges for prescriptions, other services including meals in hospital, missed appointments,
- Improve services for learning disabled and their families carers including respite care
- Improve mental health services
- Staff training
- Better use of technology
- Bring back matrons
- Community Pharmacy
- Improve roads infrastructure
- More money
- Educate people to support themselves
- Fewer managers and less bureaucracy
- Decentralise where possible
- Enhance staff morale
- Interworking - enhance cross border working
- Increase involvement of community and voluntary sector
- Family support services
- More hospice and palliative care

Do you have any other suggestions for the future provision of health and social care services in Northern Ireland? For example this may relate to how accessible services are, the quality and safety of services, or the health outcomes achieved.

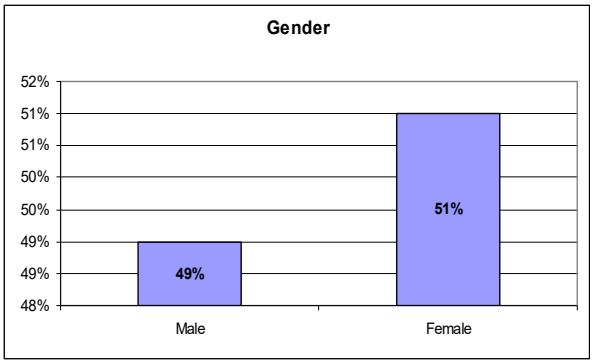
The responses given were variable and quite detailed. A very high level summary of some of the emerging themes are listed below:

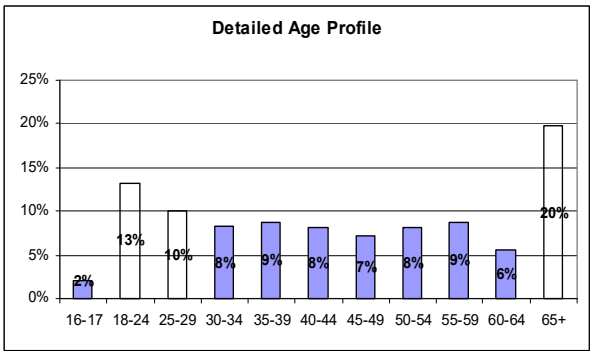
- Improve services for learning disabled and their families /carers
- Address alcohol as a public health issue
- Promote the use of Independent sector
- Reduce waiting lists
- Better use of Community Pharmacy services; more funding for Community Pharmacy services
- Better use of available services and facilities
- Promote / establish links within communities to combat loneliness
- Investment in resources / equipment
- More local services
- Introduction of charges (e.g. prescription charges)
- Equality of access for all in NI
- Invest in carers
- Invest in health promotion / prevention – make public responsible for their own health, start early; educate in schools to get public health message across
- Increase range of services offered by GPs / GP practice teams
- Stop closing A&E departments
- Reduce emphasis on targets and re focus on patient
- Fewer Managers
- Health care planning at local level
- Improve roads infrastructures thereby improve access to a range of services
- Enhance skills mix
- Improve GP accessibility
- Provision of quality training and communication
- More OTs
- Optimise use of technology
- Reconsider current location of some hospitals
- National health service for older people and those with disabilities
- Improve reporting times for diagnostic tests
- Less focus on waiting lists targets / find better ways to monitor waiting lists
- Reduce waste; reduce wastage with regard to pharmaceuticals
- Utilise skills in the community such as GPs, Pharmacists
- Better utilisation of AHPs
- More use of voluntary sector / community based services who can do the job for less
- Improve appointment systems
- More money needed

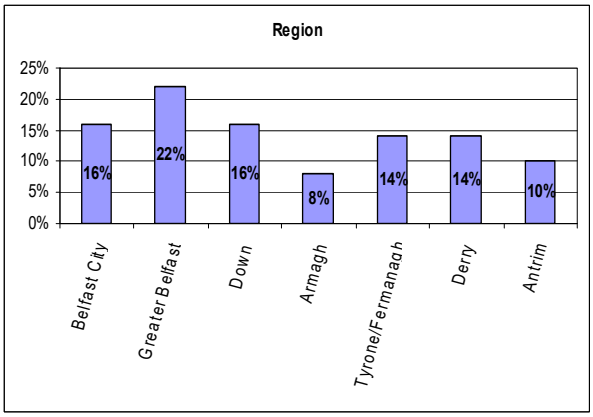
- Improve access to services for at risk youth
- Longer home help sessions
- Mobile clinics for hard to reach areas

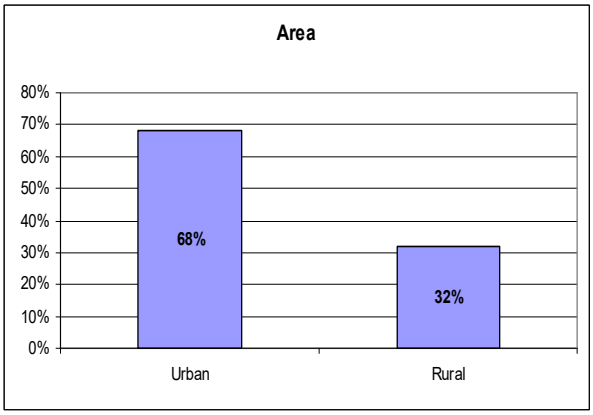
Appendix 3
Household Survey Summary of Results

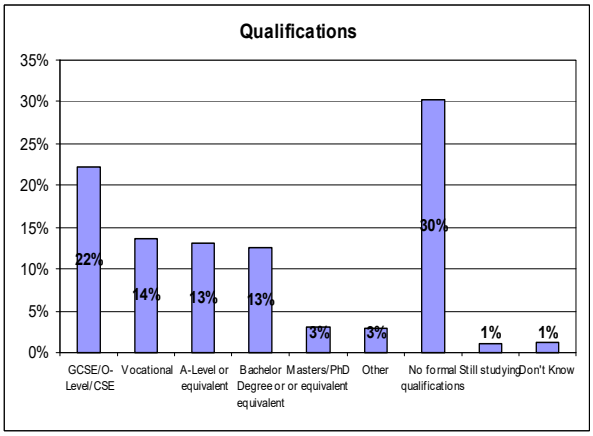
Profile Data

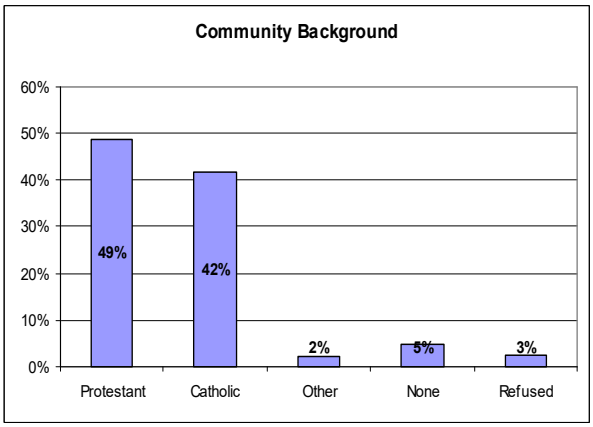


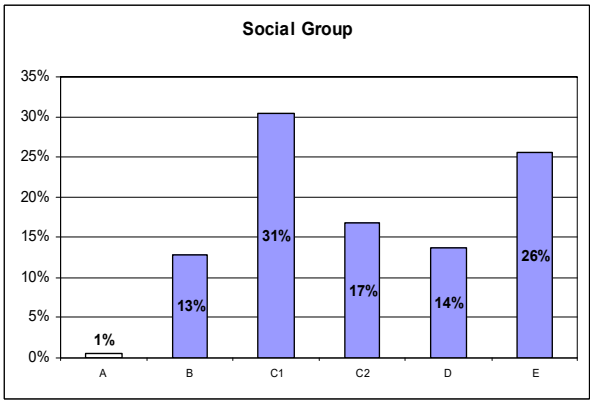


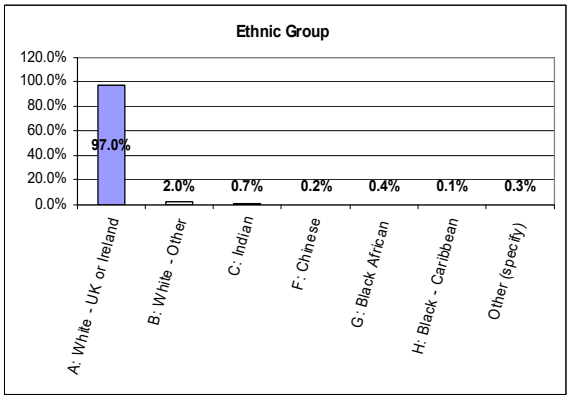






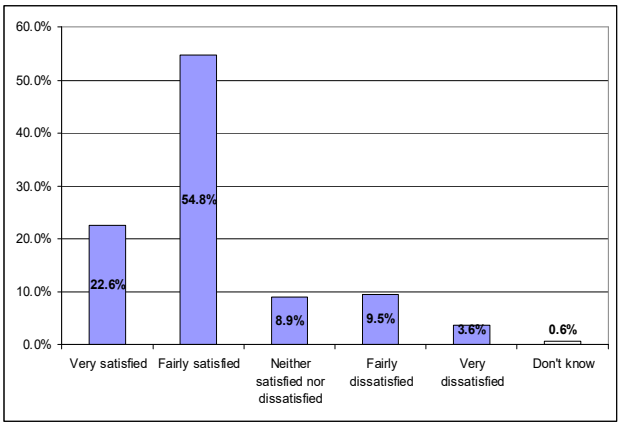


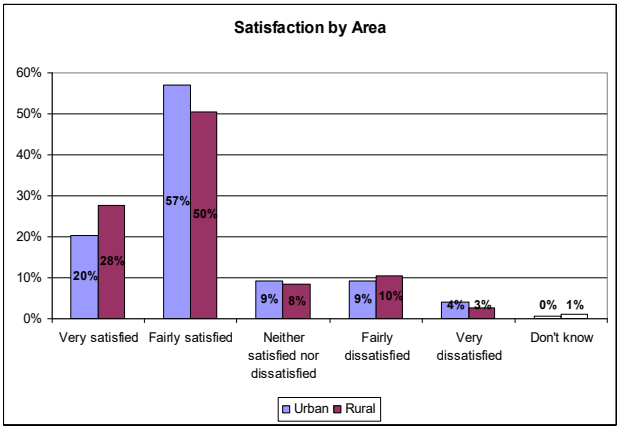


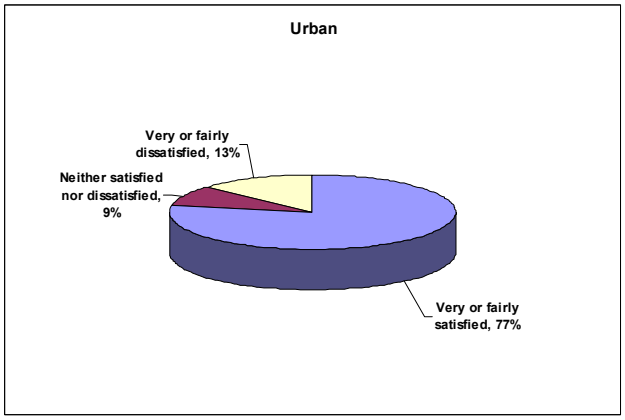


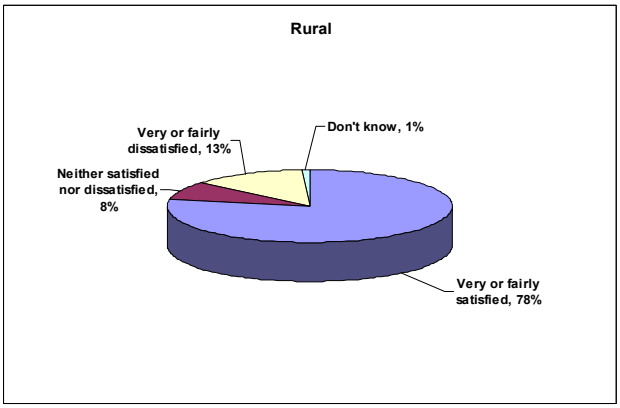
Question Responses

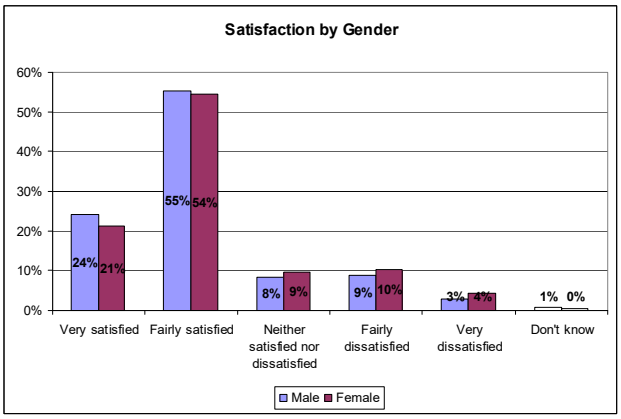
1. Overall, how satisfied or dissatisfied are you with health and social care provision in Northern Ireland at present?

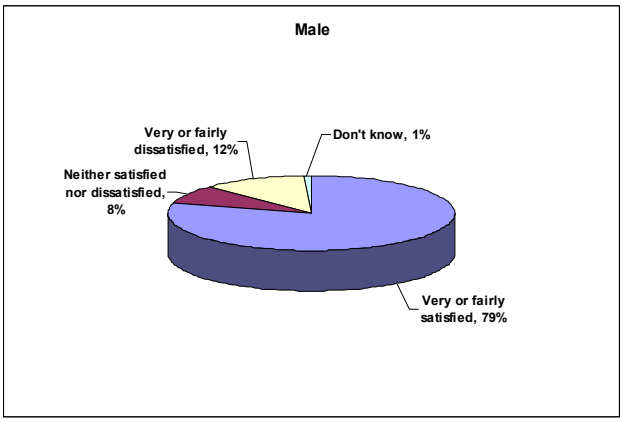


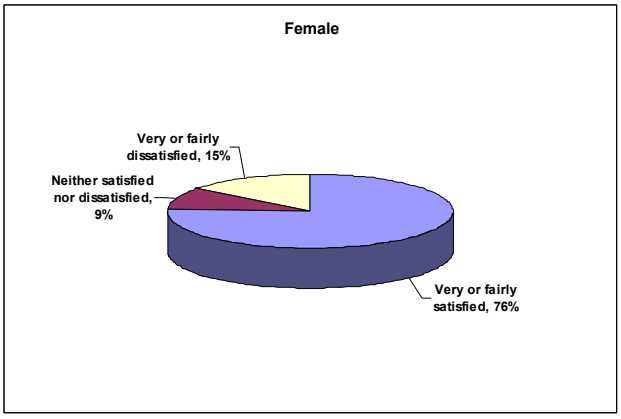


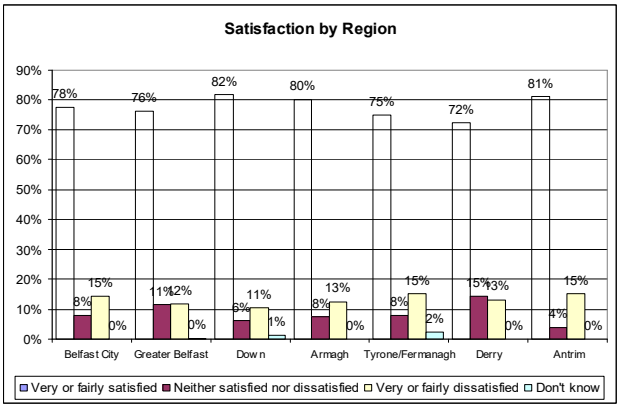




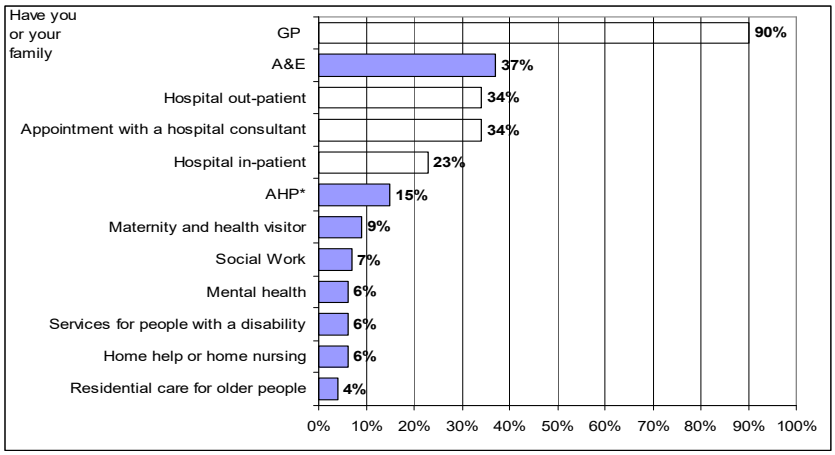




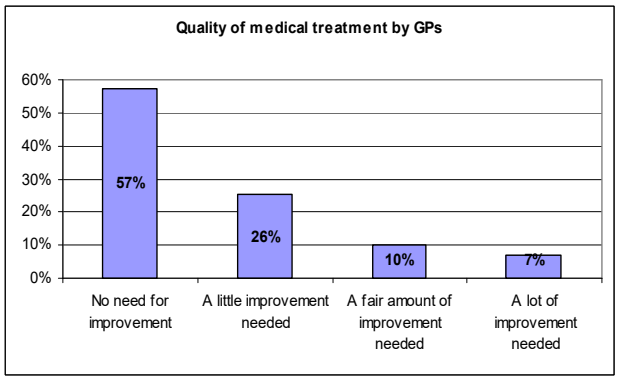


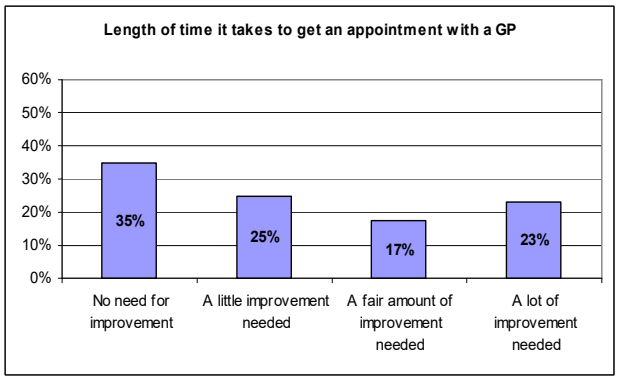


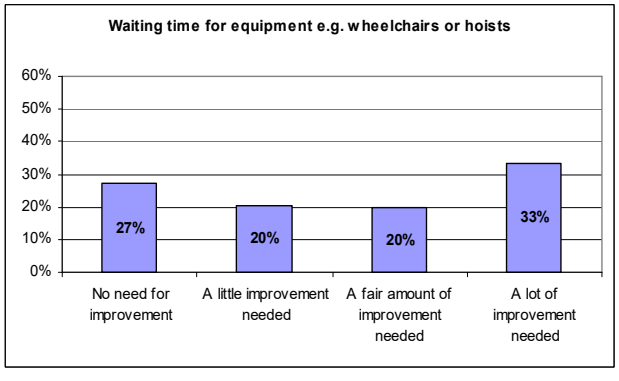
2. Have you or your family used any of these health and social care services in the last year?

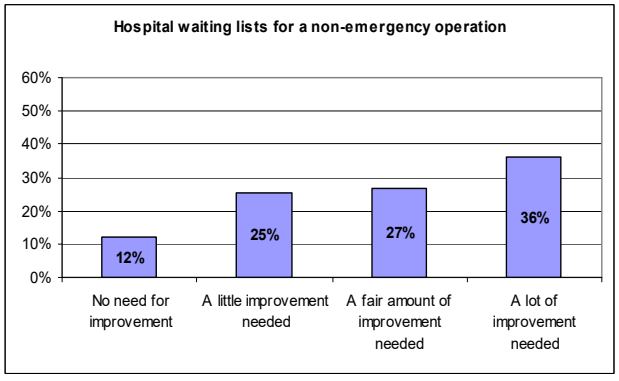


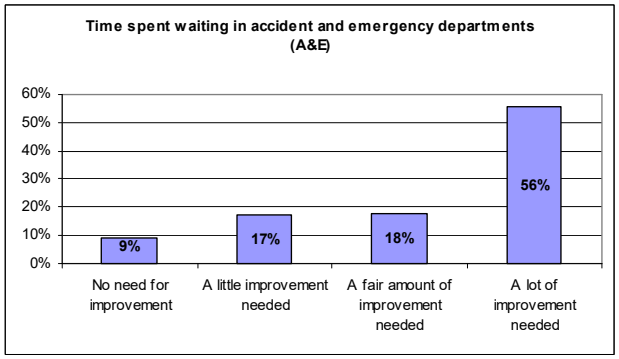
3. How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?

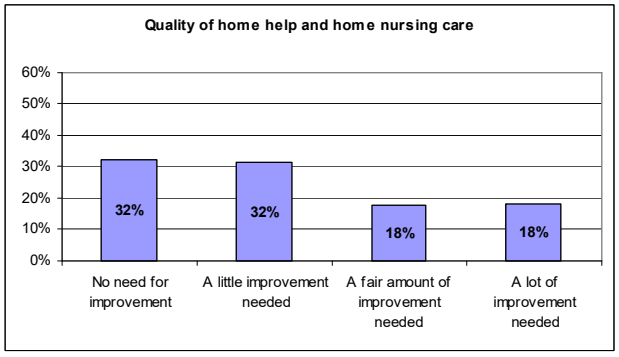


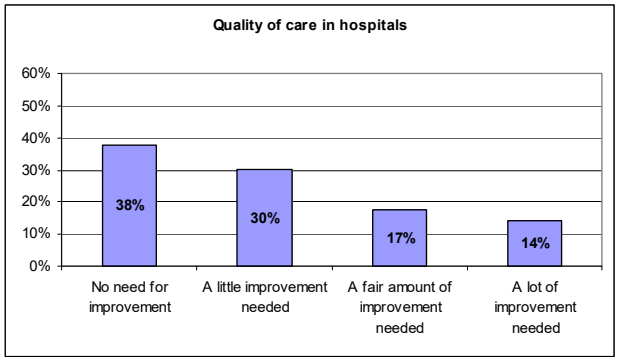


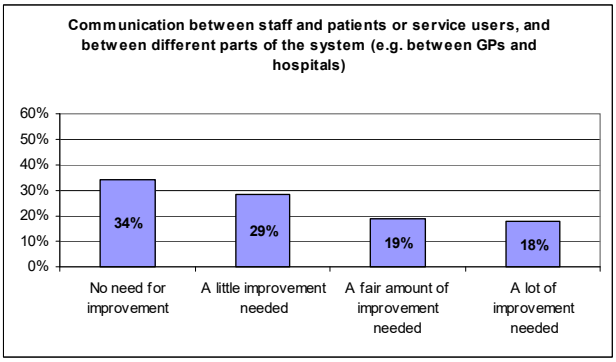


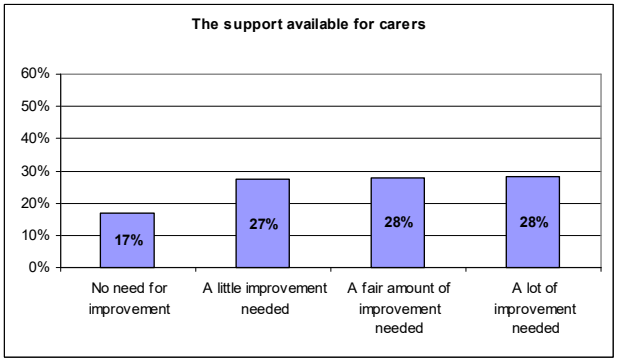




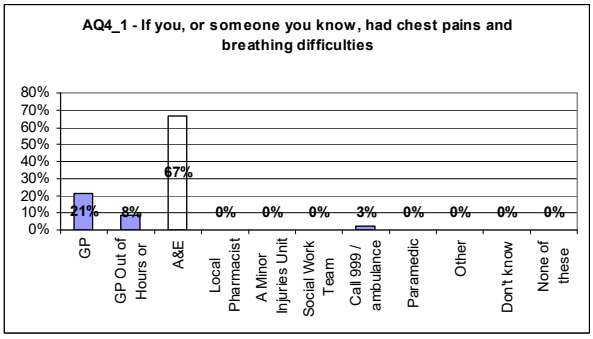


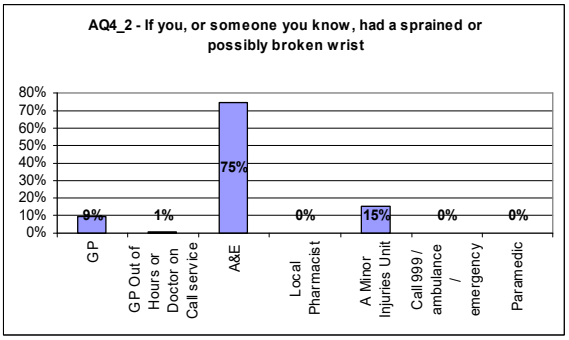


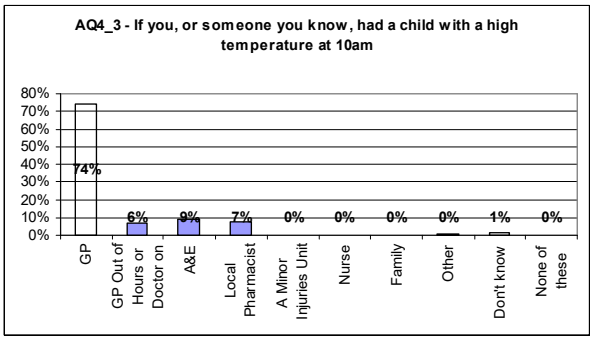


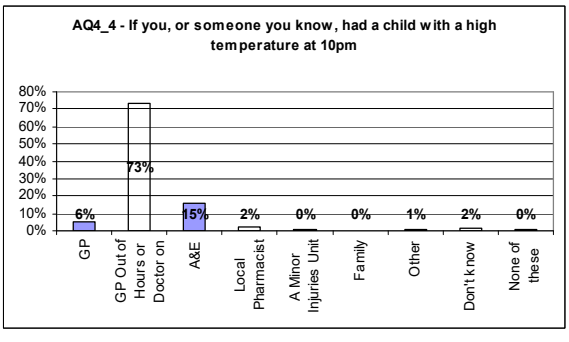


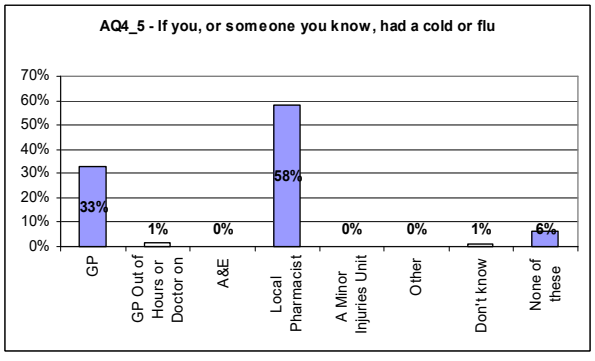
4. Which one of these services would you be most likely to go to in the following circumstances?

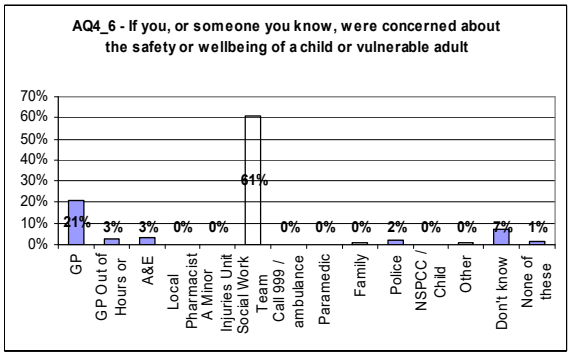




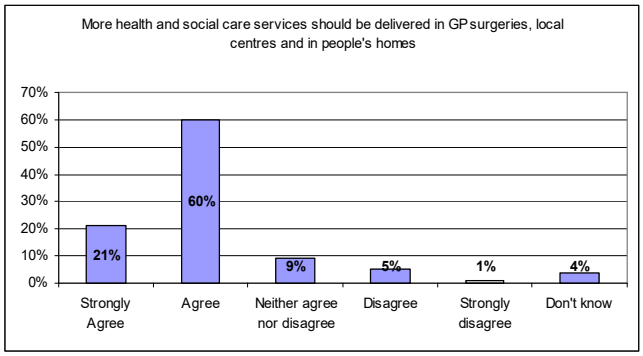


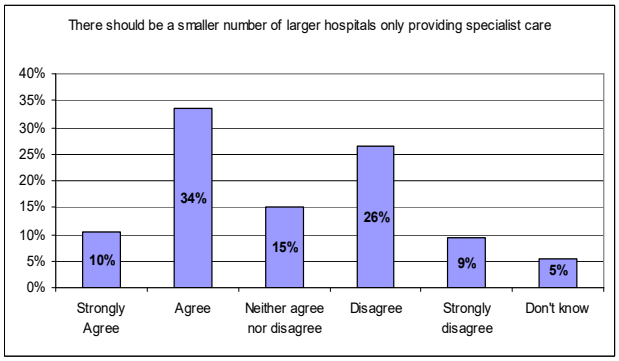


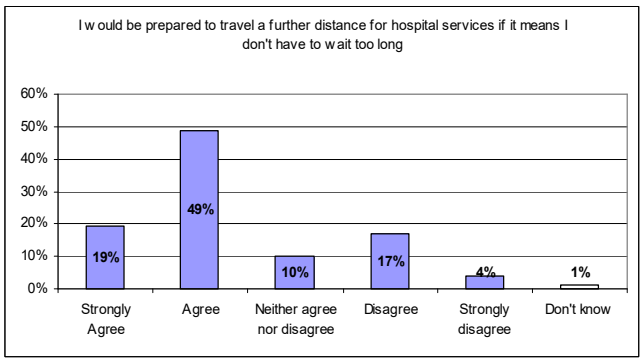


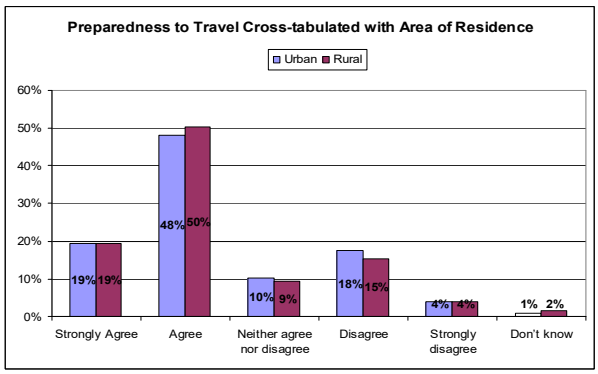


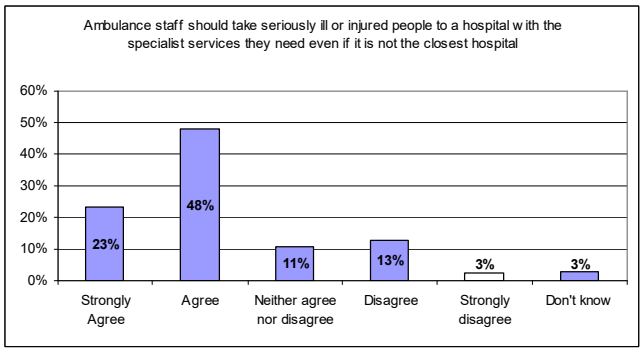
5. To what extent do you agree or disagree with the following statements?

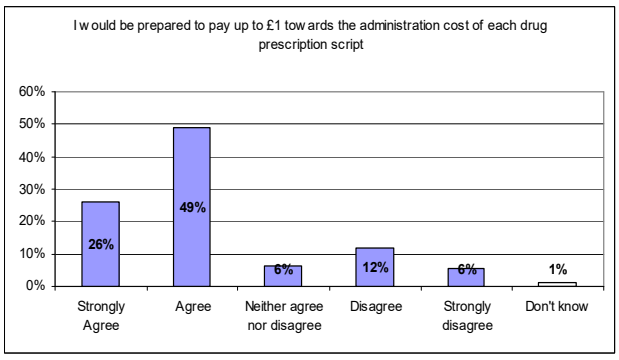




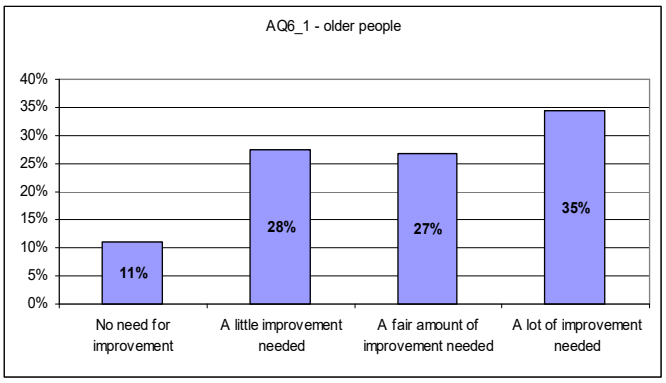


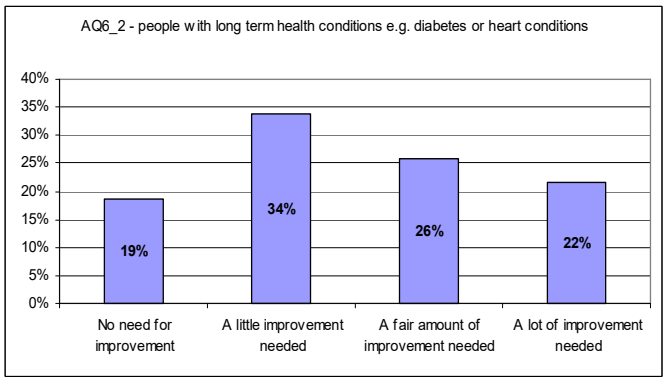


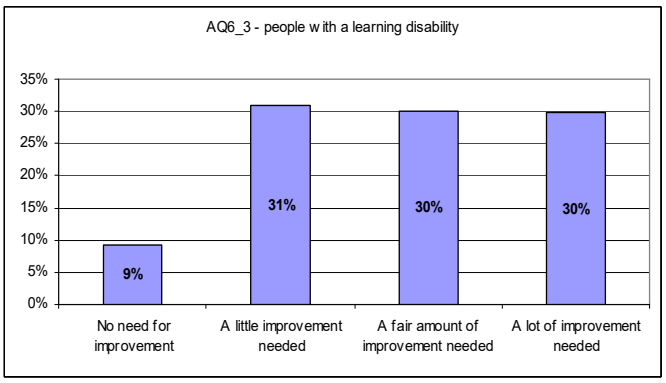


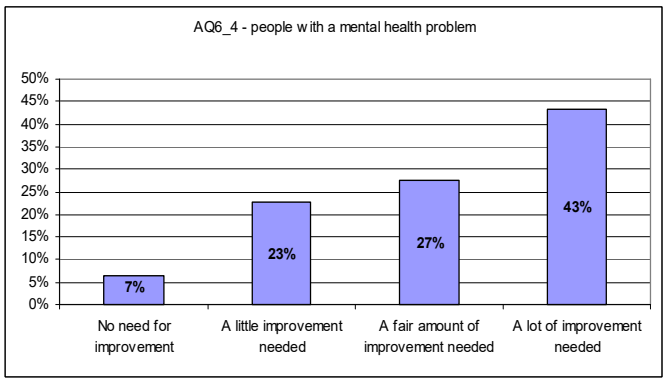


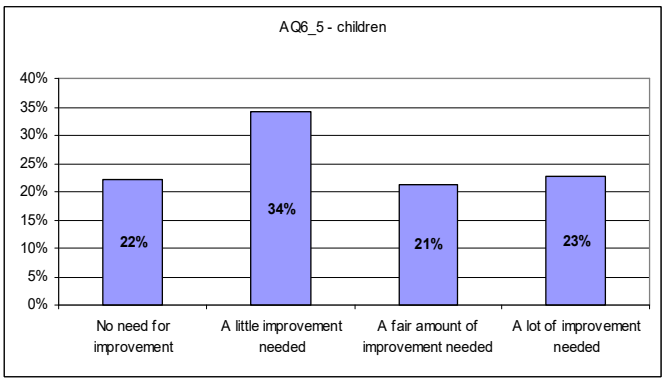
6. How would you rate the health and social care services provided for these groups in terms of whether they require improvement or not? Health and Social Care Services for:

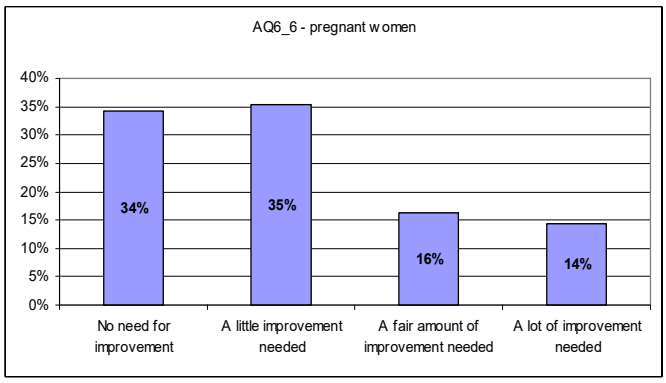




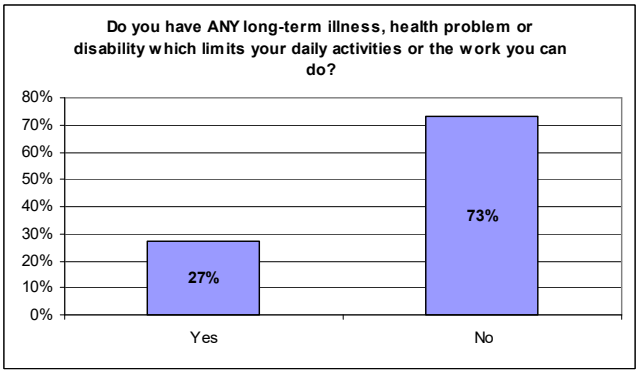


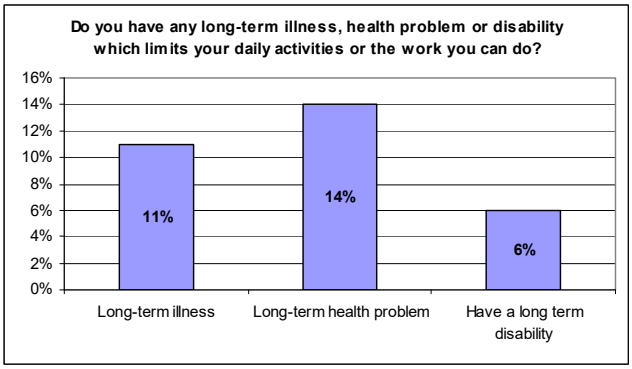




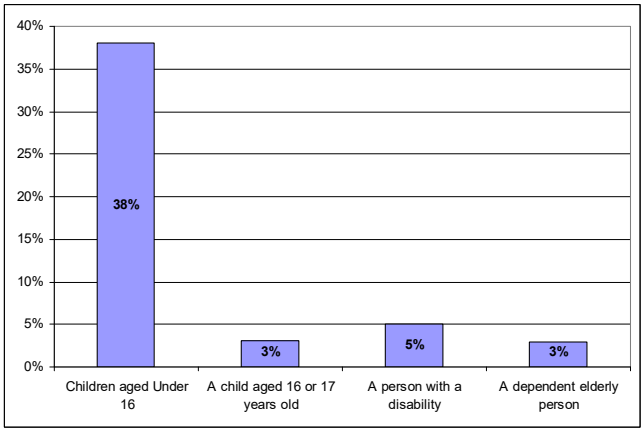


10. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

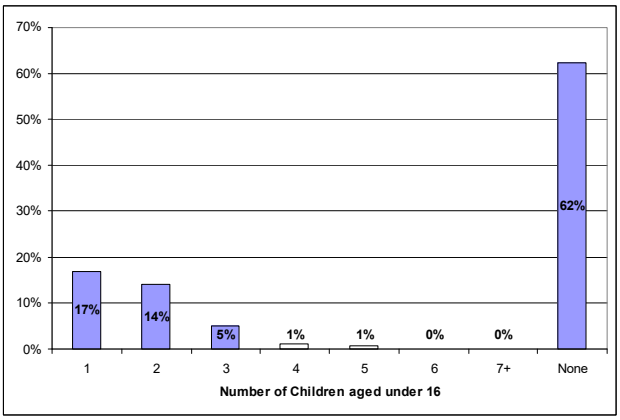




11. How many Children aged under 16 are there in your household, and do you have personal responsibility for the care of any of the following:



How many children aged under 16 are there in your household?



If you could do one thing to make health and social care services better what would it be?

Theme	No of responses	% of Total
More staff / no cutbacks on staff	126	11%
Don't know	120	11%
More money / spend money more wisely	81	7%
Shorter waiting times for GP / hospital appointments	77	7%
Reducing waiting times (general)	77	7%
Other	64	6%
Nothing	62	6%
Cut back on managers	41	4%
Keep services local / accessible	37	3%
Shorter waiting times at A&Es	34	3%
Better care for the elderly	29	3%
Improved care	24	2%
Cut down on bureaucracy / admin	23	2%
GP/doctor more accessible	23	2%
Better communication with patients / more information	22	2%
Better qualified staff / improve training	21	2%
Better mental health provision	17	2%
More flexible / longer opening hours for GPs	16	1%
More / better equipment / services	15	1%
Improve pay for nurses/doctors	14	1%
Improve A&E services	14	1%
Improve efficiency	14	1%
Keep hospitals open / more hospitals	13	1%
Bring back matrons	13	1%
Improve communication between GPs and other departments	11	1%
Cleanliness of facilities	11	1%
Making people more aware of services	10	1%
More services for children	10	1%
Keep A&Es open 24/7	9	1%
Longer opening hours for hospitals	8	1%
More beds in hospitals	7	1%
Access to specialists	7	1%
Penalties for missed appointments	6	1%
More community care / voluntary services	6	1%
Avoiding further cuts	6	1%
Consult with the public	5	0%
Fee for prescriptions / money wasted on prescriptions	5	0%
Open A&E at Lagan Valley	5	0%
More coverage in rural areas	4	0%
Improve follow-up care	4	0%
The way HSCNI is run	4	0%
Consistency of care	3	0%

Improve ambulance services	3	0%
Improving services for people with disabilities	3	0%
More time spent with patients	3	0%
More call outs	2	0%
Access to medical records	2	0%
Better working conditions	1	0%
Best practice in other countries	1	0%

Appendix 4
Questions Raised at Public Meetings

Questions Raised at Public Meetings

Tuesday 8th November 2011 at 7pm
Great Hall, Magee Campus, University of Ulster

- Mental health services have always been the "Cinderella" and are currently ten years behind UK funding levels. Will the Review Panel bring this to the notice of the Minister?

- How can the Review Team ensure relevant follow-up after care for services which take place elsewhere and are not sustainable in NI e.g. follow up for transgender people who have had surgery in other parts of the UK?

- The necessity for provision of respite care to go someway to alleviate massive carer stress and in order to allow carers to continue looking after loved ones in the community.

- How can you ensure quality of care with continual use of locum/agency staff when so many qualified practitioners/service providers are desperately seeking employment?

- Does the Panel feel that it may be time for a shift to a more social, rather than medical model of care, due to the ageing population?

- What consideration will the Health and Social Care Board be giving to building working relationships with the Health Service Executive in the Republic of Ireland in order to secure efficiencies in Service Delivery?

- Does the Panel have a view on the impact of the poor infrastructure in NI (i.e. lack of adequate rail link) on health care provision for people in the North West?

- How should the Department commission services for uncommon/rare conditions?

- Is there any recognition that we have just come out of 'conflict' and that health (especially mental health) is affected?

- Regarding mental health services, are there any plans to shift some of the budget to address the "Cinderella" service?

- Why do mental health patients go through A&E – why not have a mental health emergency room?

- How can commissioners support research to gauge the effectiveness of community interventions, which often do the most to promote inclusion but struggle to attract secure resources?

Wednesday 9th November 2011 at 7pm
Omagh Enterprise Centre, Omagh

- Why are there going to be hospital cut backs – particularly when new ones are being built but there is no money to run them?

- There is a growing emphasis on children's rights at the expense of the wishes and consent of parents. What protection will there be for the rights of parents?

- In the light of funding being withdrawn from the A5 (Derry – Aughnacloy Rd), can the Review Team use its influence to transfer the funding to the Omagh – Enniskillen (Hospital) Rd?

- Transport services to and from hospital is very poor. Older people refuse to go into hospital as they have no service to bring them home once discharged. Are there any plans to address this?

- What will the Review do to address Mental Health services as funding at present is inadequate?

- What are your greatest frustrations as a GP in a rural area (Dr. Gallagher) and what anxieties have you for our services over the next 5 years?

- The Review Team suggested a further shift of care from secondary into primary/ community care. How are planning to address the issue that primary care is already absorbing the bulk of care and there is no slack to be taken up?

- Why do we need a Board, and why do we need Trusts which have been allowed to become too powerful?

- Hospitals are not placed in the correct areas or take into account hospital across the border.

- How are hospitals going to be run? For example, the Erne has had its services cut back from what was promised.

- Communication is inefficient everywhere in the system. How does the Review plan to address this?

- Why are we not looking to innovation to reduce costs?

- Why don't the Patient and Client Council get a report from every patient after they visit a hospital?

- Can we have a nurse led midwifery stand alone unit at Enniskillen hospital?

- The Review should be carried out for the right reasons and not for an easy option. For example, safeguarding services to put another service in danger.

- Can the Review look at equity of service provision? For example, maternity services.

- Will the Review be based on an identified needs approach?

- Can we have assurances that our Health Service will remain public and free?

- Will all new initiatives be equality checked?

- Can we have assurances that the UK Health and Social care Bill will not be introduced?

- Will the Review look at statistics from the Trust Delivery Plans?

- How does the Review plan to reduce hospital bed waiting times at A&E?

Monday 14th November 2011 at 7pm
Ballymena Showgrounds, Ballymena

- There is a lack of good transport links for rural areas. How can equality be achieved for the socially poor who are left with no access to acute hospitals?

- How can HSC and society do more to protect the most vulnerable people e.g. victims of domestic violence, young and old?

- Has the Review looked at oral surgery services in primary and secondary care?

- Have there been any pilots set up to trial the emerging themes?

- How do you tackle resistance from consultants who use waiting lists to fund private practice?

- In the Northern Trust, the number of attendances and review attendances has dropped while there has been a massive increase in inpatients and daycases. We want to know what services are being given to us rather than taken away.

- The recommendations from the Comprehensive Spending Review were found to be untrue. How will you ensure this will not happen again?

- Has the Review Team engaged with community pharmacy and will it give a commitment to do so?

- With the planned closure of 100 pharmacies across the Province, how will this fit with the proposed move to primary care? What additional roles will community pharmacy have to take on?

- Will the Mid Ulster hospital receive the build and services it requires as stated in Developing Better Services?

- Are acute hospitals in the correct location to best serve patient need?

- Does the Review Team belie that a Rapid Response Vehicle is sufficient to fill the gap left by the closure of acute services in the Mid Ulster Hospital?
- Is it inevitable that fund shortages equal longer waiting times?

- What improvements can be made to case waiting times and welfare reports in relation to child abuse and acrimonious parental separation?

- Will the Review recommend making social workers give evidence under oath?

- Are there any plans to change the Dalriada Doctor on Call services within the Northern Trust i.e. move them to hospital sites?

Tuesday 15th November 2011 at 7pm
Assembly Buildings Conference Centre, Belfast

- What provision is in place in the Ulster Hospital, should it have to close, due to a super bug outbreak?

- What is the status of the McKinsey Report on/within the Review?

- Does the Panel see an expanded role for Multiple Sclerosis carers and would they be prepared to allocate some funding or shift in resources?

- The mandate is growth of domiciliary care. Is there any development in the funding?

- Do you feel that day care within the HSC Trusts is too cheap at £1.35 per day? Private day care is priced at £8 per hour.

- Out of 100 young people with severe learning disabilities leaving school each year in Northern Ireland, 20% with more complex needs have no choice but to attend a day centre – where is their choice for lifelong learning?

- Do the Panel feel that the cutting of jobs from Learning Disability services and not replacing day care workers is correct?

- Does the Review Team plan to address the short fall in Mental Health, as it is already underfunded by 44%?

- As an adult who has been diagnosed with a personality disorder, where is the promised help that the Bamford Report said was coming?

- During the Review is any thought given to the fact that we have 30% less cars here than the UK mainland and a transport system that stops at 9pm?

- What is the point in having a centre of excellence if it is located in an area unattainable to the public?

- What principles is the Review Team considering for the number of hospitals in Belfast and the services they provide? Will their funding be cut?

- What will be the acute status of all Belfast hospitals after the Review?

- Is the right to a second opinion still available?

- When one is a patient, can they be provided with a card that shows relevant standards for the service/treatment at issue? Patients don't generally know what they can expect.

- Pharmacy is not mentioned in the Review. Has the Panel considered the benefits and quality outcomes that could be achieved in Primary Care by fully engaging with Community Pharmacy?

- As the Minister has indicated he wants to close 100 Pharmacies, how will that impact on Community Pharmacy's ability to play its part in Primary Care?

- The Minister is on record of saying that there are 100 too many Pharmacies in NI. Has any consideration been given by this Review Team on the impact to the public if this was enacted?

- Why has Community Pharmacy not been covered by the Review?

- As Community Pharmacy is an integral part of the Primary Care team, has the Review Team any plans to engage with their representatives to obtain their view?

- Will the Review Team follow the Health Minister's stated intention of privatising social care services?

- You discussed ‘evidence’ of health inequalities in our society. Do you have plans as to how to address these in lower socio-economic groups with shorter life expectancy? What does that mean in relation to services?

- Does the panel believe in the principles of the NHS i.e. free at the point of need for all?

- What criteria is the there for the quality of care for the elderly in nursing homes where business people are requesting staff to cut incontinence pads?

- There is often mentioned ‘interdepartmental working/interagency working’. Describe what that would look like if it were being done successfully across all government departments. What needs to change to make it happen?

- How innovative is this Review going to be e.g. in other parts of the UK there have been introductions for playgrounds for over 60s. Will this Review be as far ranging and looking at a whole systems approach to tackling health and social care?

- When you say the workforce needs to be ‘less professionally driven’ and be shaped more towards services, what do you mean?

- What are the plans to ensure that OT services should be developed as a core element of Child and Adolescent Mental Health provision as recommended by Bamford in 2006?

- Has the Review recognised the need to resource an already stretched frontline service with the means to treat individuals ‘in the right place, at the right time and by the right people’?

Thursday 17th November 2011 at 7pm
Lagan View Enterprise Centre, Lisburn

- Who cares for the carers with health?

- How is the Downe A&E organised overnight? Is this a model that could be adopted for Lisburn?

- If the City hospital is going to become a specialist centre for chronic conditions within Belfast, could Lagan Valley become a specialist centre in the South Eastern Trust area in the same way?

- Do the panel agree that transparency is key to any planned changes and what is being done to ensure this takes place?

- What are the likely outcomes of the Review for (a) patients/users and (b) health care professionals?

- What preventative measures can be taken to reduce the obesogenic nature of our environment?

- Providing screening and enhanced services in community pharmacy can reduce NHS costs through early detection and treatment. This can remove pressure from our secondary care sector. Does the Review agree?

- Will the Review take account of the work of voluntary sector organisations and the value for money that these organisations provide?

- The N.I Assembly budget ensured that there would be no cut to Learning Disability budget. Can you confirm that this review completely safeguards this?

- Can the Review Team ensure that the recommendations made in the Bamford Review will be implemented?

- With nursing posts not being replaced and sick leave and maternity leave not being covered – how can we ensure delivery of patient-centred care?

- Why are hospitals still run on a Monday to Friday basis with skeleton staff working at weekends?

- In other parts of the UK (e.g. Scotland), community pharmacy plays a much greater role in the provision of both core and enhanced pharmaceutical services. Does the Review envisage this as the way forward in N.I?

- There is clear evidence that O.T. led reablement services deliver positive outcomes. Can the Review Team ensure that such services will be available to all service users in N.I?

- What is the potential for 24hr cover again in Lagan Valley A&E? Can local GPs help to ‘man’ the department?

- How is the RVH coping with the extra patients from LVH and BCH?

- With an annual intake of 135 medical students in QUB, where have all the doctors gone?

- Is it possible to use GP trainee doctors to staff local A&E departments as part of their training?

- There must be concern at the much lower resource spend on children in NI than elsewhere in the UK. Can the Review identify ways to increase the priority of services for children?

- How will the system deliver a more caring service to cancer patients who are terminally ill and at home? Will you work collaboratively with other depts. e.g. DSD for better housing conditions?

- What interventions can be made to ensure much needed improvements in the delivery of home care packages?

- Does the Lagan Valley hospital have a future?

Wednesday 23rd November 2011 at 7pm
St Patrick's Trian, Armagh

- How many more reports do we need? What are you going to do differently?

- The Department of Education is planning a 0-5 Early Years' Strategy – will the Review seek to link in the Department of Health, Social Services and Public Safety's pregnancy-5years provision with the Department of Education strategy?

- Are LCGs fit for purpose and how much money has been used to date? Are we getting Value for Money?

- Is there an assurance that Allied Health Professions staff will still be valued as integral to the process of effective/safe discharge planning from the acute setting into community care, as the focus appears primarily to be on community sector?

- There is a lot of talk on radio of proposed Pharmacy closures – what is the timescale for these closures?

- Would the Panel consider it a missed opportunity that the role Community Pharmacy could play in bringing health to the community is not mentioned in the Review?

- Will the Review recommend extended roles for Community Pharmacy in managing patients in the community, services to prevent ill health, health promotion etc?

- What plans are in place for more supported living accommodation in Newry? It is badly needed within the next two years.

- Are there any plans in place to build more long-term accommodation in the Newry area?

- Carers are for many the backbone of the health and social care system. In return the system has promised to deliver support to carers when it is needed. This is supposed to be achieved by offering each qualifying carer a Carers Assessment. This requirement is one of the statutory functions of the HSC Trusts. However, many Trusts do not fulfil this requirement and many carers continue to carry out their caring role without adequate support. How will the Review ensure that Trusts will no longer be able to neglect this statutory duty and how will the Board guarantee widespread compliance with this duty?

- Should service users, carers and members of the public have more say in how health and social care budgets are spent, via the use of scrutiny committees or citizen juries to ensure the public have real and meaningful input to service provision? The welcome initiative of Patient and Personal Involvement was introduced without direct funding for the development of this strategy. Will the initiative fail if health and social care fails to properly fund its development across the sector?

- What is your opinion of the proposals which include 'older people' receiving funds to pay their carers? Will this not further confuse the elderly?

- The BBC carried an article on the huge predicted increase in elderly population and the demand this will place on domiciliary care and social services. What is the Panel's view on the impact this will have on acute services for hospital admissions?

- Following speculation in the press – do you plan to close Accident and Emergency and acute services in Daisy Hill Hospital?

- With less acute hospitals how will service users access treatment from rural areas with insufficient public transport?

- Where is the infrastructure that will support a reduced number of hospitals, which is widely rumoured to be the outcome of the Review? There is no use modelling ourselves on urban environments without appropriate support and access.

- What impact will this Review have on jobs within the HSC?

- In light of the recent publicity in the press, radio and TV, is there any point in this meeting as the Review has already been written?

- What would you do to encourage appropriate restructuring of resettlement teams to include Occupational Therapists with unique skills to assess and advise on support needs equipment and adaptations in line with a number of Bamford recommendations?

- Would the Panel agree that GPs should be left to treat their patients thus leaving the complex range of other care to Trusts and other staff?

- Do the Panel believe that the independent/private sector can run services better and/or cheaper than the Trusts currently do?

- The shift in community based care – is this not more idealistic than realistic? Are the people/relatives expected to do this because of economic resources?

- Can Mr Compton give an assurance that A&E and emergency surgical services will be maintained at Daisy Hill Hospital?

- Leaks about the downgrading of Daisy Hill Hospital have already affected staff morale – can you reassure us about the future of Daisy Hill Hospital and that the level of services will be maintained?

- Commenting on a leaked report of 29/06/2011, will the Review result in: 2000 jobs lost; £40 cut from locum doctors and doctors; £30million cut from Pharmacy budget; a recruitment freeze; and the number of acute hospitals cut by 50%?

Appendix 5
List of Attendees at Clinical Workshops & Areas Covered

Workshop 1: Unscheduled Care, Specialist Services (including Cancer), Elective Care
Wednesday 12th October 2011 at 4pm
Ballymena Showgrounds, Warden Street, Ballymena, BT43 7DR

Name	Organisation
Jennifer Welsh	BHSCT
Dr Patricia Donnelly	BHSCT
Dr Dermot Maguire	GP
Dr Garth Logan	GP
Dr Sloan Harper	HSCB
Beth Malloy	HSCB
Jeff Featherstone	HSCB
Louise McMahon	HSCB
Paul Leyden	NHSCT
Tom Morton	NHSCT
Margaret O'Hagan	NHSCT
Stephanie Greenwood	NHSCT
Dr Olivia Dornan	NHSCT
Joanne McKee	NHSCT
Sean Donaghy	NHSCT
Martin Sloan	NHSCT
Jackie Elliott	NHSCT
Brenda McConville	NHSCT
Denise Quinn	NHSCT
Valerie Jackson	NHSCT
Liam McIvor	NIAS
Dr David McManus	NIAS
Liz Henderson	NICAN
Eleanor Ross	PHA
Dr Miriam McCarthy	PHA
Paul Kavanagh	PHA
Kevin McMahon	PHA
Dr Janet Little	PHA
Chris Allam	SET
Joe Toner	SET
Sean McGovern	SET
Mark Armstrong	SET
Dr Tim Harding	SET
Stephen Hall	SHSCT
Dr John Simpson	SHSCT
Seamus O'Reilly	SHSCT
Robert Carlile	SHSCT
Gillian Rankin	SHSCT
Heather Trouton	SHSCT
Charlie McAllister	SHSCT
Dr Bassam Aljarad	SHSCT

Paula Clarke	SHSCT
Phillip Murphy	SHSCT
Robin Brown	SHSCT
Ron Thompson	WHSCT
Geraldine Hillick	WHSCT
Dr Padhraig Conneally	WHSCT
Dr Brendan Devlin	WHSCT
Dr Paul McSorley	WHSCT
Stephen Clanaghan	WHSCT
Dr Caroline Mason	WHSCT
Dr Fergal McNicholl	WHSCT
Gerard Daly	WHSCT
Michael Riley	
Gloria Mills	

Workshop 2: Long Term Conditions, Care for Older People, Physical Disability, End of Life Care
Thursday 13th October 2011 at 4pm
Lisburn Civic Centre, Lagan Valley Island, Lisburn, BT27 4LR

Name	Organisation
Dr Ken Lowry	BHSCT
Dr Alister Taggart	BHSCT
Dr John McCann	BHSCT
Denise Killough	BHSCT
Dr Bernie Corcoran	BHSCT
Una McAuley	BHSCT
Bernie Kelly	BHSCT
Dr Grainne Bonnar	GP
Dr Paul McGerrity	GP
Iain Deboys	HSCB
Dr Sloan Harper	HSCB
Margaret O'Brien	HSCB
Fiona Gilmour	NHSCT
Yvonne Duff	NHSCT
Wendy Longshawe	NHSCT
Ann Orr	NHSCT
Fergal Tracey	NHSCT
Patrick Graham	NHSCT
Wendy Magowan	NHSCT
Hazel Winning	NHSCT
Adele Kennedy	NHSCT
Sean Falls	NHSCT
Melanie Phillips	NHSCT
Brian Serplus	NHSCT
Debbie Gillespie,	NHSCT
Liz Knight	NHSCT
Liam McIvor	NIAS
Brid Farrell	PHA
Siobhan McIntyre	PHA
Dr Walter Boyd	SELCG
Charlotte McArdle	SET
Janice Colligan	SET
Sarah Browne	SET
Bridie McKeating	SET
Bria Mongan	SET
Ray Elder	SET
Dr Simon Coulter	SET
Paula Clarke	SHSCT
Angela McVeigh	SHSCT
Francis Rice	SHSCT
Pat McCaffrey	SHSCT

Miceal Crilly	SHSCT
Roisin Toner	SHSCT
Cynthia Cranston	SHSCT
Dr Angela Garvey	WHSCT
Mr John McGarvey	WHSCT
Mr Brendan McGrath	WHSCT
Mr Garry Hyde	WHSCT
Dr Joe McElroy	WHSCT
Alison Cook	

Workshop 3: Family and Child Care, Maternity and Child Health
Friday 14th October 2011 at 4pm
Malone House, Barnett Demesne, Belfast, BT9 5PB

Name	Organisation
Brian Barry	BHSCT
Ann Moffett	BHSCT
Liz Bannon	BHSCT
John Growcott	BHSCT
Lesley Walker	BHSCT
Clifford Mayes	BHSCT
Paul Jackson	BHSCT
Dr Brian Patterson	GP
Dr Reggie McAuley	GP
John Duffy	HSCB
Dr Ursula Brennan	HSCB
Louise McMahon	HSCB
Mary Maxwell	NHSCT
Brenda McConville	NHSCT
Dr Michael Ledwith	NHSCT
Ian Allen	NHSCT
Martin Sloan	NHSCT
Sean Donaghy	NHSCT
Grace Edge	NHSCT
Heather Reid	PHA
Denise Boulter	PHA
Deirdre Webb	PHA
Fiona Kennedy	PHA
Joanne McClean	PHA
David Glenn	SET
Marian Robertson	SET
Heather Crawford	SET
Jackie McGarvey	SET
Ian Sutherland	SET
Elaine Madden	SET
Zoe Boreland	SET
Marian Campbell	SET
Paul Morgan	SHSCT
Geraldine Maguire	SHSCT
Patricia McStay	SHSCT
Peadar White	SHSCT
Colm McCafferty	SHSCT
Julie McConville	SHSCT
Michael Hoy	SHSCT
Janet McConville	SHSCT

Appendix 6
List of Attendees at Sector Workshops

Review of Health & Social Care Services in Northern Ireland
Northern Ireland Council for Voluntary Action Workshop
Tuesday 1st November at 10am
NICVA, 61 Duncairn Gardens, Belfast, BT15 2GB

Name	Organisation
Claire Armstrong	Addiction NI
David Barnes	Royal National Institute for the Blind NI
Paula Beattie	Trauma Recovery Network
Bernadette Best	Action Mental Health Central Office
Patricia Boyd	Shankill Women's Centre
Myrna Brown	Northern Ireland ME Association
Pauline Brown	British Red Cross (NI) Belfast
Ann Cooney	Southern Area Hospice Services
Carmel Costello	Carers UK Belfast Central Branch - Newtownabbey
Judith Cross	Age NI
Chris Deconink	East Belfast Community Development Agency
Karen Diamond	NI Music Therapy Trust
Geraldine Fennell	Carers UK Belfast Central Branch – Newtownabbey
Helen Ferguson	Carers Northern Ireland
Pauline Ferguson	Positive Futures for People with A Learning Disability
Dolores Finnerty	Caring Breaks Limited
Kate Fleck	Arthritis Care Northern Ireland Regional Office
Nicola Gault	Compass Advocacy Network Limited
Nigel Hampton	Enable NI
Claire Anne Irvine	Stratagem (NI) Limited
Dympna Johnston	Greater Shankill Partnership
Neil Johnston	NI Chest Heart & Stroke
Tom McEneaney	Aware Defeat Depression Belfast Office
Joe McGrann	Bryson Charitable Group
Joseph McKane	Forum for Action on Substance Abuse – Belfast HQ
Linda McKendry	Compass Advocacy Network Limited
Esther McQuillan	Parkinson's UK
Brian Mullan	North Belfast Partnership
Iain Neill	MACS Supporting Young People
Mary O'Hagan	Community Development Health Network
Ronnie Orr	Public Health Agency
Caitlin Reid	TinyLife
Kirsty Richardson	Greenway Womens Centre
Eddie Rooney	Public Health Agency
Mark Shepherd	Stratagem (NI) Limited
Patricia Short	Open College Network Northern Ireland
Alicia Toal	Voice of Young People in Care Ltd HQ
Anne Townsend	CRUSE Bereavement Care NI
Clare Watson	MS Society NI
Heather Woods	Dundonald Family & Community Initiative
Trevor Wright	Extern

Review of Health and Social Care Services
Business Alliance Event
Thursday 3rd November 2011 at 3pm
Boardroom, Equality Commission, Equality House, 7-9 Shaftesbury Square, Belfast, BT2 7DP

Name	Organisation
Mr John Compton	Review HSCNI
Mr Mark Ennis	Review HSCNI
Mr Mark Gibson	BT
Mr Mark Hopkins	BT
Mr Alan Irwin	BT
Ms Anne McGregor	NICC
Mr Mark Regan	Kingsbridge Private Hospital
Mr Michael Caulfield	Connected Health
Mr Nevin Ringland	Praxis Care
Mr Roger McMillan	Carson McDowell
Ms Aoife Clarke	CBI NI
Mr Bob Barber	Centre for Competitiveness

Northern Ireland Social Care Council
Registrant Engagement Event
Tuesday 8th November at 2pm
The Pavilion, Stormont, Upper Newtownards Road, Belfast, BT4 3TA

Name	Organisation
Norma Blair	Ardmonagh Family & Community Group
Avery Bowser	Centre for Effective Services
Margaret Burke	BHSCT
Clare Burke	Care Circle
Veronica Callaghan	NHSCT
Lynne Calvert	BHSCT
Janet Carter Anand	Queen's University Belfast
Martin Creed	BHSCT
Julie Cunningham	Community Nurse
Patrick Curry	NHSCT
Sharron Cushley	Salvation Army
Martin Doran	Care Circle
Rosemary Edgar	
Lorraine Gibson	NHSCT
Nuala Gorman	SHSCT
Alan Hanna	Autism Initiatives NI
Michaela Herron	Salvation Army
Linda Hook	Salvation Army
Marita Magennis	SHSCT
Fiona McCartan	Youth Justice Agency
Valerie McConnell	HSCB
Siobhan McCormac	Ardmonagh Family & Community Group
Margaret McCrudden	Newington Day Centre
Gillian McGalliard	NHSCT
Ann McGlone	Willbank Community Resource Centre
Zara McIlmoyle	NHSCT
Mary McIntosh	SHSCT
Joyce McKee	HSCB
William McKnight	BHSCT
Kerry McTeague	NHSCT
Margaret Monaghan	BELB
Seaneen Pettigrew	NHSCT
Gail Saunders	Homecare Independent Living
Joan Scott	SEHSCT
Paula Smyth	Leonard Cheshire Disability
Janene Swain	Rodgers Community Care

Northern Ireland Social Care Council
Registrant Engagement Event
Thursday 10th November at 10.30am
MDEC Building, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB

Name	Organisation
Linda Beckett	Glen Caring Services
Fiona Devlin	NHSCT
Jean Doherty	WHSCT
Marian Doherty	WHSCT
Kitty Downey	Slievemore House
Sheena Funston	WHSCT
Vanessa Hegarty	WHSCT
Louise Horner	Leonard Cheshire Disability
Jonny Hoy	Simon Community NI
Moia Irvine	WHSCT
John Jackson	Slievemore House
Geraldine Jones	Limavady Community Development Initiative
Robin Kennedy	WHSCT
Bryan Leonard	Leonard Cheshire Disability
Elizabeth Logan	Partnership Care West
Martina McGuinness	Extra Care
Paul McLaughlin	WHSCT
Pat McMenamin	WHSCT
Dolores Moran	WHSCT
Rhonda Murphy	Action for Children
Sinead Murphy	Leonard Cheshire Disability
Stephen O'Connor	Seymour Gardens Residential Home
Michelle O'Neill	Praxis Care
Lorraine O'Kane	Slievemore House
Liam Quigley	Northern Ireland Association for Mental Health
Carol Scoltock	WHSCT
Paul Sweeney	Extern
Teresa Sweidan	WHSCT
Anne Weir	Probation Board for Northern Ireland

Appendix 7
List of Stakeholders Engaged with at Small Group Meetings

List of Stakeholders Engaged with at Small Group Meetings

Age NI
Alliance Party
Assistant Director of Allied Health Professions and Public Involvement, Public Health Agency (PHA)
Assistant Director of Human Resources, Business Services Organisation (BSO)
Assistant Director of ICT, Health and Social Care Board (HSCB)
Assistant Director of Integrated Care, Head of General Medical Services, HSCB
Assistant Director of Social Care and Children, Mental Health, HSCB
Assistant National Director for Disabilities, Health Service Executive (HSE), Republic of Ireland
Assistant National Director for Mental Health Services, HSE, Republic of Ireland
Assistant National Director for Older Persons, HSE, Republic of Ireland
Assistant National Director for Primary Care, HSE, Republic of Ireland
Bamford Monitoring Group
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
Business Services Organisation
Department of Health, Social Services and Public Safety (DHSSPS)
Chair & Chief Executive, Patient and Client Council
Chairman, HSCB
Chartered Society of Physiotherapists
Chief Dental Officer, DHSSPS
Chief Economist, Health Policy, The King's Fund
Chief Executive, BSO
Chief Executive, PHA
Chief Legal Adviser, BSO
Chief Medical Officer, DHSSPS
Chief Nursing Officer, DHSSPS
Chief Pharmaceutical Officer, DHSSPS
Chief Social Services Officer, DHSSPS
Chief Officers 3rd Sector
College of Occupational Therapists
Community Pharmacy Northern Ireland
Communications Manager, HSCB
Democratic Unionist Party
DHSSPS Partnership Forum
Bishop of Down and Connor, Diocese of Down and Connor
Director General, Department of Health and Children, Republic of Ireland
Director General, Department of Health, Social Services and Children, NHS Wales
Director of Cabinet Operations, Scottish Government
Director of Commissioning, HSCB
Director of Finance, HSCB
Director of Human Resources, DHSSPS

Director of Integrated Care, HSCB
Director of Nursing and Allied Health Professionals, PHA
Director of Performance Management and Service Improvement, HSCB
Director of Planning and Redevelopment Services, BHSCT
Director of Social Care and Children, HSCB
Disability Social Care Forum
Equality Commission for Northern Ireland
Equality Manger, Business Services Organisation
Four Seasons Health Care
Head of Corporate Services, HSCB
Head of Information and Analysis Directorate, DHSSPS
Health and Social Care Board Members
Health Service Executive, Republic of Ireland
Independent Health and Care Providers
Junior Ministers, Office of the First Minister and Deputy First Minister
Law Centre – Rights in Community Care Group
Medical Adviser, HSCB
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Association for Mental Health
Northern Ireland Confederation for Health and Social Services
Northern Ireland General Practitioners Committee
Northern Ireland Human Rights Commission
Northern Ireland Social Care Council
Northern Ireland Practice and Education Council for Nursing and Midwifery
Northern Ireland Public Sector Alliance
Northern Ireland Medical and Dental Training Agency
Open University
Pharmaceutical Society of Northern Ireland
Professor the Lord Darzi of Denham PC
Programme Director, European Centre for Connected Health, PHA
Regional Director of Operations, HSE, Republic of Ireland
Regulation and Quality Improvement Authority
Royal College of General Practitioners
Royal College of Midwifery
Royal College of Nursing
Senior Adviser, Special Delivery Unit, Department of Health and Children, Republic of Ireland
Sinn Fein
Social Democratic and Labour Party
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Trust Chief Executive Forum
Trust Directors of Social Work
Ulster Unionist Party
UNITE
Western Health and Social Care Trust

Appendix 8
List of Written Submissions

List of Written Submissions

Age NI
Aisling Centre
Alliance for Choice
Alzheimer's Society
Association of the British Pharmaceutical Industry
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
British Red Cross
Business Services Organisation
CBI Northern Ireland
Centre for Effective Services
Centric Health
College of Occupational Therapists
Consultant Paediatric Surgeons, Royal Belfast Hospital for Sick Children, (BHSCT)
Co-operation and Working Together
Craigavon Lipreading Class
Cyclist Touring Club Right to Ride Network
Diabetes UK
Domestic Care
Dr Julian Kennedy
Fermanagh District Council
General Practitioners in Fermanagh (collective response)
Global Diagnostics Ireland and Ennis General Hospital
Health and Social Care Board
Independent Health and Care Providers
Intelesens Limited
Lisburn City Council
Macmillan Cancer Support
Mater Hospital Community Forum
Mencap
Mr Ian Houston
Mrs Valerie Rosenberg
National Confidential Enquiry into Patient Outcome and Death
Neurological Conditions Service User and Carer Reference Group
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Confederation for Health and Social Services
Northern Ireland Hospice
Northern Ireland Practice and Education Council for Nursing and Midwifery
Omagh Hospital Campaign Group
Pharmaceutical Society for Northern Ireland Professional Forum
Princess Royal Trust for Carers
Professor AP Passmore, Professor of Ageing and Geriatric Medicine, Queen's University Belfast
Regulation and Quality Improvement Authority
Royal College of Nursing

Royal College of Psychiatrists
Save the Mid Campaign
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Sustrans
TF3 Consortium
Trust Chief Executives Forum
United Kingdom Homecare Association
Volunteer Now
Western Health and Social Care Trust

Appendix 9
Glossary

Glossary

A&E – Accident and Emergency

CAMHS – Child and Adolescent Mental Health Services

DETI – Department of Enterprise, Trade and Investment

DHSSPS – Department of Health, Social Services and Public Safety

ECR – Electronic Care Record

GP – General Practitioner

GPSI – General Practitioner with Specialist Interest

HSC – Health and Social Care

HSCB – Health and Social Care Board

LTCs – Long-term conditions

MLA – Member of the Legislative Assembly

MRI – Magnetic Resonance Imaging

NHS – National Health Service

NIAS – Northern Ireland Ambulance Service

NICE – National Institute for Health and Clinical Excellence

NISAT – Northern Ireland Single Assessment Tool

PCC – Patient and Client Council

PCI – Percutaneous Coronary Intervention

PHA – Public Health Agency

QOF – Quality and Outcomes Framework

RQIA – Regulation and Quality Improvement Authority

HSC Health and Social Care

NCAT Section / Characteristic	Generic issue	Action/s to address	Action Product	Action owner	Action End date	Status update	RAG rating	Evidence when completed	Cross-reference to Urology SAI recommendation/s
Section 1: The Multidisciplinary Team									
1.1.1 / 1.1.3	All relevant specialities are represented in the team, cross cover for some specialities	Audits of attendance at MDM should be more regular (?quarterly) rather than review at annual business meeting - this will also assure on quoracy and allow for issues to be addressed earlier	Audit of MDT Attendance on regular basis	MDT Administrator / Projects Officer & MDT Leads	Will be on-going quarterly	Dr Tariq has written to all MDT Leads to ensure that attendance is being accurately recorded at MDT meetings. Audits of attendance to take place on a monthly basis starting from Feb 2022. Quorarcy to be shared with MDT Leads and Cancer Management Team		Monthly report of all MDT attendances available from Feb 2022 and circulated to the MDT Leads and Cancer Management Team for review and further escalation as required	Recommendation 1
1.2.1	Dedicated time in job plans for preparation & attendance at MDT	Ensure job plans of all MDT members has dedicated time included to prepare and attend the MDT meeting	Review of MDT Job plans	Dr Tariq / C.Quin	Dec-21	Dr Tariq has written to the surgical & medical directors to clarify that MDT time is included in the job plans of all MDT members. Attendance at the MDT meeting has been confirmed for all tumour sites. Preparation time is not included and falls under the time allocated for general patient admin time. C.Quin has checked with all CNS's - they all attend MDTs as required though not all have formal job plans. C.Quin to link with J.Davenport to confirm oncology input to the local MDTs.		Confirmation received per speciality that all core MDT members have dedicated time to prepare and attend MDT. Awaiting confirmation by BT in relation to oncology input to local MDTs.	Recommendation 1; Recommendation 4
1.2.6	Extended members / non-members attend for cases relevant to them	To be agreed by the MDT and detailed in the MDT operational policy	MDT Operational Policy	MDT Leads / SIL / MDT Administrator	30th Jan 2022	Discuss with MDT Leads and include agreed process in each MDT operational policy. MDT Administrator / SIL to ensure this is documented in the Operational policies.		Detailed in MDT Operational Policies. Reference 1.6 Principle Doc re. quality indicator required to audit/monitor.	Recommendation 1
1.3.5	MDT Leader has a broader remit not confined to MDT meetings	Develop role description of the MDT Lead and ensure adequate time is alocated in their job plan	Job description for MDT Lead role	Dr Tariq; Stephen Wallace	Jan-22	Dr Tariq has liaised with Stephen Wallace in relation to MDT Lead role description. A draft has been circulated to all MDT Leads for review / comment.		MDT Lead role description agreed and signed off	Recommendation 7
1.4.1	Each member has clearly defined roles / responsibilities in the team which they have signed up and included in their job plans	Define and detail the roles and responsibilities of all members involved in the MDM meetings	Review of MDT operational policies to ensure all MDT members roles are clearly defined; Review of MDT job plans	MDT Leads; MDT Administrator & Projects Officer; Medical & Surgical Speciality;AMD	Mar-22	MDT Administrator & SIL to review all MDT Operational policies with MDT Lead to ensure roles and responsibilities are included. To date LGI, UGI policies have been reviewed / updated.		Clearly detailed in each MDT Operational policy.	Recommendation 1
1.5.2	Networking opportunities to share learning & experiences with other MDTs locally	Provide opportunity for MDTs to meet locally, at least once per year, to share learning and experiences	Set up an Annual networking meeting for all MDTs	Dr Tariq; CD for Cancer; AD for Cancer services	Mar-22	Dr Tariq to contact MDTs Leads for feedback on the format and content of an annual networking event and to seek a date early 2022		An annual networking event is arranged if agreed by MDT Leads	Recommendation 6
Section 2: Infrastructure for meetings	**0**								
3.2.5	Locally agreed minimum dataset of information about patients for discussion collated and summarised prior to meeting (pathology, radiology, clinical, co-morbidities, psychosocial & spec palliative care needs	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	MDT proforma for Urology MDT agreed and will be rolled out from 4 Jan 22. Proformas for Lung, UGI and LGI to be considered next.		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.2.6	Members know what info from locally agreed minimum dataset of info they will be expected to present	To be detailed in the MDT Proforma	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT (Jan 22)		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.3.1/3.3.2	It is clear who wants to discuss a patient & why being discussed / a locally agreed dataset of information is presented on each patient including diagnostic information	To develop MDT Proforma per tumour site with locally agreed minimum dataset, clear reason for discussion and sign off from the presenting clinician	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 5
3.3.5	Core data items are collected during meetings and datasets completed in real time	Review and agreement of which data fields should be completed during MDT discussion and by whom, this should be detailed in MDT Principles/Protocol	Audit process agreed to review and monitor	MDT Leads; MDT Administrator / Projects Officer & MDT Co-ordinators; OSL	Mar-22	To start review with Breast & Gynae MDTs as they have more experienced trackers		Completion of core data fields during MDT meeting & process implemented to check compliance (ref 2.1 Principle doc)	Recommendation 5
3.4.1	Processes in place to ensure patients info needs are assessed and met; to ensure actions agreed are implemented;	CNS to use the Cancer Information Recording form to record the information provided by the clinical team to the patient and file in the patient notes. Holistic needs assessment offered to all newly diagnosed patients and a care plan developed to address concerns raised. All patients offered a written record of their management plan with diagnosis and contact details before they leave clinic.	Audits to check completion of Cancer information recording form & permanent record of consultation. Roll out of electronic health needs assessment by CNS's across all tumour sites.	HOS Cancer, Lead Nurse for Cancer and MDT Administrator / Projects Officer	Feb-22	Audits to take place when MDT Administrator is in post		Roll out of audits to check compliance	Recommendation 2
3.4.2	ensure MDT is notified of significant changes made to recommended treatment/care-plan	Any variation from recommended treatment/careplan should be documented at a MDT meeting. Develop an SOP with a clear pathway on whose role it is to capture , record and document and how this will be done per MDT for any patients that have declined further treatment.	Develop SOP; Include in MDT Principle's document (ref 2.6); agree audit process to check compliance	MDT Leads; MDT Administrator & Project Officer	Mar-22	Principles document developed and agreed. SOP to be developed and audit process to be agreed (ref 2.6 Principles Doc)		Roll out of audits to check compliance	Recommendation 5
Section 4: Patient Centred Clinical Decision-making									

4.1.1	Local mechanisms to identify all patients where discussion at MDT is needed	Define and detail what failsafe mechanisms are in place to ensure that there is a safety net to identify all patients who require MDT discussion	Failsafe mechanism agreed with Pathology	Pathology Clinical Lead; MDT Administrator & Project Officer	Mar-22	A report has been developed by Cellular Pathology & Lab service in Belfast and is currently being reviewed and tested.		Process in place to run a report to enable a cross-check across all the MDTs	Recommendation 5
4.1.3	Local agreement about if/when patients with advanced/recurrent disease should be discussed	MDT site specific agreement if/when patients with advanced or recurrent disease are listed for discussion and this is detailed in operational policy. Audit process to monitor this to be detailed in MDT Principles doc and rolled out.	To be guided by what is agreed and funded regionally. MDT Principles Doc details audit process to be caried out.	MDT Leads; OSL; HOS Cancer; MDT Administrator & Projects Officer	Mar-22	Regional discussion required to agree enhanced tracking definitions and funding secured to implement . Reference 2.6 MDT Principles Doc in relation to audit mechanism		To be guided by what is agreed and funded regionally. Audit process agreed and rolled out.	Recommendation 4
4.2.3	Named individual at MDT has responsibility for identifying a key worker for the patient	To be detailed in MDT Principles doc and audit process required; additional field to be added to CAPPs to idenitfy key worker	MDT Principles document; CAPPs	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles doc agreed, audit process to be set up once the additional field is added to CAPPs		Audit process agreed and implemented across all MDTs	Recommendation 5 & Recommendation 2
4.2.4	Named individual at MDT ensures patients information needs are assessed and addressed	To be detailed in MDT Principles doc and key worker identifed on CAPPs	MDT Principles document - audit of compliance to be agreed	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles document agreed. Meetings ongoing with CNS's to ensure that patient info needs are assessed and documented appropriately.		Audit proces in place to monitor compliance (ref. 2.8 Principles Doc)	Recommendation 2
4.3.1	A locally agreed minimum dataset of info is provided at the MDT meeting	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Leads; MDT Administrator & Project Officer	Mar-22	Proforma for Urology MDT developed and agreed, this will be used from 4 Jan 2022. Next tumour sites for consideration are Lung, LGI and UGI.		Audit process agreed and implemented across all MDTs	Recommendation 1; Recommendation 5; Recommendation 8
4.3.3	MDTs have access to all current clinical trials, consider patients suitability, relevant research nurses attends MDT where feasible	Ensure that all MDTs have access to clinical trials and recruitment is considered as appropriate	MDT Principles document (ref 2.11)	MDT Leads,Clinical research nurses; Peter Sharpe; Irene Knox;	Ongoing	When Principles doc is agreed by MDT Leads, process will be agreed to ensure that MDTs are aware of clinical trials and consider patients suitability		Audit process agreed and implemented across all MDTs	Recommendation 1;
4.3.12	MDTs collect social demographic data (age, ethnicity & gender) & consider data periodically to reflect on equality of access to active treatments	To review systems to identify how this information can be collected and agree a clear process on how this info is captured, whose role it is to do this and when this will be considered by the MDTs	Data collection	OSL/ MDT Administrator & Project Officer / SIL	Feb-22	MDT Administrator to raise at next regional CAPPS meeting. Meeting held with NICR and info request to be submitted in Spring 2022.		Data is collected and reviewed by MDT Leads	Recommendation 6
Section 5: Team Governance									
5.1.1	Organisational support demonstrated via adequate funding/resources in terms of people, time, equipment for MDT meetings to operate effectively	Review of MDT Leads job plans, clear process in place to escalate any issues that may impact negatively on the effectiveness of the MDT meeting, new MDT room suitable equipped for meetings	MDT job plans; MDT room for meetings; process in place to escalate issues of concern, monthly Cancer checkpoint meetings, attendance at MDT AGMs	Cancer Services Management Team	Jan-22	MDT Leads job plans all reviewed; room allocated for MDT meetings; MDT Administrator post; regular meetings set up to escalate issues / concerns		MDT job plans reviewed and adequate time allocated; new MDT room operational for MDMs; clear process in place to escalate concerns; monthly checkpoint meetings; Cancer management attendance at MDT AGMs	Recommendation 9
5.1.2	Trusts consider their MDTs annual assessments and act on issues of concern	Cancer Services team attend MDT annual meetings and process in place to enable escalation of MDT areas of concern	Clear process in place and communicated to all MDT Leads to escalate issues of concern; Representation from Cancer Management Team at MDT annual business meetings	Cancer Services Management Team	Feb-22	Escalation Process agreed and circulated to all MDT Leads; Schedule of MDT business meetings to be agreed at start of each year and communicated to management team to ensure		MDT annual meetings to be agreed for 2022 and Cancer services management representation agreed for all meetings; escalation of other issues of concern as per agreed	Recommendation 3
5.2.1	Data collection resource is available to the MDT	Identify what data support is required by MDTs and explore funding sources with Trust SMT and commisioners	Data resource allocated	AD / HOS Cancer / OSL /	Feb-21	The MDT Administrator took up post on 04/01 and additional data support will be considered		Adequate data support is available to all the MDTs	Recommendation 6
5.2.2	Key info that directly affects treatment decisions is collected by MDT (staging, performance status, co-morbidity)	To ensure this info is captured in the MDT Proforma	Sytems review / MDT Proforma	MDT Administrator / Projects Officer; OSL; MDT Leads	Feb-22	This has started with the Urology MDT and will be rolled out across all of the MDTs in a phased approach		Key info is collected and considered by the MDT in relation to treatment options	Recommendation 5
5.2.3	Mandated national datasets are populated prior to or during MDT meetings or shortly afterwards	Detailed in MDT Principles doc and clear process detailed on what info is collected and by whom	MDT Principles document	MDT Co-ordinator / OSL / MDT Administrator	30th Nov	Draft presented to MDT Leads at Cancer checkpoint meeting and to the Urology Task & Finish Group meeting. Document is now finalised. Audit process to be implemented.		Monitoring process is undertaken as defined in the MDT Principles Doc (ref 2.1) and results shared with MDTs	Recommendation 6
5.2.4	Data collected during MDT meetings (including social demographic data) is analysed and fed back to MDT to support learning	Agree what data is collected, who will collect & analyse it and when this will be shared with the MDTs for consideration	Data collection process agreed per MDT	MDT Leads; MDT Co-ordinator; OSL; SIL	Mar-22	Liaise with HSCB to get a regional steer on social demographic collected. Meeting held with NICR and info request to be submitted in Spring 2022.		Data collected is analysed and fed back to the MDT for review and learning	Recommendation 6
5.2.5	MDT takes part in internal and external audits of processes & outcomes, reviews audit data and takes action to change practice where necessary	MDTs to identify and agree their audits at the annual business meeting including whi will lead and what support is required	Completion and and log of audits per MDT	MDT Leads / Dr Tariq / AD / Clinical audit team	Mar-22	Dr Tariq to write to MDT Leads to seek input on completion and review of future audits and the process for this to be discussed and agreed. Additional audit resource to be secured from the Clinical Audit Team		MDTs to take part in audits, both internal and external, and takes action as appropriate. All audits are logged.	Recommendation 6
5.2.7	Patient experience surveys include questions relevant to MDT working and action is taken to implement improvements in response to pt feedback	Local patient experience surveys per MDT should be rolled out at least once every two years.	Patient experience surveys	CNS's / SIL / MDT Leads	Mar-22	Scope what patient experience surveys have been undertaken and identify any gaps across MDT teams		All MDTs undertake patient experience surveys and action plans developed in response to findings	Recommendation 6
5.3.1	Data collection resource is available to the MDT	Identify what data is required for the MDTs and by whom and how often	Data resource calculated	OSL / MDT Administrator / HOS Cancer / MDT Leads	Feb-21	This will be considered further once the MDT Administrator has had to time to settle into the post		Data support is available to all MDTs	Recommendation 6

5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice	Re-establish the Cancer Service User Group and agree the process for involvement in MDT policy and practice	Establishment of Cancer Service User Group	HOS Cancer; SIL ; Macmillan HWB Manager	Feb-22	Terms of reference developed; recruitment process underway; Group is re-established. Further discussion required to agree process for MDT involvement.		Trust cancer service user group is involved in the development of MDT policy and practice	Recommendation 6
5.3.5	Mechanisms in place to record MDT recommendation v actual treatment given and alert MDT if these are not adopted and reason for this; ensure MDT is alerted to serious treatment complications and adverse/unexpected events/death in treatment	To be detailed in MDT Principles document including quality indicator to audit; additional resource to support this needs to be identifed and secured.	MDT Principles Document; Additional resource secured	AD; DMD; OSL; MDT Administrator & Projects Officer	Mar-22	Principles document is agreed. BT audit process to be reviewed and implemented intially for the Urology MDT to test and ascertain resource required.		Mechanisms and audit process are in place	Recommendation 8
5.3.6	Strategies in place to monitor: proportion of pts discussed without sufficient information to make recommendations & proportion of patients offered and/or receiving information recommended by MDT	Agree how this data is collected & analysed for MDTs, by whom and when this will be shared with the MDTs for consideration	Data collection & analysis - AUDITS	MDT Leads; MDT Administrator & Project Officer;	Jan-22	To be agreed with MDT Leads once MDT Administrator & Projects Officer is settled into post		Agreed mechanism and audit process in place	Recommendation 1; Recommendation 2
5.3.7	MDT shares good practice & discusses local problem areas with MDTs in own trust/network	Provide opportunity for MDTs to meet locally to share learning and experiences (see 1.5.2)	MDT networking event	Cancer Services Management Team	Feb-22	Dr Tariq has contacted MDT Leads to seek feedback on whether an event is required or to agree other mechanisims to share learning		Agreed mechanism in place between MDTs to share learning	Recommendation 3
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and subject to audit	This is currently done on a one-to-one basis, a process needs to be developed and implemented	To develop an MDT Communications Protocol	MDT Administrator / MDT Leads /	Mar-22	Dr Tariq to liaise with MDT Leads to discuss process. M.Haughey and A.Muldrew to review BT communications protocol in relation to communication back to local MDTs and advise accordingly.		Agreed process and audit in place	Recommendation 6
5.3.10	MDTs reflect annually on equality issues	Data to be agreed and collected for MDT annual reports for review & reflection by the MDT members	Data collection	MDT Leads / MDT Administrator & Projects Officer	Mar-22	Data and process for collection to be agreed when MDT Administrator & Projects Officer is settled into post. M.Haughey to check with NICR.		Process agreed to collect data which are reviewed by MDTs	Recommendation 1; Recommendation 6
Additional areas	Overall governance of MDT and decisions arising from MDTs	Review of JDs for ADs, CDs and AMDs – both for cancer and specialties.	Process set up to review JDs	AMD / Medical Directorate / Specialities	Mar-22	This is ongoing via the Medical Directorate		Clear governance structure and process in place	Recommendation 6; Recommendation 7

RAG Rated Scale for Actions	
	Action not progressed
	Process in progress
	Process complete and action implemented

Terms of Reference- Agreed by Group 11 October 2021

Trust's Task and Finish Group into Urology SAI Recommendations

Terms of Reference of Task and Finish Group

The Task and Finish group is charged with implementing all the recommendations and providing assurance/evidence to the Urology Oversight Group

Membership of Task and Finish Group

Consultant	Nurse	Manager/Admin
Philip Murphy, Deputy Med Director Shahid Tariq, Deputy Med Director Mark Haynes – Deputy Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, Gen Surgery Kevin McElvanna General Surgery Art OHagan Dermatology Geoff McCracken, Gynae Helen Mathers Breast Rory Convery Lung Christina Bradford;, Hematology Anthony Glackin,; Urology Marian Korda, ENT	Clair, Quin, Cancer Lead Tracey McGuigan, Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Service Improvement Lead Sharon Glenny, performance manager Jane Scott performance manager Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Sarah Ward, Head of Service Clinical Assurance

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-disciplinary teams to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Life span of Task and Finish Group

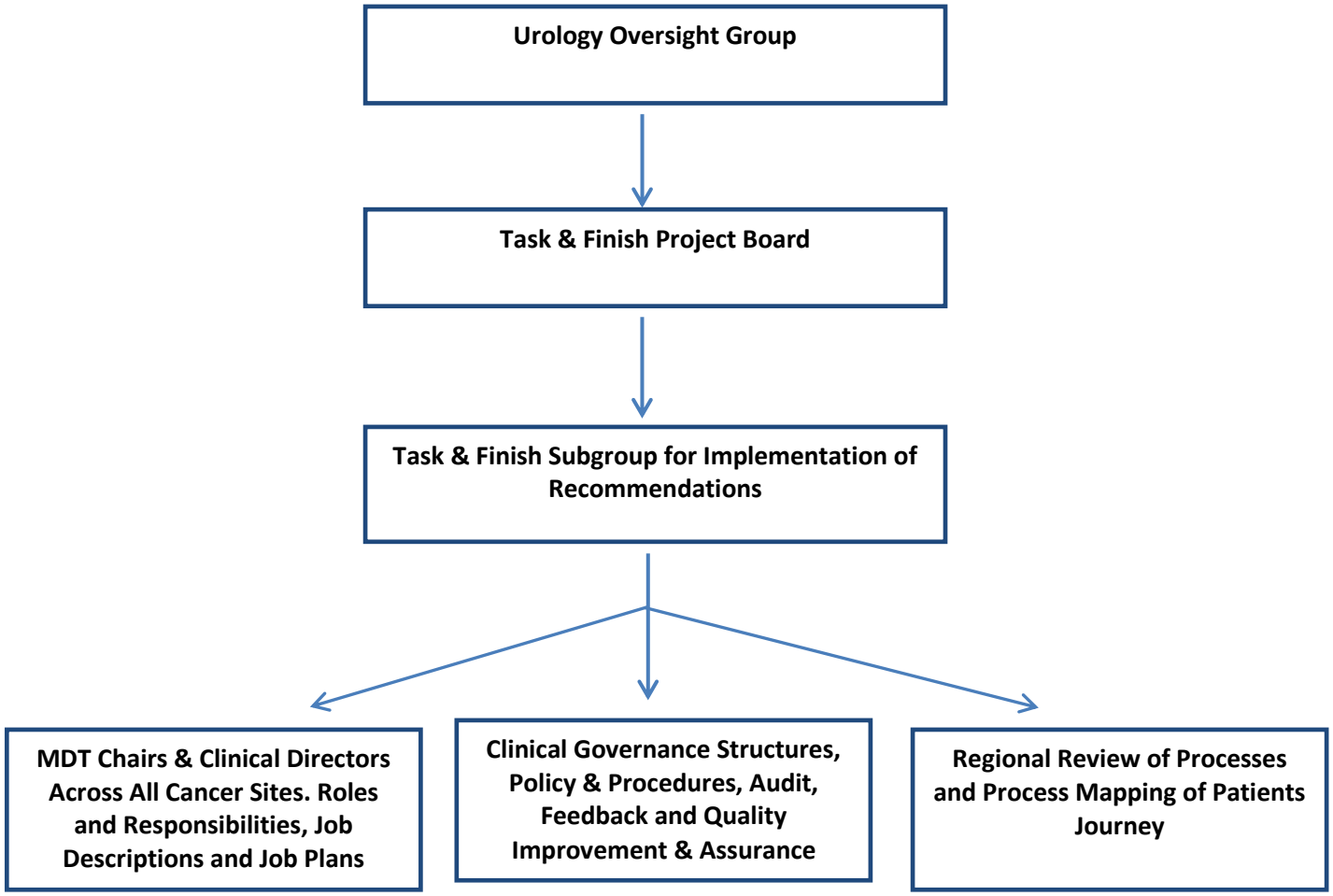
The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.

2. Task and Finish Group will report to the Urology Oversight Group Meeting and regular updates will be provided to the HSCB, DoH and families involved in the SAI's.

Governance and Accountability



Frequency of Meetings

Monthly

Southern Health and Social Care Trust

Notes and Actions
Task and Finish Group into Urology SAI Recommendations
Monday 13 September 2021 – Via Zoom

1. **Present:**
   Dr Shahid Tariq (Co-Chair)
   Ronan Carroll Assistant Director (Co-Chair)
   Barry Conway, Assistant Director
   Martina Corrigan, Assistant Director
   Anne McVey, Assistant Director
   Helen Walker, Assistant Director
   Mary Haughey, Cancer Manager
   Sharon Glenny, OSL
   Wendy Clarke, Head of Service
   Amie Nelson Head of Service
   Wendy Clayton, Head of Service
   Chris Wamsley, Head of Service
   Kay Carroll, Head of Service
   Clair, Quin, Head of Service
   Kevin McElvanna, Chair of Colorectal MDT
   Ted McNaboe Clinical Director
   David McCaul, Clinical Director
   Mark Haynes, Associate Medical Director
   Tracey McGuigan, Lead Nurse
   Sarah Ward Lead Nurse
   Leanne McCourt, Clinical Nurse Specialist
   Grace McCorry, Clinical Nurse Specialist
   Lisa Polland-O'Hare, Service User Officer

2. **Apologies:**
   Kate O'Neill' Clinical Nurse Specialist
   Janet Johnston, Family Liaison
   Jane Scott OSL
   Anthony Glackin, Urology MDT Chair
   Geoff McCracken, Gynae MDT Chair
   Helen Mathers Breast MDT Chair
   Stephen Wallace, Assistant Director
   Nicola Shannon, Clinical Nurse Specialist
   Christina Bradford, Haematology MDT Chair
   Marian Korda, Thyroid, MDT Chair
   Catherine English, Clinical Nurse Specialist

3. **Introductions and Background**
   The meeting was jointly chaired by Dr Tariq and Ronan and Dr Tariq welcomed everyone to the meeting.

   The membership of the group was discussed and it was agreed that over the course of the meetings that any staff that needed to be included should be invited.

4. **Terms of Reference for this group & Public Inquiry Terms of Reference**
   Dr Tariq shared the Terms of Reference of the Group along with the Terms of Reference for the Public Inquiry and requested that the group consider both of these and if there were any changes to advise before the T&F ToR were finalised.

5. **Tumour Groups Baseline assessments**
   Mary Haughey updated the group regarding the baseline assessments and advised that this is currently being collated and should be available soon for sharing.

6. **User Involvement Meeting Update**
   Ronan updated on the Service User Meeting held on 1 September with two service users – one a patient and one a daughter of a patient. These meetings will take place every four weeks and the service users would have all the updates from the recommendations shared and be able to comment and give their input into the work that the T&F group were planning to take forward.

7. **Recruitment of HoS Clinical Assurance**
   Ronan advised that this post would be going out in EOI shortly and that when appointed would be supporting the work of the T&F Group

8. **Next Meeting**
   It was agreed that the group would meet every 4 weeks on Monday's and this would be over lunchtime, via Zoom

   Action: Zoom link to be forwarded for recurring event and next meeting 11 October 2021 at 12:00md

Southern Health and Social Care Trust

Notes and Actions
Task and Finish Group into Urology SAI Recommendations
Monday 11th October – Via Zoom

1. **Present:**
   Dr Shahid Tariq (Co-Chair)
   Ronan Carroll Assistant Director (Co-Chair)
   Barry Conway, Assistant Director
   Martina Corrigan, Assistant Director
   Anne McVey, Assistant Director
   Mary Haughey, Cancer Manager
   Amie Nelson Head of Service
   Wendy Clayton, Head of Service
   Chris Wamsley, Head of Service
   Clair, Quin, Head of Service
   Kevin McElvanna, Chair of Colorectal MDT
   Anthony Glackin, Urology MDT Chair
   Philip Murphy, Divisional Medical Director
   Helen Mathers, MDT Chair
   Ted McNaboe Clinical Director
   Tracey McGuigan, Lead Nurse
   Sarah Ward Lead Nurse
   Leanne McCourt, Clinical Nurse Specialist
   Kate O'Neill' Clinical Nurse Specialist
   Matthew Kelly, Clinical Nurse Specialist

2. **Apologies:**
   Sharon Glenny, OSL
   Nicola Shannon, Clinical Nurse Specialist
   Christina Bradford, Haematology MDT Chair
   Wendy Clarke, Head of Service Midwifery and Gynaecology
   Rory Convery, Consultant Physician

3. **Introductions and Background**
   The meeting was jointly chaired by Dr Tariq and Ronan and Dr Tariq welcomed everyone to the meeting. Sarah Ward was welcomed as HOS for the enquiry and Ronan outlined that her role will be focused on overseeing and providing assurance on implementation of recommendations and look back exercise. Sarah will commence post as of 1st Nov and will be working closely with all members of the group to meet the timeframes outlined.

4. **Terms of Reference for this group & Public Inquiry Terms of Reference**
   Dr Tariq asked if there was any comments on the Terms of Reference of the Group along with the Terms of Reference for the Public Inquiry. There were no comments and group happy to accept the terms.

5. **Tumour Groups Baseline assessments**
   Mary Haughey updated the group regarding the baseline assessments and advised that this has been completed across all MDT incorporating all tumour sites. Mary advised she will now be completing 2 action plans, 1 for tumour specific and 1 overarching. Mary will be linking with Sarah when she is in post.

6. **User Involvement Meeting Update**
   Ronan updated on the Service User Meeting held last week with two service users – one a patient and one a daughter of a patient. This was the 2nd meeting with the user group. This meeting had been agreed to move to fall after the groups meeting to allow for further updates to the user group. Advised that the daughter of the patient has made it very clear that they do not want to participate in the public enquiry. The user group was updated on the meeting with the DLS and they have been issued via the Chief Executives Office, their first letter following the 1st meeting. These meetings will take place every four weeks and the service users would have all the updates from the recommendations shared and be able to comment and give their input into the work that the T&F group were planning to take forward.

7. **Recommendations**
   Martina shared the recommendations (11) and Ronan advised these are to be applied to all cancer sites. Advised that a request for approx. 77 pieces of information was received last week, with a 4 week timeframe for submission. These items will be directed to individual teams and involves providing evidence for eg minutes of meetings, job plans, concerns escalations etc. Martina advises that processes for all MDTS will be looked at, not just cancer.

8. **Public Enquiry**
   Has commenced. Christine Smith has expressed she is keen to meet with patients/ families firstly. We are to expect approx. April 2022 that we will be asked for individual statements and supporting evidence. We need to get prepped for this.

9. **Next Meeting**
   It was agreed that the group would meet every 4 weeks on Monday's and this would be over lunchtime, via Zoom. Sarah Ward when in post (1st Nov) will draft agenda, send link and record and circulate minutes for this meeting going forward.

   Action: Zoom link to be forwarded for recurring event and next meeting 8th November at 12:00

Southern Health and Social Care Trust

Notes and Actions
Task and Finish Group into Urology SAI Recommendations
Monday 8 November – Via Zoom

1. **Present:**
   Dr Shahid Tariq (Co-Chair)
   Ronan Carroll Assistant Director (Co-Chair)
   Barry Conway, Assistant Director
   Martina Corrigan, Assistant Director
   Mary Haughey, Cancer Service Improvement Lead
   Amie Nelson Head of Service
   Wendy Clayton, Head of Service
   Chris Wamsley, Head of Service
   Clair, Quin, Head of Service
   Sarah Ward, Head of Service
   Tracey McGuigan, Lead Nurse
   Paula McKay, Lead Nurse
   Leanne McCourt, Clinical Nurse Specialist Urology
   Matthew Kelly, Clinical Nurse Specialist
   Janet Johnston, Social Worker
   Fiona Sloan, Family Liaison Officer
   Catherine English, Head & Neck Cancer Nurse Specialist
   Jane Scott, Acting Operational Support Lead ATICS/SEC

2. **Apologies:**
   Sharon Glenny, OSL
   Nicola Shannon, Clinical Nurse Specialist
   Christina Bradford, Haematology MDT Chair
   Rory Convery, Consultant Physician
   Fiona Keegan, Colerectal Nurse
   Helen Mathers, Consultant Surgeon
   Lisa Polland-O'Hare, Service User Involvement
   Kate O'Neill, Clinical Nurse Specialist Urology
   Geoff McCracken, Obs & Gynae Consultant
   Wendy Clayton, Head of Service

3. **Introductions and review of Minutes from Last meeting**
   Dr Tariq welcomed everyone to the meeting and confirmed all in attendance had no comments or amendments on the previous minutes.

4. **Tumour Groups Baseline assessments**
   Mary Haughey provided update. All baseline assessments have been completed. MDT leads have all been met with and 2 draft action plans have been completed. First one is on the common themes throughout all MDT's and second is specific to cancer sites. A draft principals document has been completed which will be standardised for all MDT's. They have started to look at elements of this starting with a minimum date set for urology. Once this is standardised and agreed this will role out to all cancer sites. A demand and capacity analysis is ongoing also. Cross referencing of the recommendations will be completed to outline exactly where cancer team can input. NCAT tool wont address all the recommendations and for those it doesn't we need to establish how we implement for these.

   Dr Tariq advised that the NCAT tool focuses on the cancer MDT process. The recommendation's from the baseline assessments will outline various aspects including for eg how we can support them. Advised there is a generic Job Description for MDT chair being devised through the Medical Directors office. Once we are fully compliant with the NCAT tool we will have a large majority of the action plan completed. Emphasis on need for all tumour site leads to review the action log to ensure agreement.

   Barry Conway advises that going forward we need a clear outline of who owns what on the action plan and where responsibility lies. This is either Cancer or specific speciality

   Ronan Carroll advised that as members of the T&F group we are all held to account within this group to ensure all documents are read and implemented. There must be open dialogue and all to contribute.

5. **User Involvement Meeting Update**
   Ronan updated on the Service User Meeting held last month with two service users – one a patient and one a daughter of a patient. These are specifically for Urology SAI. Next meeting is next Thursday (18th) and will incorporate the update provided today. Trust has committed to 3 updates in writing and the next is due in Jan 2022.

6. **Recommendations**
   The 11 recommendations were read out. Dr Tariq wishes this to be a standard agenda item to ensure all remain focused on what is being asked of us.

7. **Next Meeting**
   It was agreed that the group would meet every 4 weeks on Monday's and this would be over lunchtime, via Zoom. Sarah Ward will draft agenda, send link and record and circulate minutes for this meeting going forward.

   Action: Zoom link to be forwarded for recurring event and next meeting 6th December at 1pm

Notes from SAI Recommendation Implementation Super Group Meeting
6 December @ 13:00 pm Via Zoom

Present:
Tariq, Shahid
Conway, Barry
Clayton, Wendy
Convery, Rory
Corrigan, Martina
Glackin, Anthony
Glenny, Sharon
Haughey, Mary
Haynes, Mark
Johnstone, Janet
Keegan, Fiona
Kelly, Matthew
Loughan, Patricia
Mathers, Helen
McCourt, Leanne
McCracken, Geoff
McElvanna, Kevin
McGuigan, Tracey
McNaboe, Ted
McVey, Anne
Nelson, Amie
ONeill, Kate
Polland-OHare, Lisa
Sloan, Fiona
Wamsley, Chris

Apologies
Carroll, Kay
Carroll, Ronan
Clarke, Wendy
Walker, Helen

Purpose of Meeting
Review and update of SAI implementation actions from MDT across all cancer sites. Whilst these originated from Urology the group will provide assurances that these are implemented to all.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.
- Dr Tariq welcomed everyone and noted the representation from specialities and thanked them for this. Noted that this is needed going forward as we cannot implement these recommendations without them.

Terms of Reference

- TOR have already been agreed for this group. MDT lead in Respiratory has asked for these to be shared with them for review. **Action:** Dr Tariq to circulate.

MDT Baseline Assessment

- Mary Haughey provided an update on this work. All assessments completed and action plan devised following this for each tumour site to complete. This was revised on 2.12.21 and circulated amongst leads.
- Mary advised new MDT Cooridnator is in place from 4.1.22 who will take forward actions, including quoracy at MDT and will devise audits.
- MDT proforma has been devised which will cover a minimum date set for MDT but also recognising specifics that need to be included unique to each tumour site.
- Theme identified that key worker allocation and patient information needs being assessed.
- Ongoing demand and capacity assessment
- Pathology lab process being updated to allow cross checking of all pathology results with MDT
- Draft principals document has been shared with MDT leads. This covers 3 key aspects and will allow us to assure ourselves that we are doing what is required. Barry advised we need strong endorsement from MDT chairs on this. Advised he asked chairs to review this document this week and provide comments. Advised that the CNS also needs to have oversight of the principals document.
- Kevin McIlvanna asked how principals document relates to the peer review process. Mary advised as peer review has been stood down during covid and potential of this being in a different format when it may be reinstated in 2023 the thoughts were that the principals documents covers all included in peer review, is more detailed and allows us to identify gaps early and can be seen as good practice to be doing this.

Action Plan Update

- Sarah shared the draft template and advised this is currently work in progress.
- Reinforced the need for collective support and buy in from MDT Chairs to input into the actions and feedback to group.
- Sarah detailed the service user involvement and scope to have them involved in patient feedback/ surveys
- Ted McNaboe asked how this internal “checks and balances” process links with the regional MDT processes. Mary advised that all MDT s are being subjected to this process and following discussions with the board, there is a need for regional MDTs to self assess as we are doing and address deficits.
- Tony Glackin advised that currently there are 3 MDTs they feed into regionally that do not have guidelines to follow, unclear lines of responsibility etc and this needs to be formalised in operational policies. Mary explained there is currently a draft communication policy in development.
- Tony also noted that in order to audit effectively there needs to be staffing resource and supportive training to do this. Recognising that audit can be generic but needs to reflect the specifics in each. Barry explained that there is

an expectation for a potential data manager to oversee the MDT coordinator role.

- Sharon Glenny advised there is 3 new trackers in post but they are to address the number of patients currently on an open pathway (currently 6500 down to 4500 with the work ongoing) would not be scope to assist in MDT audits at present. Suggests we need MDT coordinator in post then reassess and recruit.
- Dr Tariq advised he has shared the MDT Job Description with leads and asks all to review and provide comments.
- Patients will receive their next letter from chief Executive in Jan 2022 detailing progress on SAI recommendations.
- Barry explained this is the time we need the MDTs to be inputting, this is the opportunity to ask for what we need to implement recommendations.
- Geoff McCracken noted we really require infrastructure behind us to continue this process
- Lisa Polland O'Hare noted that with PPI being so involved at this stage this will only be of benefit to us in the future.
- Sarah provided update from service user group last month. Noting that one user in particular felt our progress was slow and I received some constructive feedback which enabled me to adapt the action plan to what you are seeing today. Advised that we have identified elements of the process that they can get involved in, predominately devising surveys and questionnaires. We hope our next meeting with them this Thursday will be a positive one and we hope they are feeling assured we are making progress.
- Helen Mathers asked Dr Tariq what was priority for the cancer MDT leads to be doing. Advised review of the principals document and the MDT role document was essential and feedback to him.
- Barry advised that all MDT leads need to look at the recommendations and advise in regards to their own MDT process.

Next Meeting Scheduled for 10th January at 1pm. Zoom link will be sent in advance

Notes from SAI Recommendation Implementation Super Group Meeting
7th February 2022 @ 13:00 pm Via Zoom

Present:
Tariq, Shahid
Conway, Barry
Clayton, Wendy
Corrigan, Martina
Glackin, Anthony
Glenny, Sharon
Haughey, Mary
Haynes, Mark
Johnstone, Janet
Keegan, Fiona
Kelly, Matthew
Loughan, Patricia
Mathers, Helen
McCracken, Geoff
McNaboe, Ted
McVey, Anne
Polland-OHare, Lisa
Sloan, Fiona
Wamsley, Chris

Apologies
Mr Epanomeritakis

Purpose of Meeting
Review and update of SAI implementation actions from MDT across all cancer sites. Whilst these originated from Urology the group will provide assurances that these are implemented to all.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.
- Ronan Carroll welcomed everyone and noted the representation from specialities and thanked them for this. Noted that this is needed going forward as we cannot implement these recommendations without them.

Terms of Reference
- TOR have already been agreed for this group. Reviewed and Ronan Carroll advised that this action plan needs to be owned & actioned by MDT Leads. Feedback at each T&F group should be provided by each Tumour MDT with regard to how compliant their MDT is against the core recommendations. ~~Requirement for each to feedback at each meeting rather than the managers.~~
-

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MDT Baseline Assessment/ Review of SAI Action Plan (action plan shared with group and attached to meeting agenda)

- GMcC advised he is concerned about this that the ownership lies with the chair. Feels this is responsibility of corporate/ governance and managers. Discussed that there is a clinical responsibility within recommendations and also some are very process related (RC) but the senior leaders across the MDT are responsible for overseeing and assuring that all processes are in order.
- Dr Tariq advised that there is an operational and clinical side of the process. Clinicians are to ensure the standards of care whilst all working together.
- Mr McNaboe advised that there is a requirement to ensure that all MDT processes are ~~as~~ robust ~~as the next~~. Same principals across all, consistent and any exceptions of care sits at a clinical level. We need all MDTS at a similar standard.
- Mary Haughey provided update on the key priorities ~~and we shared the document on the screen. Has been attached to the agenda for all to see.~~
- Sarah updated on the valuable input from service users group and the importance of ensuring a link to this group.
- Sarah asked was there any element of the SAI that ~~clinicans~~clinicians thought was not achievable. Mr Glackin advised that Rec 5 relating to triage deadlines was not achievable. Referrals come in 2 ways-electronic and written. There is delays in paper referrals. And the need to triage within 48 hours is not possible as it would require weekend work to achieve. Discussed the previous GPP and Trust agreement regarding referrals. RC advised that he Commissioner is expecting us to come with a list of requirements to meet the recs and Mr Haynes (MH)suggested we need to establish what we would need to meet the triage guideline for eg job plan time, contingency for weekends/ BH cover. This is an opportunity to ask for resources from the Board.
- MH advised that triage is generally done in OOH period and if that is busy, it ~~wont~~won't be ~~done~~completed. Suggestion to establish a timeline across sites for completion. England triage model involves trained clerical staff completing and Consultant is only required ad hoc. Starting point is when the referrer meets the criteria for information contained within the referral, this makes for an easy triage. This process resulted in better quality referrals. GMcC advised of concerns ~~with "getting fingers burnt"~~ when there is a 'push back' to GP regarding lack of info/ detail on referral which may delay and there is an issue with the patient. Agreed that the CCG system and triage system i~~s not up to standard for what it needs to be. We need a slick system.~~
- Dr Mathers explained variances across the Trust especially with downgrading of referrals. There is ~~+++~~ great pressure on Consultants to triage. Should be e-referral system rather than e-triage system with standardised criteria to be completed. Finds there ~~is +++~~are several complaints regarding downgrading of referrals. Mr Glackin advised that Urology tried e- referral years ago and it was ~~a non starter~~unsuccessful as GP's~~S~~ ~~wont~~won't buy in that they need to include more information/ input ~~from GPS for the~~ into the referral.
- GMcC advised that GP referrals need to be completed as close to the pts consultation when the pt is with the GP not at the end of the ~~clinic~~clinic~~prospective rather than retrospective. We need assurance that GPS are following referral guidelines~~. **Action**: Mr Glackin will share the information on the triage process they trailed in urology.
- MH advised we need a process for when a GP does not complete a form according to the guidelines. Mary advise~~d~~s that this was~~in~~ contained in the

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Principals Dd~~o~~cument ie what information a referral must contain but we would need to ~~ensure there is~~ a clear SOP ~~for this scenario~~to covering the action when a referral does not meet the ~~referral~~referral ~~criteria~~criteria. ~~Also~~

- ~~need to c~~Consideration also need to be given to ~~the~~ the process ~~if there is a governing locum~~governing locum consultant and what is our process if off sick etc.
- Sharon Glenny shared the process that BHSCT has in place for checking MDT discussions and the pathway ~~was~~ followed. ~~We are currently scoping feedback on F~~funding options to implement this are being scoped ~~into SHSCT.~~
- MH advised NI did not adopt the NG12 guideline. Individual GPs did not want to do but it was agreed regionally. GPs not being held to account for not doing. **Action**: needs raised with commissioner
- MH Has met with GP's~~S~~ previously and some do~~to~~ not have access to CCG. ~~Elements were agreed to be inputted into the free text box but there is no essential fields.~~ We need ~~to demonstrate~~system and ~~a p~~processes that makes it easier to refer and get patients seen quicker.
- Sarah advised that these discussions are exactly what is needed to collate into the action plan and issues/thoughts/suggestions need to be forwarded to her, Ronan/ Dr Tariq

Next Meeting Scheduled for 7th March 2022 at 1pm. Zoom link in calendar as rolling meeting and agenda/ previous meetings minutes will be circulated prior to meeting

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Notes from SAI Recommendation Implementation Super Group Meeting
7th March 2022 @ 13:00 pm Via Zoom

Present:
Tariq, Shahid
Conway, Barry
Corrigan, Martina
Haughey, Mary
Haynes, Mark
Mathers, Helen
Wamsley, Chris
Quinn, Clair
McGuigan, Tracey
McVey, Anne
Ward, Sarah
Bacon, Miriam
Sloan, Fiona
Muldrew, Angela

Apologies
Ronan Carroll
Geoff McCracken

Terms of Reference

- TOR were agreed at the last meeting, but will be regularly reinforced in order to oversee the implementation of the recommendations across all the cancer tumour sites.

Minutes of last meeting.

- The notes from the SAI recommendation implementation group meeting are to be recirculated and any factual inaccuracies to be fed back.
- Shahid Tariq requested the update from the action notes from the meeting on 07.02.2022. Mark Haynes advised that urology referrals were triaged by consultants within their job planned admin time. Mark Haynes also updated that the commissioners were aware of, but had not endorsed or actioned, the NG12 guidelines.

SAI action plan tasks to complete/recommendations

- Barry Conway asked for an update on reasonable timescales to complete the outstanding recommendations. Of the 11 recommendations three are completed and 8 are outstanding.

Recommendation one, split into four areas, needs some further work to bring this to a completed status.

- Data Map process for urology and upper GI pathways is awaiting feedback from MDT leads and realistically will not be achievable for another 3 months. MDT action plan elements are being collated for the individual plans, looking at feedback and themes and then the development of these action plans. Mary Haughey explained that the priority was currently to process the monthly attendance figures and business meetings for activity and data collection.

- QI project involving service users has been meeting and are very keen for a patient questionnaire to be devised and given to patients at diagnosis. This is in the early stages of a phased approached. The project team are keen that patients are given a full understanding of the journey and of what to expect at each stage. The group will meet again on Friday.

Recommendation two, six and eight, split into six areas.

- Standardisation of information recorded on the MDT proforma, this is being rolled out across sites.

  Mark Haynes raised the issue of duplication of data needing to be input on each form and that the form does not pull patient details across from ECR. This also represents a risk of incorrect transcription of patient details and a plausible resistance to repeated input of standard data, such as email addresses. Barry Conway and Mary Haughey to follow up on making the process sleeker and more user friendly.

  Mark Haynes also pointed out the imbalance between demand and capacity and the need to identify the gap and evidence this moving forward. Services were never set up for the growing demographic of patients being seen and treated for cancer and all services could experience an explosion of demand and recognition of this fact is important.

  Helen Mathers advised that the Breast MDT proforma was agreed and available online, but not widely used as it was not user friendly and concurred with Mark Haynes that the repetition of information was off putting and time consuming.

  A concern was also raised that if the form were not completed then the patient would not be seen in regional MDT and this was detrimental to patient care. Angela Muldrew to double check that if there is no profoma completed can a patient be seen in MDT.

  Mark Haynes also raised the issue of duplicating forms for patients who have been reviewed in an MDT meeting and requiring further investigations then

requiring another form to be completed. An MDT tracker being required to progress patients.

Mark Haynes, Helen Mathers and Barry Conway all agreed that clinical input was required to ensure the proformas were more user friendly. Mary Haughey and Angela Muldrew to build this into the SOP.

A set KPI for form completion was discussed.

- Securing advanced communication training is still at the scoping of funding and resources stage to enable this training to be delivered in-house.

- Breaking bad news clinics and coding is currently at the stage whereby how is this information being recorded, how is the activity being captured and what coding is being used.

- Standardization of recording of keyworker is awaiting regional signoff.

- KPI framework for CNS implementation is underway and a workshop has been arranged for the discussion and development of this at the end of March.

- Regional CNS workforce for cancer plan phase one used the 2018 data and is now entering phase two. 94 CNS roles have been identified across the region and a plan is in place regionally and dependant on funding.

  Mark Haynes raised the concern that historically the workforce training plan for CNS's came through working on the specialised inpatient wards and now these are no longer in existence what is the development plan for CNS nurses. Clair Quinn recognised this and the need for lead in time for training of approximately 2-3 years for a CNS, based on relevant courses and commissioning.

Recommendation four, seven and nine, split into four areas.

- MDT action plan elements
- Job description sign off for MDT leads
- Job plan sign off for MDT leads

Tariq Shahid reported that these three elements are in progress and he will report back at the next meeting and these should be at a point to be completed on the action plan by then.

- MDT auditor roles

Job description proforma required and pending recruitment process

Recommendation five

- Pathology report format and SOP for use

Draft report has not yet been received from Belfast and this will be requested by Angela Muldrew.

Recommendation nine

- Medical leadership, appraisal and revalidation, governance and private practice.

Presentation to medical teams with a few elements to tease out with an update at next meeting.

Tumour site leads to work closely to achieve with acute and corporate directorate level input to achieve.

Barry Conway concluded that several of the outstanding recommendations were at a point whereby these could be achievable by the end of March and some were more challenging requiring 2/3 months more work to achieve.

Date of next meeting: Monday 4th April 2022 @ 2pm
Zoom link in calendar as rolling meeting. Agenda and previous meeting notes will be circulated prior to meeting.

Notes from SAI Recommendation Implementation Super Group Meeting
4th April 2022 @ 13:00 pm Via Zoom

Present:
Ronan Carroll
Barry Conway
Sarah Ward
Tony Glackin
Marian Korda
Janet Johnston
Sharon Glenny
Helen Mathers
Ted McNaboe
Catherine English
Kevin McElvanna
Wendy Clayton
Anne McVey
Caroline Keown
Angela Muldrew
Martina Corrigan
Mark Haynes
Matthew Kelly

Apologies:
Dr Tariq
Clair Quinn

Minutes of last meeting.
These were agreed and signed off.

Ronan Carroll thanked everyone for attending and shared with the group that a short notice meeting had been called on Friday 1st April 2022 to discuss the issuing of Section 21 notices and the need to provide two positive and two negative findings from the SAI Recommendation Implementation Super Group.

The two negatives were:

- Lack of audit support for all MDT's
- Lack of support to patients on a cancer pathway, both allocation of a key worker and information

The two positives were:

- MDT baseline assessment tool for all tumour sites
- Additional trackers being appointed and Angela Muldrew's role

Ronan Carroll asked the group if they agreed with these negatives and positives. Tony Glackin agreed with the negatives and certainly the lack of audit team support and the challenge within teams and staffing to provide CNS's.

Anne McVey raised the issue of the time challenge to implement all the work required and Ronan Carroll advised that two auditors are being recruited to support the MDT teams.

Ted McNaboe queried whether the support of CNS's was being challenged. Sarah Ward explained the role of the Service User Framework and project which had highlighted a need for allocated key worker input and better information provision.

Wendy Clayton advised that they were struggling to get MDT reviews by CNS's due to sickness. This was not singled out to any service but across the tumour sites as a whole.

Outstanding SAI recommendations

Ronan Carroll reflected on the 11 recommendations and requested feedback from MDT leads to start moving these into green and that as a Task and Finishing group we need to assure MDT can deliver on what we have in place and have been tasked with.

Barry Conway gave a summary, highlighting attendance at MDT was required to provide quoracy.

A new pathologist is due to join the Trust – Dr Southall. A radiologist is returning early from a trip to Australia, who has expertise in urology. Palliative medicine has a new doctor, Jane McCauley, who will link in with MDT leads and review palliative job plans regarding support for MDT's.

Angela Muldrew is working on the SOP's for pathology.

Barry Conway pointed out that further support was required to move these processes forward and an administration request had been put forward to Dr O'Kane.

The new MDT meeting room would be functional from week commencing 11th April 2022.

Angela Muldrew updated on addition of the keyworker details on CaPPs is in progress. Kevin McElvanna queried the recording of this information and Angela advised that this was currently a YES, NO or NA function at present. This cannot be made mandatory due to the function and work was needed for all CNS's to be encouraged to complete and for reports to be run to ensure completion.

Kevin McElvanna raised the point of how feasible it is to record the keyworker details at the MDT as a patient may not have been allocated or aligned to a CNS at this point. Ronan Carroll advised this needs to be agreed regionally.

Janet Johnston raised the positive of how well the Trust has communicated with families and that the depth and knowledge of information provided was exceptional.

- **Recommendation one**

Data Map Process – Tony Glackin stated he did not know what this is.

MDT action plan – Tony Glackin advised that urology were 'up to speed'. Helen Mathers advised Breast were not aware of MDT action plan. Kevin McElvanna was also not aware of Colorectal plan. Caroline Keown will chase this with Geoff Kennedy. Anne McVey will chase this with Respiratory.

Wendy Clayton advised that Sarah Ward is attending the next ENT departmental meeting. Ted McNaboe advised that there were two MDT meetings locally and one MDT regionally.

Barry Conway advised that Mary Haughey meets with him weekly and it is needed that MDT Chairs keep the momentum going at each MDT.

- **Recommendation two**

The standardisation of information recorded on the MDT proforma has been rolled out and is currently 'live' in urology and gynaecology. The Lung team are working on a final issue.

KPI framework is in progress and Clair Quinn has a draft for regional sign off.

Job descriptions for Chairs are all at various stages of completion.

- **Recommendation five**

Pathology reports are being generated and received weekly. Barry Conway advised this is a cross check for patients to be brought to MDT. Kevin McElvanna questioned the overall pathology report and Angela Muldrew advised that all positive results for SHSCT patients were being received and currently this information was being looked at how we can make this more user friendly and the development of SOP's.

- **Recommendation nine**

This is with Stephen Haughey and Dr Scullion.

Ronan Carrol asked if there were anything we had not focused on to make patient care safer and ensure governance.

Matthew Kelly asked if there were a mechanism in place that MDT outcome is completed. It was advised that currently asking cancer trackers to check minutes of MDT to ensure actions are completed. Barry Conway advised regarding the Belfast job description for auditing MDT's and the additional resource identified and commencement in urology with support from Angela Muldrew. Sharon Glenny advised BHSCT employed MDT audit role of one week per month and focused retrospectively ensuring actions had taken place, treatment plans agreed and actioned. Matthew Kelly agreed that we need something prompt and felt the process of using cancer tracker is better and quicker. Ronan Carroll advised that a discussion with all MDT leads was needed to how best utilise the audit resources. Mark Haynes advised that prospective checks of tracking is of real benefit to patients. Sharon Glenny advised that we need to be mindful of escalation process when there are things we cannot do anything about, like capacity. Barry Conway advised of the previous escalation protocol and the need to look at capacity issues.

Sarah Ward and Mary McVey are to attend each tumour site group and review outstanding recommendations.

Ronan Carroll advised of the timelines for the Urology Service Inquiry. Anyone being served a Section 21 will have 6 weeks to complete the document. The families and patients are being interviewed, in private, in June 2022. With the full inquiry to begin in November 2022.

Of the eleven recommendations 3 were green with 3 others almost within target and these will be easy gains. If these can be achieved then 75% of the recommendations could be achieved by the date of the next meeting.

Date of next meeting: 4 weeks' time with updates from each MDT lead on action plan progress

Southern Health and Social Care Trust

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Patient Tracker/MDT Co-Ordinator
Band 4
Temporary - Full time (37.5 hours)

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JOB DESCRIPTION

JOB TITLE	Patient Tracker/MDT Co-Ordinator
BAND	4
DIRECTORATE	Acute Services – Cancer Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Cancer Services Co-ordinator
ACCOUNTABLE TO	Operational Support Lead

JOB SUMMARY

a) Proactively tracks the progress of suspected cancer patient along their pathway from point of referral to diagnosis and first treatment; this will include the co-ordination of reports, X-Rays/investigation results and clinic appointments to expedite the patients diagnosis and treatment
b) Responsible for the Co-ordination and organization of the Multidisciplinary Team (MDT) meetings and will attend meetings obtaining, recording relevant information facilitate the timely provision of care for patients
c) Liaise closely with all departments involved in providing timely care for patients. He/She will be required to work closely and proactively with the clinical teams and work collaboratively to ensure that planned patient treatment progresses smoothly and in a timely manner
d) Collect, record and report cancer information as required in order to meet national, regional and local reporting requirements

KEY DUTIES / RESPONSIBILITIES

PATIENT TRACKER:

1. Proactively track all patients with cancer or suspected cancer and take appropriate action to ensure a timely diagnosis and treatment for cancer patients, as required to achieve cancer access targets. This will include the pre-booking of some diagnostic tests and treatments.

2. To have ensure their knowledge of the wide range of procedures involved, in booking appointments enables patients to be effectively recorded onto PAS and as appropriate for pre booked for appointments.

3. To support the flow of information to and from Primary Care, including acknowledging receipt of suspected cancer referrals and responding to queries regarding appointment details.

4. Responsible for ensuring all patients with cancer or suspected cancer have pre booked appointments and treatment in line with the cancer access patient pathways.

5. To negotiate with clinical staff, waiting list staff and admin staff when clinic slots are insufficient in order to facilitate an appointment for patients at the earliest opportunity. To escalate this to the relevant Senior Officer/Manager if there is insufficient capacity to meet the agreed patient pathway standards.

6. To contact other sites across the Regional Network and to liaise with other patient tracker/MDT co-ordinators in order to identify available capacity.

7. Making decisions which require analysis as to the most appropriate appointment for a cancer patient whilst considering other patient needs and workload.

8. Provide information to the clinical teams and cancer services team in relation to the timely treatment of cancer patients.

9. To collect, maintain and input information to support databases for weekly performance reports relating to cancer patients including the tracking of patients and discussion at the MDT.

10. To monitor performance against agreed waiting time targets for diagnosis and treatment.

11. Provide accurate and timely data to the cancer management team.

12. Progress patients through their cancer journey, ensuring that all test/scans are ordered and the patients notes, results and reports are made readily available to the appropriate clinician in time for the next step of the pathway.

13. To communicate sensitively with patients & carers who have recently received a diagnosis of cancer.

14. Assist in meeting the regional cancer access targets.

15. Provide audit support to the MDT meetings relating to patient tracking.

16. Assist in the analysis and preparation of information for reports for monitoring waiting times, monthly/quarterly, for Trust Board and Cancer Management

Team.

17. Maintain timely and accurate data collection, maintaining cancer MDT database, taking corrective action when data is incomplete or inaccurate.

MDT CO-ORDINATOR:

1. Responsible for the co-ordination, organisation and management of the weekly MDT meetings Trust wide, ensuring all relevant people are notified, all required information, notes, reports, results and X-Rays are available.

2. Generate a list of relevant patient names for the meetings and distributing this to the MDT members prior to meeting.

3. Responsible for collection and preparation of patient notes.

4. To work with the members of the MDT to ensure that all patients diagnosed with a new primary cancer are discussed at a MDT meeting.

5. Attend weekly MDT meetings, complete detailed proforma or summary for each patient discussed, including ensuring the details are sent to the relevant GP within 24 hours of MDT.

6. Responsible for typing, distributing of minutes, noting action points and follow-up action following up to ensure actions are taken in a timely manner.

7. Maintain a record of treatment decisions made at multi-disciplinary team meetings and ensure that these decisions are recorded in patient notes.

8. Maintain an accurate record of attendance at MDT meetings ensuring all cancelled meetings are recorded with a cancellation reason.

9. Ensure all documentation is kept in such a manner that any cancer patient tracker is able to take on the work.

10. When required receive telephone calls, communication with patients and/or their relatives.

12. Ensure all referrals made from MDT are forwarded to relevant professional.

13. Responsible for requesting relevant x-ray images and charts for MDTs.

14. To assist and participate in MDM Peer Review process

RAISING CONCERNS - RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

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

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

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

June 2021

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND Patient Tracker/MDT Co-ordinator- Band 4

DEPARTMENT / DIRECTORATE Cancer Services, Acute Services

SALARY

HOURS Full time (37.5hours – Monday –Friday)

Ref No: June 2021

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
	You must be employee of the Southern Health & Social Care Trust within Acute Services.	Shortlisting by Application Form
Qualifications/ Experience	1. Level 4 qualification (on the Qualifications and Credit Framework, QCF), i.e. HNC or equivalent / higher qualification in a business/administrative related subject **AND** 1 years' experience in a clerical / administrative role **OR** 4 GCSEs at Grades A-C including	Shortlisting by Application Form

	English Language and Maths or equivalent / higher qualification AND 2 years' experience in a clerical / administrative role **OR** 3 years' experience in a clerical / administrative role 2. Experience in the use of Microsoft Office products including Word, Excel, Powerpoint	
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	1. Ability to work as part of a Team 2. Ability to use own initiative 3. Ability to identify problems and recommend appropriate solutions. 4. Effective Planning & Organisational skills with an ability to prioritise own workload 5. Effective Communications skills to meet the needs of the post in full. 6. Ability to maintain thoroughness and attention to detail at work 7. Flexible with regard to working arrangements with possibility of working cross-sites (CAH & DHH)	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	Experience in the use of hospital based systems, eg, Patient Administrative System (PAS), Cancer Access Patient Pathway System (CAPPS), etc	Shortlisting by Application Form

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

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

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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#bettertogether

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