Clayton, Wendy

From: Clayton, Wendy
Sent: 13 May 2022 12:56
To: McMullen, Joanne; Haynes, Mark; Haugh, Karen
Cc: Carroll, Ronan; Parks, Zoe
Subject: RE: Consultant Urologist CAH *URGENT**

Great Joanne, I was not aware this was added in.

I will email the 2 Spanish candidates now.

Regards

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

From: McMullen, Joanne <Personal Information redacted by the USI>
Sent: 13 May 2022 12:37
To: Clayton, Wendy <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Parks, Zoe <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Wendy

The permanent file is still currently live. However we have added the below paragraph to the JD and advert:

We would encourage all doctors who are interested in this post but who do not currently hold GMC registration to contact us. The Southern Trust will give consideration to alternative roles to support a transition process while you commence the process of verification and registration with the GMC. If this would interest you, then please contact Mrs. Joanne McMullen - Medical Recruitment – Personal Information redacted by the USI ***or email*** Personal Information redacted by the USI ***.***

Can you please make the 2 applicants aware of this?

Thanks

Joanne

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 12 May 2022 20:05
To: McMullen, Joanne <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Parks, Zoe <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Joanne – is there any movement on the advertisement of the Consultant Urologist – "advert detailing such a supported 'transition' post to support doctors while they get on the specialist register we may get a larger number of applicants and so a thought through personnel spec for this would be important."

We urgently need Consultant Urologist and are having no luck with Locums
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: Clayton, Wendy
Sent: 04 April 2022 08:07
To: McMullen, Joanne <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Great Joanne, chat soon

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: McMullen, Joanne <Personal Information redacted by the USI>
Sent: 03 April 2022 22:37
To: Clayton, Wendy <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Thanks Wendy

I have a meeting scheduled with our advertising agency to see if they have any suggestions / options of international journals to advertise.

I have also sourced it out to non-contracted agency to see if they what the can source for me.

Will link in with you at the start of the week.

Joanne

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 01 April 2022 17:00
To: Haynes, Mark <Personal Information redacted by the USI>; McMullen, Joanne <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Hi Joanne / Stephen / Karen

Just chasing up on below Urology consultant recruitment for permanent or if there are any potential locum Urology Consultant CV's about?

Would you mind giving it another push again next week

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: Haynes, Mark <[redacted]>
Sent: 23 March 2022 15:42
To: McMullen, Joanne <[redacted]>; Clayton, Wendy <[redacted]>; Haugh, Karen <[redacted]>; Morrison, Stephen <[redacted]>
Cc: Carroll, Ronan <[redacted]>
Subject: RE: Consultant Urologist CAH *URGENT**

Thanks Joanne

I think it would be important to have a clear idea of what they need to do and what we need to do such that this can form part of the job plan and be included for appraisal etc.

I am also conscious that if we were to put out an advert detailing such a supported 'transition' post to support doctors while they get on the specialist register we may get a larger number of applicants and so a thought through personnel spec for this would be important.

Is there any way we can get clear guidance of what would be needed from a Europe trained urologist to get recognised on the GMC specialist register (and therefore what support and likely timescales would follw)?

Mark

From: McMullen, Joanne <[redacted]>
Sent: 23 March 2022 15:37
To: Haynes, Mark <[redacted]>; Clayton, Wendy <[redacted]>; Haugh, Karen <[redacted]>; Morrison, Stephen <[redacted]>
Cc: Carroll, Ronan <[redacted]>
Subject: RE: Consultant Urologist CAH *URGENT**

Thanks

To my knowledge, if the doctor has completed their medical degree in a English speaking university then this is taken into account and the doctor will not be required to take a separate English test / exam for their GMC registration.

All our temporary Consultant posts have always been advertised with the requirement for the applicant to have at least GMC Specialist registration and to date we have never advertised it any different.

There was an occasion last year where a doctor came through one of the agencies contracted for the International Medical Recruitment project, and we offered her a temporary post x 2 years with the view of her working towards her specialist registration. This was agreed with the Deputy HR Director at the time given circumstances.. (however this doctor ended up declining the offer due to family reasons.)

Just in the last week or so we have identified 2 other doctors suitable for Radiologist posts who do not have specialist registration (this was through a recruitment agency not our own advert). We are hoping to offer the temporary consultant posts x 1 year with a view of them working towards their specialist registration.

However as this outside our normal working practice we will be seeking further approval from the Director of HR / Deputy Director of HR to proceed and if you want I will add this to the list also. Especially when we are planning on advertising these posts outside normal practice.

As you know we have locums who work at consultant level who do not have specialist registration – so this is definitely an option worth exploring if we have potential suitable candidates.

Thanks

Joanne

From: Haynes, Mark <[redacted]>
Sent: 23 March 2022 13:30
To: McMullen, Joanne <[redacted]>; Clayton, Wendy <[redacted]>; Haugh, Karen <[redacted]>; Morrison, Stephen <[redacted]>
Cc: Carroll, Ronan <[redacted]>
Subject: RE: Consultant Urologist CAH *URGENT**

Hi Joanne

Not got round to replying.

Re the potential applicants they have not done English test. One was educated in new York so not certain if there is an exception for that?

Re adverts in light of no applicants can we look to review the advert etc prior to re-advertising?

RE the '2 year consultant post while working towards specialist registration we also need to look at what an advert for this would look like, what requirements are for support etc, create job spec / shortlisting criteria etc.

How is it best for us to do this (both)? Meet and run through?

Is there any examples for other specialities or in other trusts of what the 2 year post advert / spec may look?

Mark

From: McMullen, Joanne <Personal Information redacted by the USI>
Sent: 23 March 2022 12:09
To: Clayton, Wendy <Personal Information redacted by the USI>; Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>
Cc: Haynes, Mark <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH *URGENT**

Wendy

I emailed Mr Haynes on 14 March 2022 as there was a query re the English test for this doctor who was to check with the doctor and let me know.

I have not progressed with the advert to date as I was waiting on clarity.

Thanks

Joanne

From: Clayton, Wendy <Personal Information redacted by the USI>
Sent: 23 March 2022 11:05
To: Haugh, Karen <Personal Information redacted by the USI>; Morrison, Stephen <Personal Information redacted by the USI>; McMullen, Joanne <Personal Information redacted by the USI>
Cc: Haynes, Mark <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>
Subject: FW: Consultant Urologist CAH *URGENT**

Karen – we need to push again for Locum Urology Consultant due to no applicants for the permanent post. Mr Young retires May 2022 which will leave 3.5 permanent vacancies. We do have one locum against this deficit of Urology consultants

Can we put back out asap?

Joanne – any progress on advert for applicants working towards their GMC, conscious that we are running out of time?

Regards

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

From: McClements, Melanie <Personal Information redacted by the USI>
Sent: 15 March 2022 15:31
To: McIlkenny, Andrea <Personal Information redacted by the USI>; Haynes, Mark <Personal Information redacted by the USI>; Glackin, Anthony <Personal Information redacted by the USI>; Corrigan, Martina <Personal Information redacted by the USI>; Donaghy, Geraldine <Personal Information redacted by the USI>; Comac, Jennifer <Personal Information redacted by the USI>; Hogan, Kerri <Personal Information redacted by the USI>; Andrew Thomas <Personal Information redacted by the USI>
Cc: McMullen, Joanne <Personal Information redacted by the USI>; McCracken, Lydia <Personal Information redacted by the USI>; Clayton, Wendy <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>
Subject: RE: Consultant Urologist CAH

That's disappointing , thanks Andrea, mel

From: McIlkenny, Andrea <[redacted]>
Sent: 15 March 2022 14:36
To: Haynes, Mark <[redacted]>; Glackin, Anthony <[redacted]>; Corrigan, Martina <[redacted]>; Donaghy, Geraldine <[redacted]>; Comac, Jennifer <[redacted]>; McClements, Melanie <[redacted]>; Hogan, Kerri <[redacted]>; Andrew Thomas <[redacted]>
Cc: McMullen, Joanne <[redacted]>; McCracken, Lydia <[redacted]>; Clayton, Wendy <[redacted]>
Subject: RE: Consultant Urologist CAH
Importance: High

Dear All

May I confirm that the Consultant Urologist post closed today at 12.30pm with no applicants. You can all now release the date saved for interview which was **Tuesday 26th April 2022 between 1pm - 5pm.**

Andrea McIlkenny
Medical HR Officer
HROD Directorate
Southern Health & Social Care Trust
The Brackens
Craigavon Area Hospital
68 Lurgan Road
Portadown
Northern Ireland
BT63 5QQ

[redacted]
[redacted]
(Working Hours - Mon to Fri : 9am – 5pm)

From: McIlkenny, Andrea
Sent: 16 February 2022 12:42
To: Haynes, Mark; Glackin, Anthony; Corrigan, Martina
Cc: McMullen, Joanne ([redacted]); McCracken, Lydia
Subject: RE: Consultant Urologist CAH
Importance: High

Dear Mr Haynes/Mr Glackin

May I confirm that we plan to hold interviews for the above post on **Tuesday 26th April 2022 between 1pm - 5pm**.
Melanie and Geraldine Donaghy (NED) have confirmed their availability.
Could you both confirm if you would be available before I source an Assessor?

Andrea McIlkenny
Medical HR Officer
HROD Directorate
Southern Health & Social Care Trust
The Brackens
Craigavon Area Hospital
68 Lurgan Road

Portadown
Northern Ireland
BT63 5QQ

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

(Working Hours - Mon to Fri : 9am – 5pm)

From: McIlkenny, Andrea
Sent: 09 February 2022 10:59
To: Haynes, Mark; Glackin, Anthony; Corrigan, Martina; Clayton, Wendy; Kelly, Brigeen
Cc: McMullen, Joanne (Personal Information redacted by the USI); McCracken, Lydia
Subject: Consultant Urologist CAH
Importance: High

Dear All

May I confirm that we are proceeding to advertisement this week with the post of Consultant Urologist again.

This post will close on **Tuesday 15th March 2022 at 12.30pm**.

I will be in touch over the next few days to organise an interview date.

Andrea McIlkenny
Medical HR Officer
HROD Directorate
Southern Health & Social Care Trust
The Brackens, Craigavon Area Hospital

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

(Working Hours - Mon to Fri : 9am – 5pm)

HSCB/SOUTHERN TRUST SERVICE ISSUES and PERFORMANCE MEETING – ACTIONS/ISSUES REGISTER – 23 September 2020

ATTENDEES: **TRUST** – Lynn Lappin, Barry Conway, Ronan Carroll
HSCB/PHA – David McCormick, Raymond Curran, Michael Taylor, Caroline Cullen, Sophie Lusby, Michael O'Hare

Issue	Action	Lead Responsibility / Deadline
OVERVIEW OF PERFORMANCE AGAINST 2020/21 CPD TARGETS		
Unscheduled Care		
4 and 12 hours • HSCB (DMcC) stated that the Trust's 4-hour performance for April-August 2020 (71%) was an improvement on the same period in 2018/19 (66%). • The Trust's 12-hour position showed 2,107 patients waiting longer than 12 hours from April-August 2020 compared to 4,327 during the same period in 2019.		
Elective Care		
Elective Waiting Times • HSCB (DMcC) reported that at August 2020, the number of patients waiting longer than 9 weeks for an OP assessment was 41,154 compared to 32,829 at August 2019. • Similarly, the number of patients waiting longer than 52-weeks at August 2020 (18,578) had increased significantly compared to the same month in 2019 (10,740). • With regard to IPDCs, 14,946 patients were waiting longer than 13 weeks at August 2020 compared with 8,700 at August 2019. 7,028 patients were waiting longer than 52 weeks for treatment at August 2020 against 3,084 at August 2019. *Diagnostics* • HSCB (DMcC) highlighted that at July 2020, there were 26,334 patients waiting longer than 9 weeks for a diagnostic test compared to 17,138 at July 2019. However, the Trust's position steadily improved since May 2020. • Similarly, the number of patients waiting longer than 26 weeks at July 2020 (17,267) had increased from July 2019 (7,757) and had steadily deteriorated since April 2020. • The HSCB (DMcC) questioned whether the Trust was on course to spend the £2.5mn allocation. The Trust		

Issue	Action	Lead Responsibility / Deadline
(LLa) confirmed that at present there was no indication of risk against the allocation. • The Trust (LLa) explained that the decrease in 9-week waits and increase in 26-week waits was due to there being a significant number of urgent patients in the 9-week group. Comparatively, 26-week waits were significantly comprised of routine cases. Even where there were IS contracts in place, these had focused on red flag and urgent cases. Scanning times had also been impacted on by the necessary cleaning arrangements between patient appointments due to COVID-19. • The Trust (BC) also noted that social distancing rules meant that capacity had been notably affected. • The Trust (LLa) outlined a key issue with IS providers' management of waiting lists: when lists could not be used at short notice, the provider would still charge the Trust at full cost; yet at the same time, the provider would only give short notice for notifications which made it notably difficult for the Trust to get processes in place. • The Trust (RC) updated on urology services, advising that a locum had been appointed (one applicant for the two recently advertised posts). The HSCB updated that the Fermanagh transfer would now be operational which would alleviate some pressure from the team in terms of triaging these referrals. • The Trust (RC) confirmed that when appointed, the seventh urologist would operate in DHH, and this post would be advertised at the beginning of 2021. *Endoscopy* • The waiting time position for those waiting longer than 9 weeks at the end of August 2020 (3,511) had improved gradually since May, however this was a deterioration on the same period in 2019 (1,226). In relation to delivery of core for the period of April-July 2020, the Trust had significantly under-delivered on its commissioned activity- 1,835 SBA v 455 actual (-75.2%), however the HSCB (DMcC) acknowledged the present impact on colonoscopy procedures that the Trust faced. • The HSCB (DMcC) referenced the £550k non-recurrent allocation, for which the Trust (LLa) updated that they had advertised for an IS provider to utilise Trust facilities at weekends. Given the current timescales and capacity, the Trust highlighted no risk for the allocation.	**Action 1:** HSCB to raise issue of short notice notifications and cancellations with IS.	**HSCB** (David McCormick)
Cancer Services		
• The HSCB (DMcC) stated that this area would be discussed more fully in the forthcoming Cancer Performance meetings, and that the Trust's performance would be difficult to accurately gauge given the reduction in demand through lower referral levels in light of current circumstances. With regard to 62-		

Issue	Action	Lead Responsibility / Deadline
day patients, there were many patients actively breaching at present which would not be reflected fully through the data until the coming months.		
Mental Health Services		
CAMHS • The HSCB (DMcC) acknowledged the Trust's significant improvement in patients waiting longer than 9 weeks since April (63 as of July 2020). However, this was a deterioration on the same month in 2019 (0). • The Trust (LLa) stated that the CAMHS team had made efficient use of virtual calls to see patients and the Trust envisaged a return to a position of 0 breaches by October. *Adult Mental Health* • The HSCB (DMcC) noted the Trust's continued improvement in recent months: at April there were 697 patients waiting longer than 9 weeks for Adult Mental Health compared to July's position, 435. *Dementia* • There continued to be a significant number of patients waiting longer than 9 weeks, from 162 at 30 April 2020 to 249 at 31 July 2020, as well as a deterioration on the same month last year (18). *Psychological Therapies* • The HSCB (DMcC) reported that there were 460 patients waiting longer than 13 weeks at 31 July 2020, compared to 224 during the same month in the previous year. • The Trust (LLa) explained that there had been no allocation for Psychological Therapies in the current year (also affecting to the trajectory to date for Dementia). Furthermore, the spread of the psychology team had extended to supporting staff psychology during the pandemic, and so were only beginning to fully resume elective activity towards the end of Phase 2/ beginning of Phase 3.	**Action 2:** HSCB to query with Social Care colleagues as to whether there have been any bids for psychological therapies.	**HSCB** (David McCormick)
PROGRESS AGAINST HSC REBUILDING PLAN		
• The HSCB (DMcC) reported that the Trust had exceeded plans to date with the exception of outpatients face to face activity, an underdelivery of 2,061(86% delivery of Jul-Aug plan), however also noted that this was offset by outpatients virtual activity of +3,057 (185% delivery of Jul-Aug plan) which had been		

Issue	Action	Lead Responsibility / Deadline
understandable in the current setting.		
SERVICE DELIVERY ISSUES		
[No issues formally raised by the Trust] • The Trust (BC) noted bed pressures which had impacted the operation of the unscheduled care pathway, in addition to staffing issues across services as a result of having to self-isolate.		
AOB		
Rebuilding of Ophthalmic Services • The HSCB (RC) reported that the Rebuilding Management Board (RMB) had asked for a detailed action plan for the rebuilding of all ophthalmic services, one action of which from the last meeting was to gain input into Trust Phase 3 planning. He asked that, due to Banbridge Health Centre's services having been decanted out to South Tyrone Hospital, which had in turn destabilised rebuilding plans for cataracts, whether the Trust could advise when the Banbridge service would resume as normal in order to enable capacity to be free up capacity in STH as before (or failing this, if alternative accommodation could be found). The Trust (RC) agreed to explore possible solutions, including the possibility of using Tower Hill or other buildings in the Trust. *Urology IPTs* • The HSCB (DMcC) advised that the Finance team undertook a costing based on the Northern Ireland average, however the NI average worked out as being less for the Urology IPT Trust costed by the Trust.	**Action 3:** Trust (RC) to explore options internally for other buildings that can be used so that capacity can be freed up in South Tyrone Hospital for cataract work to resume. **Action 4:** SHSCT Finance to discuss further with Karen McKay (HSCB Finance) to verify IPT costings.	**Trust** (Ronan Carroll/ Martina Corrigan) **Trust** (Linda-Jayne Martin)

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

WEDNESDAY 23 MAY 2018

10.00am – 12.00pm

5th Floor Meeting Room, HSCB, Linenhall Street

SEE TRUST PREP NOTES IN RED ON THIS AGENDA – DRAFT V1.0

AGENDA

HSCB ATTENDEES:

JOYCE MCKEE (MENTAL HEALTH ISSUES) , MIRIAM MCCARTNEY, LISA MCWILLIAMS, BRID FARRELL(STROKE) , PAUL CUMMINGS(TBC) , ROSIE BYRNE, DAVID MCCORMICK, MOHAMED SARTAJ (SSI SURVEILLIANCE) , LINUS MCLOUGHLIN; ALISON JEYNES (TBC)

1. Welcome and introductions

- **Mental health Services(to be taken early on the agenda to Allow Carmel and team to leave)**
  - Transfer of Annalong/Kilkeel strip to SHSCT Draft proposal being developed and HSCB agreed that any transfer of services would be into the SHSCT agreed model; **HSCB committed to fund the difference between SET current funding and SHSCT cost**
    Ongoing queries re information to establish the new demand
    Impact on SHSCT bed capacity once transfer is agreed – will no longer be able to be a net importer of admissions to meet regional bed demand
    Some initial engagement with Kilkeel community via mental health patient/client rep
    (Adrian – can you provide an update on timescale for next engagement with HSCB and for IPT/Project Management arrangement)

  - Emerging new long stay populations in MH and LD – Trust update : pressures that effect patient flow in mental health, absence of a rehab service and suitable community placements for complex placements
    (Adrian/Miceal – can you provide a brief for the performance meeting please

  - Addictions Service – presentation of Caseload demand/Impact on Performance Improvement Trajectories

Trust provided early alert to HSCB when submitting its Performance Improvement Trajectories (PIT) for Adult Mental Health today in respect of Addictions.
The PIT for 2018/2019 demonstrates a significant decrease in performance from 0 breaches to 273 breaches @ March 2019.
Assumptions based on the need to address the growth and capacity gap for treatment/intervention (secondary waits) by transferring existing resources from new assessments to treatments/intervention activities.
In parallel the service is initiating a review/service improvement process to streamline the existing work including a review of strategies to reduce DNA/CNA rates and shorter assessments for re-presentations within 6-months streamlining assessment processes allowing for additional clinics to be factored in to facilitate prompt re-entry to the service.

- Dementia – update on regional work around service model/future regional direction

- Psychology Services – update on ongoing workforce challenges
  (Ivor – can you provide a brief in advance of the performance meeting please)

2. Service Delivery Issues

- ***Items added by Trust***
  - *Transformation Proposals – update on process and timescales*
  - *Commission Plan Direction/Trust Delivery Plan/Finance – Update on process, expectations and timescales*
  - *Elective Funding;*
    - *Q1 bids and authorisation*
    - *Q2,3,4 bids against £30m and position in relation to bids for long wait*
    - *CT mobile*

3. 2017/18 CPD standards/targets (HSCB presentation to follow)

Appendix 1 (year end summary report attached & Access Times for year end)

- Elective care

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note

4.10	**OUT-PATIENT APPOINTMENT:** *By March 2018, 50% of patients should be waiting no longer than 9-weeks for an out-patient appointment and no patient waits longer than 52-weeks (OGI = <9 weeks = 50%, >52 weeks = 0)*	R	R	**Validated: Assessment at 31 March 2018 = 33.1% less than 9 weeks; 5,888 greater than 52-weeks; longest wait is 173 weeks.** *Baseline assessment at 31 March 2017 demonstrated 38.2% of patients waiting less than 9 weeks; 2,225 patients were waiting in excess of 52-weeks with the longest wait at 103 weeks.* 31 March 2018 demonstrated a total of 40,008 patients waiting for OP appointments, which is +5,611 (+16.3%) increase in comparison to 2016/2017 (34,397).	**Actual position end of March 2018:** **<9-weeks** • BHSCT 27% • NHSCT 29% • SEHSCT 21% • SHSCT 29% * • WHSCT 30% • **Regional Average 27%** **>52-weeks (% of total)** • BHSCT 32,218 (39%) • NHSCT 10,199 (12%) • SEHSCT 21,112 (25%) • SHSCT 8,824 (11%) * • WHSCT 11,040 (13%) • **Regional Total 83,393**	The total number of patients waiting first outpatient assessments increased by +5,611 to 40,008 in 2017/2018 with the number of patients waiting in excess of 52 weeks, within this volume, also increased by +3,663. Achievement of this OGI continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment into specialties with recurrent capacity gaps. Waits over 52-weeks, for SHSCT specialties, are reported across 13 specialties: Breast Family History; Cardiology; Diabetology; Endocrinology; ENT; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine and Urology. All of which have established capacity gaps and/or accrued backlogs. The Trust continues to prioritise available capacity to red flag and urgent referrals in the first instance and to direct any non-recurrent funding to these areas. Recurrent investment will be required to address
4.11	**DIAGNOSTIC TEST:** *By March 2018, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks. (OGI = <9 weeks = 75%, >26 weeks = 0)*	R	R	**Validated: Assessment at 31 March 2018 = 57.2% <9-weeks; 2,963 >26-weeks; and longest wait 87-weeks** *Baseline assessment at 31 March 2017 demonstrated a total of 22,963 patients.* 31 March 2018 demonstrated a total of 22,963 patients waiting for diagnostics, which is +2,776 (+13.8%) increase	**Actual position at end of March 2018:** **<9-weeks** • BHSCT 44% • NHSCT 73% • SEHSCT 71% • SHSCT 57% • WHSCT 85% • **Regional Average 60%** **>26-weeks (% of total)** • BHSCT 10,134 (68%) • NHSCT 1,121 (8%)	The total number of patients waiting diagnostics tests has increased by +2,776 to 22,963 in 2017/2018 with the number of patients waiting in excess of 26 weeks, within this volume, also increased by 2,329. Waits in excess of 26 weeks are demonstrated in: • Endoscopy 126; (74 in 2016/2107) • Imaging 1,466 (predominantly CT; Dexa; and MRI); (476 in 2016/2017) and • Non-Imaging 1,371 (Ambulatory BP; ECG; and Urodynamics). (84 in 2016/2017) Recurrent investment has been made in Endoscopy; CT, MRI and cardiac investigations over the last two years which has addressed in part capacity gaps however demand continue to increase and residual

				in comparison to 2016/2017 (20,187).	• SEHSCT 628 (4%) • SHSCT 2,837 (19%) • WHSCT 141 (1%) • **Regional Total 14,861**	capacity gaps remain, along with a requirement for non-recurrent capacity to facilitate backlog clearance. New gaps are also emerging in Dexa. The Trust has identified new demand to the Commissioner. Diagnostic non-recurrent funding has been used in-house and in the independent sector to reduce the longest waits in year.
4.12	**IN-PATIENT / DAY CASE TREATMENT:** *By March 2018, 55% of patients should wait no longer than 13 weeks for in-patient/day case treatment and no patient waits longer than 52 weeks.* *(OGI = <13 weeks = 55%, >52 weeks =0)*	R	R	**Validated: Assessment at 31 March 2018 = 33.9% <9-weeks; 2,079 >52-weeks; and longest wait 217-weeks** *Baseline assessment at 31 March 2017 demonstrated 46.5% of patients waiting less than 13 weeks, with 1,014 patients waiting in excess*	**Actual position at end of March 2018:<13-weeks** • BHSCT 31% • NHSCT 64% • SEHSCT 45% • SHSCT 40% • WHSCT 35% • **Regional Average 38%**	The total number of patients waiting inpatient/ daycase treatment increased by 664 to 9,221 in 2017/2018 with the number of patients waiting in excess of 52 weeks, within this volume, also increased by 1065. Achievement of the OGI continues to be impacted by multiple factors and with competing demands for available capacity prioritisation continues to be given to red flag and urgent cases in the first instance. Waits over 52-weeks are reported across five specialties: Cardiology; General Surgery; Orthopaedics; Pain Management; and Urology. All of which have established capacity gaps and/or accrued backlogs. In-year a key challenge has been the ability to secure elective admissions, with a 30% cap from November 2017 to May 2018, in the face of increasing unscheduled care demands. Recurrent investment will be required to address capacity gaps in the longest waiting areas (>52 weeks) and non-recurrent capacity will be required to address accrued backlogs.
		R	R	*of 52-weeks with the longest wait at 165-weeks.* 31 March 2018 demonstrated a total of 9,221 patients waiting for in-patient/day case treatment which is an increase of 664 (+7.8%) compared with 2016/2017.	**>52-weeks (% of total)** • BHSCT 7,446 (45%) • NHSCT 345 (2%) • SEHSCT 1,715 (10%) • SHSCT 2,398 (15%) • WHSCT 4,550 (28%) • **Regional Total 16,454**	

- Unscheduled care

OGI	Objectives and Goals for Improvement	TDP RAG	SHSCT Year-End RAG	SHSCT 2017/2018 Year-End Performance Assessment	HSCB 2017/2018 Year-End Comparative Information	Key Issues/Points of Note
4.4	**EMERGENCY DEPARTMENT (Collective Assessment)**	R	R	Note: *Sub-targets* are assessed individually and specified below.		
4.4.1	**EMERGENCY DEPARTMENT (4-Hour Arrival to Discharge/Admission):** *By March 2018, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department. (OGI = 95%)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 74.5%** *Baseline assessment in 2016/2017 was 75.10% with* 2017/2018 demonstrating performance -0.6% lower than this. Total attendances in 2017/2018 172,339 compared to 166,232 in 2016/2017	**Cumulative position for April 2017 to March 2018:** • BHSCT 72% • NHSCT 68% • SEHSCT 76% • SHSCT 75% • WHSCT 76% • **Regional Average 73%**	Cumulative performance for 2017/2018 was -0.6% lower than 2016/2017. In actual terms the number of patients seen within 4-hours increased from 124,885 to 128,459 in 2017/2018 however the % performance dropped associated with an increased in attendance volumes (+6,107). Whilst general trends in activity are not significantly increased, the ability to improve performance has been challenging and is the focus for improvement in 2018/2019 with particular focus on streaming of suitable referrals to ambulatory services to increase space improving throughput and flow of patients including minor streams.
4.4.2	**EMERGENCY DEPARTMENT (12-Hour Arrival to Discharge/Admission):** *By March 2018, no patient attending any emergency department should wait longer than 12 hours. (OGI = 0)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 3656** *Baseline assessment in 2016/2017 was 910 patients in excess of 12-hours with 2017/2018 demonstrating an increase of +2746 patients.* Patients waiting in excess of 12-hours equated to 2% of total ED attendances compared to	**Actual (% of Total) Cumulative April 2017 to March 2018:** • BHSCT 3,044 (18%) • NHSCT 4,488 (26%) • SEHSCT 4,914 (28%) • SHSCT 3,656 (21%) • WHSCT 1,245 (7%) • **Regional Total 17,347**	The level of breaches demonstrated in 2017/2018 was significantly higher than in 2016/2017 reflecting the pattern of pressures throughout the Region. The Trust continues to be challenged with patient flow with high numbers of medical patients in non-medical beds (outliers). Due to the recognised inability to increasing medical beds on our sites, associated with the challenge of securing key clinical staff, initiatives focused on enhanced patient flow/discharge and appropriate admission avoidance Review of the operational management of demand and views of staff during this period will inform unscheduled care resilience planning for 2018/2019. Focus will include development of ambulatory care

				0.5% in 2016/2017.		as an alternative pathway to admission.
4.5	**EMERGENCY DEPARTMENT (2-Hour Triage to Treatment Commenced):** *By March 2018, at least 80% of patients to have commenced treatment, following triage, within 2 hours. (OGI = 80%)*	**G**	**G**	**Validated: Cumulative period April 2017 to March 2018 = 80.3%** Equating to 123,483 patients having treatment commenced within 2-	**Cumulative position April 2017 to March 2018:** • BHSCT 77% • NHSCT 76% • SEHSCT 87% • SHSCT 80%	Whilst performance is in line with the objective level sought, the ability to sustain this is more challenging as unscheduled care pressures continue. It is also of note that the actual number of patients commencing treatment within 2 hours reduced between December 2017 to March 2018 in

HIP FRACTURES*: By March 2018, 95% of patients, where clinically appropriate, wait no longer than 48-hours for in-patient treatment for hip fractures. (OGI = 95%)*	**A**	**A**	**Validated: Cumulative period April 2017 to March 2018 = 90.2%.** *Baseline assessment 2016/2017 demonstrated 91.7% of hip fractures treated within 48-hours.* In 2017/2018 370 out of 410 hip fractures treated within 48-hours. 2016/2017 demonstrated 333 out of 363 hip fractures treated within 48-hours.	**Cumulative position April 2017 to March 2018:** • BHSCT 77% • NHSCT *Not applicable* • SEHSCT 65% • SHSCT 90% • WHSCT 91% • **Regional Average 80%**	Whilst performance has demonstrated a slight decrease in comparison to 2016/2017, by -1.5%, in actual terms more patients had their surgery within 48 hours (370 in 2017/2018 compared to 333 in 2016/2017). This is associated with an increase demand in hip fractures of +13% (410 in 2017/2018 versus 363 in 2016/2017). To achieve this performance the Trust has increased capacity for trauma however this impacts on the routine level of elective orthopaedic surgery that can be undertaken. The Trust is developing a proposal to sustain an increased trauma capacity and in parallel increase orthopaedic capacity. This will require both investment in infrastructure and Commissioner's commitment to increased revenue funding.

- Cancer services

4.9	**CANCER PATHWAYS (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
4.9.1	**SUSPECT BREAST CANCER (14-days):** *During 2017/2018, all urgent suspected breast cancer referrals should be seen within 14-days. (OGI = 100%)*	**R**	**R**	**Validated: Cumulative period April 2017 to March 2018 = 47.2%** *Baseline assessment in 2016/2017 demonstrated 43.3%.* 2017/2018 demonstrated 1,159 out of 2,456 patients seen within 14-days with 1,297 patients not seen within 14-days. These volumes exclude SHSCT patients that were seen in other Trusts. In comparison 2016/2017 demonstrated 1045 out of 2412 patients seen within 14-days (43.3%) with 1,367 patients not seen within 14-days.	**Cumulative position April 2017 to March 2018:** • BHSCT 96% • NHSCT 89% • SEHSCT 99% • SHSCT 47% • WHSCT 99% • **Regional Average 87%**	Challenges associated with the ability to secure and sustain medical workforce continued from 2016/2017 into 2017/2018 and affected the ability to achieve this objective level in Quarters 1 to 3. Quarter 4 reflected significant improvement in performance, close to 100%, associated with a recovery plan which facilitated increase capacity within the Trust and ongoing support received over the last 6 months from the other NI Trusts in the management of SHSCT patients. Plans for 2018/2019 anticipate this current improvement will be sustained, however remains subject to workforce issues. Quality developments in the local breast team have been recognised. A Regional review of breast assessment services is on-going to secure more sustainable Regional position.
4.9.2	**CANCER PATHWAY (31-Day):** *During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. (OGI = 98%)*	**G**	**Y**	**Validated: Cumulative period April 2017 to March 2018 = 96.96%** *Baseline assessment in 2016/2017 demonstrated 98.99%.*	**Cumulative position April 2017 to March 2018:** • BHSCT 90% • NHSCT 93% • SEHSCT 95% • SHSCT 97%	Whilst performance was slightly lower, by -2%, a comparable volume of patients where seen within 31-days. Demand increased in the same period. The SHSCT continues to perform well on this part of the cancer pathway. Of the 47 patients who did not receive their treatment, within 31-days of their

				2017/2018 demonstrated 1,497 out of 1,544 patients seen within 31-days compared to 1,472 out of 1,487 patients seen within 31-days (98.99%) in 2016/2017.	• WHSCT 100% • **Regional Average 94%**	decision to treat, 40 (85%) of were within Breast Surgery and was reflective of the pressures that the Breast Service faced throughout 2017/2018. The Trust anticipates continued strong performance on this pathway in 2018/2019 subject to demand.
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
4.9.3	**CANCER PATHWAY (62-Day):** *During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.* *(OGI = 95%)*	R	R	**Validated: Cumulative period April 2017 to March 2018 = 74.28%.** *Baseline assessment in 2016/2017 demonstrated 84.2%.* 2017/2018 demonstrated that 499.5 out of 672.5 patients were seen within 62-days compared to 605 out of 718.5 patients seen within in 2016/2017.	**Cumulative position April 2017 to February 2018:** • BHSCT 58% • NHSCT 72% • SEHSCT 51% • SHSCT 73% • WHSCT 89% • **Regional Average 67%**	Performance against the 62-day cancer pathway in 2017/2018 demonstrated a decrease in comparison to 2016/2017. This less favourable performance is associated with the total volume of patients on these pathways which present increased demand on the resources available including red flag out-patient and diagnostic capacity. The two predominant breaching specialties in 2017/2018 were Urology (46%) and Breast Surgery (14%) which was reflective of workforce pressures demonstrated throughout 2017/2018.

- Mental health services

4.13	**MENTAL HEALTH ELECTIVE SERVICES (Collective Assessment)**	**G**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
4.13.1	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (CAMHS):** *By March 2018, no patient waits longer than nine weeks to access child and adolescent mental health services. (OGI = >9 weeks = 0)*	**R**	**G**	**Validated: Assessment at 31 March 2018 = 0 patients waiting in excess of 9-weeks.** *Baseline assessment at 31 March 2017 demonstrated 2 patients waiting in excess of 9-weeks.* March 2018 demonstrated a total waiting list of 242 patients in comparison to 240 at March 2017.	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 56 (85%) • NHSCT 0 (0%) • SEHSCT 0 (0%) • SHSCT 0 (0%) • WHSCT 10 (15%) • **Regional Total 66**	The Trust was challenged throughout 2017/2018 to achieve this objective associated with demand outstripping capacity and reduced capacity associated with workforce challenges. The current positive position is welcomed however sustainability will continue to be a key challenge including the management of the caseload.
4.13.2	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Adult Mental Health):** *By March 2018, no patient waits longer than nine weeks to access adult mental health services.*	**R**	**R**	**Validated: Assessment at 31 March 2017 = 101 waiting in excess of 9-weeks; longest wait 25-weeks**	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 179 (27%) • NHSCT 0 (0%) • SEHSCT 43 (8%)	Whilst the Trust failed to achieve this objective the number of patients in excess of 9-weeks has improved with from 269 in 2016/2017 to 101 this year. The Trust has undertaken a number of actions to
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
	(OGI = >9 weeks =0)			*Baseline assessment at 31 March 2017 demonstrated 269 patients waiting in excess of 9-weeks with the longest wait at 27-weeks.* March 2018 demonstrated a total waiting list of 965 patients	• SHSCT 101 (15%) • WHSCT 318 (50%) • **Regional Total 641**	support Adult Mental Health including additional recurrent investment for core staffing; review of appropriate threshold for Tier 3 services; and additional capacity in the Independent Sector for lower intensity interventions. Increasing demand and workforce challenges associated with sick leave and vacancies presented challenges throughout this area in 2017/2018 which includes Primary Mental Health Care; Cognitive

				in comparison to 1,329 at March 2017.		Behavioural Therapy; and Eating Disorders.
4.13 .3	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Dementia Services):** *By March 2018, no patient waits longer than nine weeks to access dementia services.* *(OGI = >9 weeks = 0)*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 15 patients waiting in excess of 9-weeks, longest wait 22-weeks** *Baseline assessment at 31 March 2017 demonstrated 4 patients waiting in excess of 9-weeks with the longest wait at 12-weeks.* March 2018 demonstrated a total waiting list of 217 patients in comparison to 159 at March 2017.	**Actual position at end of March 2018: >9-weeks (% of total)** • BHSCT 77 (42%) • NHSCT 0 (0%) • SEHSCT 9 (5%) • SHSCT 15 (8%) • WHSCT 82 (45%) • **Regional Total 183**	Performance this year is comparable to last year with 15 patients waiting in excess of 9 weeks. Waits in excess of 9-weeks are, in the main, associated with direct Consultant to Consultant referrals, where there continues to be a shortfall in capacity. The service continues to be challenged with current and impending increases in demand linked to demography and disease prevalence. The Regional review and development of a new dementia pathway is not yet finalised, however, the Trust has agreed its new pathway; mapped its capacity against the pathway; and confirmed capacity gaps for the delivery of this. Recurrent investment will be required to implement this pathway and demonstrate improvement against this objective. The ability to secure the key medical staff may also further impact on the ability to migrate to the new pathway.
4.13 .4	**MENTAL HEALTH OUT-PATIENT APPOINTMENT (Psychological Therapies):** *By March 2018, no patient waits longer than thirteen weeks to access psychological therapy services.*	**R**	**R**	**Validated: Assessment at 31 March 2018 = 84 patients waiting in excess of 13-weeks, longest wait 56-weeks** *Baseline assessment at*	**Actual position at end of March 2018: >13-weeks (% of total)** • BHSCT 577 (39%) • NHSCT 31 (2%) • SEHSCT 228 (15%) • SHSCT 84 (6%)	Performance this year is comparable to last year with 84 patients waiting in excess of 13-weeks. Recruitment and retention of workforce continues to impact on capacity with the service operating with 11 funded vacancies, which is reflective of the Regional shortage of skilled psychologists.
OGI	**Objectives and Goals for Improvement**	**TDP RAG**	**SHSCT Year-End RAG**	**SHSCT 2017/2018 Year-End Performance Assessment**	**HSCB 2017/2018 Year-End Comparative Information**	**Key Issues/Points of Note**
	(OGI = >13 weeks =0)			*31 March 2017 demonstrated 97 patients waiting in excess of 13-weeks with the longest wait at 60-weeks.* March 2018	• WHSCT 554 (38%) • **Regional Total 1,474**	A number of actions have been undertaken within the Trust to support this area, including the development of a new workforce model; and re-direction of appropriate lower level referrals to other services. In addition a review of Psychological Therapies is planned to be undertaken in 2018/2019.

				demonstrated a total waiting list of 486 patients in comparison to 450 at March 2017.		

- HCAI

2.3	**HEALTHCARE ACQUIRED INFECTIONS (Collective Assessment)**	**R**	**R**	Note: *Sub-targets* are assessed individually and specified below.		
2.3.1	**HEALTHCARE ACQUIRED INFECTIONS (C Diff):** *By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of Clostridium Difficile Infection in patients aged 2 years and over compared to 2016/2017.* *(OGI = 31)*	**R**	**R**	**Validated: Cumulative period of April 2017 to March 2018 = 48 cases (55% higher (17 cases) than OGI)** *Baseline assessment in 2016/2017 reported 34 cases against a target of 32 (6% higher (+2 cases) than OGI).*	**Actual (% of Total) April 2017 to March 2018:** • BHSCT 113 (33%) • NHSCT 49 (15%) • SEHSCT 61 (18%) • SHSCT 50 (15%) * • WHSCT 64 (19%) • **Regional Total 337**	The Trust continues to work towards low incidence of C-Difficile against a background of an increasing complex clinical needs and an ageing population. This year's performance (48 in total) was a decrease in performance from 2016/2017 (32) and whilst one of the lowest in the Region, was outside the improvement level. Antibiotic stewardship remains a key area for improvement and the Trust has appointed an additional pharmacist to support this and is seeking to increase microbiology cover. Targeted training has been launched in 2017/2018.
2.3.2	**HEALTHCARE ACQUIRED INFECTIONS (MRSA):** *By March 2018, to secure a Regional aggregate reduction of 15% in the total number of in-patient episodes of MRSA Infection compared to*	**R**	**G**	**Validated: Cumulative period of April 2017 to March 2018 = 4 cases** *Baseline assessment in*	**Actual (% of Total) April 2017 to March 2018:** • BHSCT 18 (40%) • NHSCT 14 (31%) • SEHSCT 5 (11%)	This year has seen an improvement in performance with a reduction in incidences compared to 2016/2017. The number of incidences reduced from 6 to 4. Whilst the Trust continues to seek improvement its
	2016/2017. *(OGI = 4)*			*2016/2017 reported 6 cases, 25% higher (+1) than OGI.*	• SHSCT 4 (9%) • WHSCT 4 (9%) • **Regional Total 45**	ability to achieve further reductions in MRSA incidences is challenging. Regional performance continues to be strong with the Trust having one of the lowest levels of incidences.

4. 2018/19 Performance Improvement Trajectories

SMT paper attached detailing areas by exception (Appendix 2)

Outpatient/Inpatietn & D/C – Trajectories against SBA (included in appendix 2) -*ASD Performance: Exceptions below – (directorate to respond with reason for performance)*

Out-Patients

- General Surgery -122 -22%
- Paediatrics -22 -9%

In-Patients/Day Cases

- Dermatology (Consultant-led) -22 -18% (Nurse-led on-track. Consultant-led trajectory set higher than SBA due to additional sessions being undertaken by new Consultants.)
- ENT -39 -24%
- Orthopaedics -26 -18% (Note that underdelivery in Orthopaedics is not offset by increase in Trauma. Noting +22 FCEs equating to +13 admissions only overperforming for Trauma.)

Other areas to be inserted / in compilation by Performance

5. SSI surveillance related issues

SSI covers orthopaedic surgical site infections and C-section surgical site infections

C-section – no known issues

Orthopaedic Brief – see below

- *PHA has met with Trust (like all trusts) about reporting mechanisms etc. SHSCT meetings not well attend/right people not in the room and further meeting to be arranged re assurances etc*
- *Ssome assurance provided re processes; SSI now collected via TMS ; Process in place and submitted to PHA*
- *Low rate of SSI in CAH, traditionally which is welcomed however infections can occur after discharge and some potential concern that these may not be fully picked up with Trust reliant on post operative review apts or re-admission to identify same. Some sense that PHA want to explore this process more fully*
- *PHA has requested meeting further meeting with Trust to discuss SSI for orthopaedic surgery; date Proposed for 14 June although date might need to be changed to ensure clinical lead in attendance; previous date arranged cancelled by PHA.*

- *Sense that PHA might want assurance – Trust willing to engage – engagement needs to be with clinical and operational staff who are responsible. Internal meeting required*

Orthopaedic Surgical Site Infection Patient Safety Dashboard Q4 2017

Aim: To maintain the Trust's SSI Rate (Last 8 Quarters) below the NI Average (Last 8 Quarters) during 17/18									
All Procedures	PERIOD	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017	Q3 2017	Q4 2017
	NI Quarterly SSI Rate (%)	0.61 (20/3284)	0.34 (11/3243)	0.23 (7/3010)	0.33 (11/3332)	0.34 (11/3240)	0.21 (7/3274)	0.38 (12/3175)	0.19 (6/3214)
	Cumulative NI Rate (%) (Last 8 Quarters)	0.47 (98/20890)	0.46 (103/22249)	0.40 (93/23216)	0.36 (88/24147)	0.33 (83/25521)	0.34 (88/26231)	0.34 (88/25689)	0.33 (85/25772)
	CAH Quarterly SSI Rate (%)	0.34 (2/582)	0.17 (1/575)	0.20 (1/501)	0 (0/590)	0.17 (1/579)	0 (0/601)	0.35 (2/571)	0.33 (2/599)
	Cumulative CAH Rate (%) (Last 8 Quarters)	0.25 (9/3658)	0.26 (11/4202)	0.23 (10/4402)	0.22 (9/4164)	0.18 (8/4355)	0.15 (7/4588)	0.17 (8/4588)	0.20 (9/4598)

Due to the period of surveillance (up to 1 year) SSI Rates may change over time

Infection Key:

Red: **Rate above NI average**
Amber: **Rate equal to NI average**
Green: **Rate below NI Average**

C/Section Surgical Site Infection Patient Safety Dashboard March 2018

Aim: To ensure 95% overall compliance with the SSI Bundle by March 2018														
HOSP	**SSI Bundle**	**Baseline Aug 08**	**Jun 15**	**Sep 15**	**Dec 15**	**Mar 16**	**Jun 16**	**Sep 16**	**Dec 16**	**Mar 17**	**Jun 17**	**Sept 17**	**Dec 17**	**Mar 18**
CAH	Appropriate use of Prophylaxis Antibiotics	45	100	95	75	80	100	100	95	90	100	85	90	100
	Appropriate Hair Removal	0	100	100	95	85	95	90	90	95	100	95	95	100
	Normothermia	25	100	100	95	95	100	100	100	100	100	100	100	100
	Glucose Control (Diabetic pts)	0 (0/1)	0 (0/1)	100 (2/2)	50 (1/2)	67 (2/3)	100 (2/2)	100 (1/1)	100 (2/2)	33 (1/3)	50 (1/2)	0 (0/2)	0 (0/2)	0 (0/2)
	Overall Bundle Compliance	0	95	95	70	60	95	90	85	80	95	70`	85	90
HOSP	**SSI Bundle**	**Baseline Aug 08**	**Jun 15**	**Sep 15**	**Dec 15**	**Apr 16**	**Jun 16**	**Sep 16**	**Dec 16**	**Mar 17**	**Jun 17**	**Sept 17**	**Dec 17**	**Mar 18**
DHH	Appropriate use of Prophylaxis Antibiotics	0	95	95	90	85	100	100	95	100	95	100	95	100
	Appropriate Hair Removal	0	100	90	100	100	100	100	100	95	90	90	100	100
	Normothermia	100	100	100	100	95	100	100	100	100	100	100	100	100
	Glucose Control (Diabetic pts)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Overall Bundle Compliance	0	95	85	90	85	100	100	95	95	85	90	95	100

Trust Aim: To maintain the Trust's SSI Rate below the NI Average during 2017/18									
PERIOD	**Q4 2015**	**Q1 2016**	**Q2 2016**	**Q3 2016**	**Q4 2016**	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**
CAH SSI Rate (%)	7.4	4.6	2.5	3.8	5.6	6.4	3.2	1.8	4.4
DDH SSI Rate (%)	10.2	3.0	4.0	4.6	3.7	2.2	1.8	1.0	0.0
Trust Rate (%)	8.6	4.0	3.0	4.1	5.0	5.3	2.8	1.6	3.1
NI Average (%)	6.8	5.7	4.2	6.1	4.5	5.6	5.2	6.2	5.1
Percentage HISC Returns: Aim - To achieve a Completion Rate = to or above NI Average									
PERIOD	**Q4 2015**	**Q1 2016**	**Q2 2016**	**Q3 2016**	**Q4 2016**	**Q1 2017**	**Q2 2017**	**Q3 2017**	**Q4 2017**

	CAH (%)	45.8	72.0	78.1	83.7	81.6	86.7	85.2	83.1	84.3
	DHH (%)	67.9	67.3	82.9	90.5	94.4	70.2	82.2	73.8	60.6
	TRUST (%)	53.1	70.4	79.7	86.0	85.5	81.8	84.3	80.4	75.6
	NI Average (%)	75.4	84.6	86.1	88.3	88.2	86.9	82.8	81.7	76.8

Key: Bundle Compliance
Red: 0% → 50% - Work done but limited progress
Amber: 51% → 94% - Target partly achieved
Green: 95% → 100% - Target fully achieved

Key: SSI Rate
Red: Above NI Average
Amber: Equal to NI Average
Green: Below NI Average

Key: HISC Returns
Red: 10% or more below NI Average
Amber: Within 10% of NI Average
Green: Equal to or above NI Average

Performance in National Audits – SSNAP (Brid Farrell presentation)

SHSCT currently sitting at a 'D' level IN CAH and 'C' level in DHH against the audit and not able to secure improvement. (see dashboard below

Key challenges related to

- *Inability to get patient to a stroke unit in a timely manner due to lack of dedicated stroke beds (Protected lysis bed in CAH in place and working, however challenged in trying to keep a protected assessment bed due to bed pressures; DHH – trying to protect a lysis bed on stroke ward but not achieved*
- *Diagnosis time and delays getting to CT scanner associated with diagnosis lead in time and CT emergency capacity (Awareness session planned to improve diagnosis for clinical staff in ED to support timely & Second CT scanner may assist in due course)*
- *Unable to meet AHP assessment targets as no 7 day service over weekend for this (6.4 wte additional AHP staff required to meet requirements(??link to 7-day working transformational bid)*

Stroke group in place to look at light touch proposals (papers attached – appendix 3 below) and monthly DIY SSNAP audits in place to test compliance (March included for reference)

SSNAP Quarterly August –November 2017 (scored from A- E Nationally)

CAH SSNAP – Level D (No change)

Areas Improved	No Change	Deteriorated
Stroke unit	Discharge Process (A) maintained	Scanning
Thrombolysis		Occupational Therapy

Specialist Assessments		**Speech and Language**
Physiotherapy		**Standards By Discharge**
Multidisciplinary Team working		

DHH SSNAP – Level C (Improved from D)

Areas Improved	No Change	Deteriorated
Thrombolysis	**Scanning (maintained at C)**	
Occupational Therapy	**Stroke Unit (remains at E)**	
Physiotherapy	**Specialist Assessments (remains at E)**	
Speech and language	**Multidisciplinary Team working (remains at D)**	
	Standards by Discharge(maintained B)	
	Discharge Process (maintained A)	

6. Trust Issues:

- Acute Services
  - Paediatric Surgery & Change for Children Strategy – Trust update
    Email update on volumes of paediatric surgery in two comparable periods attached (appendix 4)
  - Breast Assessment Services – Trust Update on performance and quality aspect from service; HSCB update on regional review of assessment services
    Dashhoard attached – appendix 4
    Brief to follow
    2-3 May breaches. April showing good position: Flow to other Trusts in April limited to one Trust (NT) providing capacity
    Reviews 45 weeks for routines
  - Trauma & orthopaedics – Trust update on service issues relating to development of additional provision

7. AOB

Appendix 1 – year end report

20180521_YearEnda
tMarch2018_AccessT

Appendix 2 - performance improvement trajectory

OP/IP & DC

20180515_1819
PIT_UPDATED_SHSC

Appendix 4

Analysis from dataset on paediatric surgical cases recorded on theatre management system for period jan- – April 2017 – v – 2018

- **High level analysis – all cases including elective and emergency**

Children </= 13 - cases reduced by 105 in this period (14.1%)
Children 14 – 16 – cases reduced by 31 in this period
Total = reduction of -136 cases (14.7%)

Elective only cases reduced by -121 and Emergency cases increased by +16 in the same period

- **Specialty analysis of </= 13 years only**

ENT and community dental makes up 99% of the elective cases

ENT

Specialty	CAH	DHH	STH	Total
ENT – 2017	215	139	69	423
Ent – 2018	169	86	34	289
Variation	-46	-53	-35	-134
Dental – 2017	18	22	169	209
Dental – 2018**	0	188	50	238
Variation	-18	+166	-119	+29

**note centralisation of community dental session took place removing sessions from CAH and STH. Also additional recording of activity now on TMS from dental session which may skew this data slightly

2018/19 PERFORMANCE IMPROVEMENT TRAJECTORY

Delivery of Core - New Outpatients

Trust: Southern

PIT Lead: Ronan Carroll, Assistant Director ATICS & SEC; Barry Conway, Assistant Director IMWH; Anne McVey, Assistant Director MUSC; Heather Trouton, Assistant Director CCS; Julie McConville, Assistant Director CYPS; Roisin Toner, Assistant Director OPPC

Date Submitted (HSCB): 20 April 2018

Reduce the percentage of funded activity associated with elective care services that remains undelivered

Month: 1 (April 2018)

Specialty	SBA		Outturn													Performance Against Trajectory Volume					Performance Against Agreed SBA Volume				
	2017/18	2018/19	2017/18 SHSCT Operational Trajectory Volume	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19 Cumulative Volume (to date)	2018/19 Cumulative Expected Volume (to date)	Variance	% Variance	RAG status	2018/19 Cumulative SBA (to date)	2018/19 cumulative expected SBA	Variance	% Variance	RAG status
Breast Family History	218	218	184	10	18	18	10	10	18	18	18	10	18	18	18										
Breast Family History Actual activity				13												13	10	3	30%	G	13	18	-5	-28%	R
Breast Surgery	4,205	4,205	3236	265	260	293	220	240	283	295	295	217	278	292	298										
Breast Surgery actual activity				321												321	265	56	21%	G	321	350	-29	-8%	R
Cardiology	2,415	2,415	2488	187	195	209	150	180	240	228	328	185	206	200	180										
Cardiology actual activity				199												199	187	12	6%	G	199	201	-2	-1%	Y
Chemical Pathology	140	140	140	10	15	14	8	8	15	15	10	8	15	10	12										
Chemical Pathology				13												13	10	3	30%	G	13	12	1	11%	G
Dermatology (Cons-Led only)	7,322	7,322	7965	500	680	780	520	710	680	800	810	510	695	630	650										
Dermatology (Cons-Led only) actual activity				555												555	500	55	11%	G	555	610	-55	-9%	A
Diabetology	418	418	418	36	38	38	26	28	38	39	37	31	32	39	36										
Diabetology actual activity				35												35	36	-1	-3%	Y	35	35	0	0%	G
Endocrinology	537	537	547	44	46	55	40	44	54	56	48	40	42	38	40										
Endocrinology				59												59	44	15	34%	G	59	45	14	32%	G
ENT	9,463	9,463	9297	624	894	820	600	748	873	811	800	727	800	800	800										
ENT actual activity				691												691	624	67	11%	G	691	789	-98	-12%	R
Gastroenterology	2,006	2,006	2076	146	150	160	150	180	179	210	180	160	208	158	195										
Gastroenterology actual activity				143												143	146	-3	-2%	Y	143	167	-24	-14%	R
General Medicine	487	487	386	26	32	34	27	30	40	38	40	25	29	31	34										
General Medicine				29												29	26	3	12%	G	29	41	-12	-29%	R
General Surgery	9,839	9,839	7159	543	639	607	535	610	555	745	605	500	575	600	645										
General Surgery Actual activity				421												421	543	-122	-22%	R	421	820	-399	-49%	R
Geriatric Medicine (combined)	1,912	1,912	2128	149	190	187	147	192	189	188	181	140	158	197	210										
Geriatric Medicine actual activity				175												175	149	26	17%	G	175	159	16	10%	G
Gynae Colposcopy	1,354	1,354	903	58	97	105	70	60	81	80	81	55	60	78	78										
Gynae Colposcopy				89												89	58	31	53%	G	89	113	-24	-21%	R
Gynae Fertility	137	137	135	10	10	15	0	10	20	10	20	10	10	10	10										
Gynae Fertility				17												17	10	7	70%	G	17	11	6	49%	G
Gynae Urodynamics	400	400	276	18	28	20	10	18	28	24	28	18	24	32	28										

Gynae Urodynamics				**16**											**16**	**18**	**-2**	**-11%**	**R**		**16**	**33**	**-17**	**-52%**	**R**
Neurology	**2,790**	**2,790**	**3216**	180	299	337	287	315	255	260	319	240	212	252	260										
Neurology Actual activity				**237**											**237**	**180**	**57**	**32%**	**G**		**237**	**233**	**5**	**2%**	**G**
Obs and Gyn (Gynaecology)	**6,853**	**6,853**	**6749**	450	575	640	402	482	630	670	670	530	550	570	580										
Obs and Gyn (Gynaecology) actual activity				**628**											**628**	**450**	**178**	**40%**	**G**		**628**	**571**	**57**	**10%**	**G**
Paediatrics	**2,600**	**2,600**	**2829**	251	236	236	210	210	251	251	236	210	251	251	236										
Paediatrics actual activity				**229**											**229**	**251**	**-22**	**-9%**	**A**		**229**	**217**	**12**	**6%**	**G**
Pain Management	**1,190**	**1,190**	**1194**	80	95	100	70	90	120	120	116	83	105	115	100										
Pain Management actual activity				**90**											**90**	**80**	**10**	**13%**	**G**		**90**	**99**	**-9**	**-9%**	**A**
Rheumatology	**1,692**	**1,692**	**1620**	130	140	145	105	100	150	160	160	130	130	130	140										
Rheumatology actual activity				**229**											**229**	**130**	**99**	**76%**	**G**		**229**	**141**	**88**	**62%**	**G**
Thoracic Medicine	**1,724**	**1,724**	**1551**	136	155	145	130	115	141	120	150	90	130	120	119										
Thoracic Medicine actual activity				**135**											**135**	**136**	**-1**	**-1%**	**Y**		**135**	**144**	**-9**	**-6%**	**R**
Trauma and Orthopaedics (Orthopaedics)	**2,872**	**2,872**	**2836**	200	270	250	180	180	270	260	255	221	250	250	250										
Trauma and Orthopaedics (Orthopaedics)actual activity				**230**											**230**	**200**	**30**	**15%**	**G**		**230**	**239**	**-9**	**-4%**	**R**
Urology	**3,591**	**3,591**	**3928**	252	350	342	218	253	345	380	415	288	366	389	330										
Urology actual activity				**292**											**292**	**252**	**40**	**16%**	**G**		**292**	**299**	**-7**	**-2%**	**Y**
Total	**64,165**	**64,165**	**61,261**	**4,305**	**5,412**	**5,550**	**4,115**	**4,813**	**5,455**	**5,778**	**5,802**	**4,428**	**5,144**	**5,210**	**5,249**										
TOTAL ACTUAL ACTIVITY				***4,846***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***4846***	***4305***	***541***	***13%***	**G**		***4846***	***5347***	***-501***	***-9%***	**A**

KEY RISKS AND MITIGATIONS TO DELIVERY OF PLAN			
Risk Description	**Risk Rating**	**Mitigations**	**Risk Owner**

RAG status:

G	• SBA at 0% and above
Y	• SBA underperformance between -0.1% & -4.9
A	• SBA underperformance between -5% & -9.9%

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

NEW OUT-PATIENTS								
Specialty	**Activity Type**	**SBA Performance +/- at 31/03/18 (incl. IRR)**	**Review Backlog Position at 31/03/2018 *(OP or IPDC (Planned)) (Longest Waiter)***	**Routine (Longest Waiter)**	**Urgent (Longest Waiter)**	**>9-Weeks**	**>52-Weeks**	**Total Waiting**
Breast Family History	NOP	-13% (-28)	March 2016	80 weeks	23 weeks	94	11	**130**
Breast - Symptomatic	NOP	-22% (-913)	October 2016	42 weeks	2 weeks	268	0	**553**
Cardiology (includes ICATS)	NOP	6% (+140)	April 2015	74 weeks	70 weeks	1006	15	**1772**
Cardiology – Rapid Access Chest Pain (RACPC) - *Nurse-Led*	NOP	65% (+929)	Not applicable	11 weeks	7 weeks	1	0	**177**
Chemical Pathology	NOP	10% (+14)	June 2017	25 weeks	7 weeks	33	0	**84**
Colposcopy	NOP	-34% (-454)	October 2016	6 weeks	7 weeks	0	0	**107**
Dermatology Cons-Led (incl Virtual & ICATS)	NOP	11% (+821)	June 2016	23 weeks	11 weeks	501	0	**1609**
Endocrinology	NOP	3% (+16)	November 2015	71 weeks	55 weeks	301	17	**391**
Diabetology	NOP	-6% (-27)	September 2015	63 weeks	63 weeks	132	15	**231**
Ear, Nose & Throat (includes ICATS)	NOP	-4% (-332)	June 2015	80 weeks	62 weeks	4200	21	**6108**
Gastroenterology	NOP	2% (+31)	August 2015	100 weeks	88 weeks	1988	623	**2372**
General Medicine	NOP	-23% (-113)	May 2015	13 weeks	20 weeks	8	0	**79**
Geriatric Medicine	NOP	14% (+104)	July 2017	43 weeks	14 weeks	11	0	**70**
Geriatric Assessment	NOP	-14% (-63)	October 2017	20 weeks	6 weeks	3	0	**81**
Geriatric Acute	NOP	23% (+153)	Not applicable	8 weeks	5 weeks	0	0	**42**
Orthopaedic-Geriatric	NOP	27% (+12)	October 2017	141 weeks	62 weeks	153	100	**205**
General Surgery (includes Haematuria)	NOP	-39% (-3825)	November 2015	107 weeks	173 weeks	6323	1577	**7924**
Gynaecology (includes Family Planning)	NOP	-2% (-220)	April 2017	12 weeks	8 weeks	17	0	**990**
Gynae Fertility (Cons-Led)	NOP	36% (+49)	Not applicable	7 weeks	Not applicable	0	0	**5**
Haematology	NOP	32% (+130)	September 2017	30 weeks	8 weeks	63	0	**150**
Anti-Coagulant	NOP	-14% (-44)	July 2017	4 weeks	Not applicable	0	0	**6**
Nephrology	NOP	24% (+39)	Not applicable	18 weeks	14 weeks	16	0	**80**
Neurology	NOP	15% (+425)	August 2016	94 weeks	51 weeks	2444	1113	**2934**
Orthodontics	NOP	-53% (-287)	January 2017	16 weeks	Not applicable	15	0	**64**
Fractures	NOP	9% (+564)	March 2016	8 weeks	10 weeks	1	0	**241**
Orthopaedics	NOP	-12% (-347)	October 2014	114 weeks	77 weeks	2053	600	**2743**
Orthopaedic ICATS	NOP	-7% (-372)	October 2017	32 weeks	20 weeks	1415	0	**2553**
Paediatrics - Acute	NOP	5% (+137)	April 2017	47 weeks	20 weeks	275	0	**945**
Paediatrics - Community	NOP	No SBA	May 2017	18 weeks	Not applicable	21	0	**315**
Pain Management	NOP	-6% (-71)	February 2015	44 weeks	22 weeks	742	0	**1044**
Palliative Medicine	NOP	-4% (-5)	January 2018	5 weeks	2 weeks	0	0	**14**
Rheumatology	NOP	-4% (-75)	June 2014	100 weeks	87 weeks	898	405	**1235**
Thoracic Medicine	NOP	-12% (-209)	November 2016	75 weeks	67 weeks	1482	323	**1878**

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

Urology (includes ICATS)	NOP	6% (+206)	September 2014	114 weeks	107 weeks	2253	1079	**2988**

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

MENTAL HEALTH								
Specialty	**Activity Type**	**SBA Performance +/- at 31/03/18 (incl. IRR)**	**Review Backlog Position at 31/03/2018 *(OP or IPDC (Planned)) (Longest Waiter)***	**Routine (Longest Waiter)**	**Urgent (Longest Waiter)**	**>9-Weeks**	**>52-Weeks**	**Total**
Child & Adolescent Mental Health Services (CAMHS):	NOP	No SBA	Not applicable	8 weeks	2 weeks	0	0	**242**
CAMHS Step 2	*NOP*	*No SBA*	*Not applicable*	*8 weeks*	*Not applicable*	*0*	*0*	***125***
CAMHS Step 3	*NOP*	*No SBA*	*Not applicable*	*8 weeks*	*2 weeks*	*0*	*0*	***115***
Eating Disorder Services (CAMHS)	*NOP*	*No SBA*		*5 weeks*	*2 weeks*	*0*	*0*	***2***
Adult Mental Health Services:	NOP	No SBA		25 weeks	TBC	101	0	**965**
Primary Care Mental Health Team	*NOP*	*No SBA*		*14 weeks*	*TBC*	*64*	*0*	***564***
Community Mental Health Teams	*NOP*	*No SBA*		*10 weeks*	*TBC*	*5*	*0*	***73***
Community Mental Health Teams for Older People	*NOP*	*No SBA*		*14 weeks*	*TBC*	*2*	*0*	***8***
Forensic Services	*NOP*	*No SBA*		*Not applicable*	*Not applicable*	*0*	*0*	***0***
Eating Disorder Services	*NOP*	*No SBA*		*25 weeks*	*TBC*	*26*	*0*	***44***
Addiction Services	*NOP*	*No SBA*		*10 weeks*	*TBC*	*4*	*0*	***276***
Memory / Dementia Services	NOP	No SBA	April 2015	22 weeks	2 weeks	15	0	**217**
Psychological Therapies	NOP	No SBA		56 weeks	TBC	84	1	**486**
Adult Mental Health	*NOP*	*No SBA*		*56 weeks*	*TBC*	*76*	*1*	***267***
Adult Learning Disability	*NOP*	*No SBA*		*16 weeks*	*TBC*	*4*	*0*	***74***
Children's Learning Disability	*NOP*	*No SBA*		*11 weeks*	*TBC*	*0*	*0*	***19***
Adult Health Psychology	*NOP*	*No SBA*		*14 weeks*	*TBC*	*4*	*0*	***114***
Children's Psychology	*NOP*	*No SBA*		*9 weeks*	*TBC*	*0*	*0*	***11***
Neurodisability Services	*NOP*	*No SBA*		*8 weeks*	*TBC*	*0*	*0*	***1***
Autism - Assessment	NOP	No SBA	Not applicable	12 weeks	Not applicable	0	0	**122**
Autism - Treatment	NOP	No SBA	Not applicable	5 weeks	Not applicable	0	0	**7**

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

IN-PATIENTS AND DAY CASES

Specialty	Activity Type	SBA Performance +/- at 31/03/18 (incl. IRR)	Review Backlog Position at 31/03/2018 *(OP or IPDC (Planned)) (Longest Waiter)*	Routine (Longest Waiter)	Urgent (Longest Waiter)	>13	>52	TOTAL
Breast Surgery	IP	-8% (-32)	September 2017	75 weeks	33 weeks	18	1	**41**
Breast Surgery	DC			41 weeks	18 weeks	6	0	**27**
Cardiology	IP/DC	13% (+247)	August 2016	104 weeks	86 weeks	631	180	**958**
Community Dentistry	IP/DC	-17% (-301)	Not applicable	19 weeks	4 weeks	3	0	**198**
Dermatology Cons-Led	IP/DC	18% (+195)	Not applicable	38 weeks	25 weeks	119	0	**302**
Dermatology Nurse-Led	IP/DC	8% (+25)	Not applicable	35 weeks	19 weeks	50	0	**129**
Ear, Nose & Throat (ENT)	IP	-27% (-772)	Not applicable	57 weeks	27 weeks	90	7	**164**
Ear, Nose & Throat (ENT)	DC			72 weeks	42 weeks	491	29	**990**
Gastroenterology (Non Scopes)	IP/DC	342% (+701)	January 2017	Not applicable	40 weeks	2	0	**2**
General Medicine	IP/DC	-19% (-354)	Not applicable	Not applicable	Not applicable	0	0	**0**
Geriatric Specialties	IP/DC	240% (+24)	Not applicable	Not applicable	Not applicable	0	0	**0**
General Surgery (includes Haematuria & Minor Ops)	IP	-34% (-1963)	October 2016	131 weeks	139 weeks	164	55	**209**
General Surgery (includes Haematuria & Minor Ops)	DC			113 weeks	123 weeks	1086	216	**1664**
Gynaecology	IP	-20% (-525)	Not applicable	49 weeks	24 weeks	143	0	**239**
Gynaecology	DC			37 weeks	20 weeks	60	0	**251**
Haematology (incl Nurse-Led)	IP/DC	65% (+742)	January 2018	6 weeks	Not applicable	0	0	**23**
Neurology	IP/DC	56% (+218)	December 2017	16 weeks	Not applicable	4	0	**21**
Orthopaedics	IP	-22% (-432)	November 2016	163 weeks	113 weeks	1194	547	**1426**
Orthopaedics	DC			123 weeks	107 weeks	691	299	**953**
Paediatric Medicine	IP/DC	-18% (-21)	Not applicable	69 weeks	TBC	41	1	**55**
Pain Management	IP/DC	-7% (-41)	May 2016	145 weeks	55 weeks	586	326	**678**
Rheumatology	IP/DC	9% (+275)	June 2017	24 weeks	22 weeks	21	0	**252**
Thoracic Medicine	IP/DC	-20% (-98)	Not applicable	5 weeks	4 weeks	0	0	**11**
Urology	IP	12% (+496)	July 2016	217 weeks	200 weeks	670	413	**803**
Urology	DC			204 weeks	165 weeks	692	279	**954**

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

DIAGNOSTICS (ENDOSCOPY; IMAGING; AND PHYSIOLOGICAL MEASUREMENT)								
Specialty	**Activity Type**	**SBA Performance +/- at 31/03/18 (incl. IRR)**	**Review Backlog Position at 31/03/2018 *(OP or IPDC (Planned)) (Longest Waiter)***	**Routine (Longest Waiter)**	**Urgent (Longest Waiter)**	**>9-Weeks**	**>26-Weeks**	**Total**
CT Scans General (Excl CTC & Angio))	Imaging	19% (+4509)	Not applicable	52 weeks	16 weeks	268	2	**1317**
CT Colonography (CTC)	Imaging			43 weeks	16 weeks	75	30	**128**
CT Cardiac Angiography (excluding CT Calcium Scoring)	Imaging			79 weeks	8 weeks	972	664	**1132**
Non-Obstetrics Ultrasound Scans (NOUS)	Imaging	0% (-164)	Not applicable	19 weeks	14 weeks	166	0	**3696**
DEXA Scans	Imaging	4% (+97)	Not applicable	39 weeks	Not applicable	1713	602	**2411**
MRI Scans	Imaging	-17% (-2655)	Not applicable	61 weeks	34 weeks	1437	165	**3173**
Plain Film X-Ray	Imaging	15% (+26132)	Not applicable	21 weeks	Not applicable	9	0	**1084**
Fluoroscopy	Imaging	No SBA	Not applicable	21 weeks	21 weeks	15	0	**269**
Barium Enema	Imaging	No SBA	Not applicable	2 weeks	Not applicable	0	0	**1**
Gut Transit Studies	Imaging	No SBA	Not applicable	3 weeks	Not applicable	0	0	**2**
Radio Nuclide	Imaging	No SBA	Not applicable	17 weeks	8 weeks	3	0	**146**
Endoscopy - Symptomatic	Diag. IP	-12% (-1015)	May 2015	Not applicable	76 weeks	5	1	**8**
Endoscopy - Symptomatic	Diag. DC			87 weeks	62 weeks	307	42	**1348**
Endoscopy - Bowel Cancer Screening (BCS)	Diag. IP/DC	-1% (-4)	Not applicable	Not applicable	9 weeks	9	0	**97**
Cardiac Investigations - Echo & Non Echo (Combined WL)	Diag.	2% (+233) (for TTE only)	Not applicable	62 weeks	34 weeks	4116	1278	**6214**
Neurophysiology	Diag.	-38% (-577)	Not applicable	25 weeks	12 weeks	116	0	**263**
Audiology	Diag.	0% (+80)	Not applicable	9 weeks	Not available	0	0	**798**
Sleep Studies	Diag.	No SBA	Not applicable	23 weeks	15weeks	216	0	**512**
Urodynamics (Gynaecology)	Diag.	-44% (-177)	Not applicable	14 weeks	Not available	14	0	**52**
Urodynamics (Urology)	Diag.	No SBA	Not applicable	84 weeks	Not available	241	93	**367**

SOUTHERN HEALTH AND SOCIAL CARE TRUST - YEAR-END PERFORMANCE - ACCESS TIMES & VOLUMES

ALLIED HEALTH PROFESSIONALS

Specialty	Activity Type	SBA Performance +/- at 31/03/18 (incl. IRR)	Review Backlog Position at 31/03/2018 *(OP or IPDC (Planned)) (Longest Waiter)*	Routine (Longest Waiter)	Urgent (Longest Waiter)	>13-Weeks	Total
Dietetics - Acute	AHP	4% (+239)		13 weeks	3 weeks	0	0
Dietetics - Paediatrics	AHP		February 2018	27 weeks	6 weeks	2	222
Dietetics - Elderly and Primary Health Care	AHP			17 weeks	TBC	16	737
Dietetics - Mental Health	AHP			Not applicable	Not applicable	0	0
Dietetics - Learning Disability	AHP			1 week	Not applicable	0	1
Dietetics - Physical Disability	AHP			Not applicable	Not applicable		0
Occupational Therapy - Acute	AHP	-9% (-696)		31 weeks	4 weeks	166	326
Occupational Therapy - Paediatrics	AHP			42 weeks	11 weeks	207	341
Occupational Therapy - Elderly and Primary Health Care	AHP			58 weeks	36 weeks	446	1015
Occupational Therapy - Mental Health	AHP			Not applicable	Not applicable	0	0
Occupational Therapy - Learning Disability	AHP		July 2017	13 weeks	3 weeks	0	27
Occupational Therapy - Physical Disability	AHP		January 2017	40 weeks	3 weeks	214	454
Orthoptics	AHP	1% (+13)	January 2018	27 weeks	6 weeks	106	816
Physiotherapy - Paediatrics	AHP	-8% (-2294)		39 weeks	3 weeks	128	294
Physiotherapy - Elderly and Primary Health Care	AHP			34 weeks	3 weeks	1726	5734
Physiotherapy - Mental Health	AHP			Not applicable	Not applicable	0	0
Physiotherapy - Learning Disability	AHP		October 2017	30 weeks	3 weeks	5	27
Physiotherapy - Physical Disability	AHP		January 2017	41 weeks	3 weeks	18	87
Podiatry	AHP	-6% (-346)	January 2018	25 weeks	2 weeks	351	1526
Speech and Language Therapy - Acute	AHP	-4% (-121)		21 weeks	4 weeks	21	64
Speech and Language Therapy - Paediatrics	AHP		August 2017	42 weeks	Not applicable	410	1031
Speech and Language Therapy - Elderly and Primary Health Care	AHP			46 weeks	TBC	135	340
Speech and Language Therapy - Learning Disability	AHP			16 weeks	TBC	1	18
Speech and Language Therapy - Physical Disability	AHP			9 weeks	TBC	0	1

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING
SOUTHERN TRUST
WEDNESDAY 21 SEPTEMBER 2016
11.00am – 1.00pm

Conference Rooms 3 and 4, 2nd Floor, HSCB, Linenhall Street

AGENDA

1. Welcome and introductions
2. Actions from last meeting (24.6.16)
3. 2016/17 CPD standards/targets
   - Elective care

Hip fractures – 100% in August
***noting 62% for all fractures, which is well below the regional averages; linked to demand & casemix/sub-specialism issues*
Analysis underway of breaches to identify if specific to body parts (upper limb)
Trust to identify models in other Trusts
Future potential to operate new T&O ankle surgeon as part of network

- Delivery of core

Do we have recovery plans /projections???
Any idea why july so poor

Areas of underperformance, greater than 2016 in comparison to 2015, are:

Out-Patients:
** Symptomatic Breast – due to medical workforce issues*
** Orthopaedics – due to Trauma and 10th Consultant in trauma facing job plan*
** Pain Management – annual leave*
** General Medicine – due to medical workforce issues – Dr Duffin* [Personal Information redacted by the USI] *; Dr S Murphy on sabbatical from June and replacement not commenced until August*
** Endocrinology and Diabetology - ??*
** Dermatology – due to conversion of new out-patient capacity to review out-patient capacity for governance concerns*
** Thoracic Medicine – annual leave*
** Gynaecology – associated with Dr Morsy and his replacement cover*
** Urodynamics (Gynaecology) – associated with lack of demand*

In-Patients/Day Cases:
** Cancellations of elective activity associated with unscheduled care pressures*

	Apr-16		May-16		Jun-16		Jul-16		Aug-16		Total
	IP	DC	IP	DC	IP	DC	IP	DC	IP	DC	
ENT	6	2	5	3	10	16	0	0	0	0	**42**
Urology	19	0	5	0	7	7	0	0	0	0	**38**
G Surg	0	1	6	2	28	15	0	0	0	0	**52**
Ortho	27	17	7	11	12	4	2	13	6	6	**105**
Gynae	9	0	6	1	5	0	0	0	0	0	**21**
Total	**61**	**20**	**29**	**17**	**62**	**42**	**2**	**13**	**6**	**6**	**258**

** General Surgery – change in casemix; loss of high volume low value procedures ie. Minor Ops and Robin Brown's flexible cystoscopies – new SBA proposal sent to Commissioner*
** Breast – associated with medical workforce issues*
** ENT – impact of cancellations from bed pressures*
** Gynaecology – change in casemix – new SBA proposal sent to Commissioner*

- Q1/2 Allocations (£700,000)
-

** No risk to underdelivery of £700,000*
** Any underutilisation / risk has been reallocated to other specialties to utilise*

- Diagnostics

** Neurophysiology – underperforming associated with demand*
** TTE – underperforming as SBA uplifted for investment and post only recently recruited to – also existing vacancy again only recruited to*

** CT Q1/2 OK*
** CTC awarded to 352 – date for completion extended*
** Plain Film – IS awarded and date for completion extended to mid-November*

- Endoscopy

** SBA recovery plan states will achieve -22% which equates to -1975*
** Lost 1 WTE for 2016/2017 (KB) equating to -1302*
** SBA uplifted in 2016/2017 for IPT investment – lost capacity from 1 x new Nurse Endoscopist on maternity leave*
** Endoscopy DC wait @ August 51-weeks – @ March 45-weeks*
** 1112 >9-weeks @ March – 972 >9-weeks @ August*
** 67 >26-weeks @ March – 355 >26-weeks @ August*

** Q1/2 allocations IHA overperforming – IS contract just awarded*

** Demand reviewed with HSCB on 5 August – current additionality will not return to normal*

** Would require an additional 2846 scopes along with 100% SBA and IHA/IS allocation to achieve 9-weeks routine; 6-weeks urgent; red flag 14-days; urgent planned repeat on time; routine planned repeat 6-months beyond*

** IS tested for capacity – contract awarded to one provider and available additional capacity from this provider and a second provider – could utilise subject to funding*

AHP
** Formal response letter submitted*
** Demography committed to gaps*
** Recruitment proceeding – anticipate posts in place February or earlier if Regional waiting lists still in place*
** Inability to clear backlog*

** SBA collectively on-track, however, Physiotherapy only profession underperforming – issues around vacancies*

- Unscheduled care

  - Resilience plan update from Trust

(slides attached from B Conway presentation to S \McGirr)
Risks /Points to highlight:
** Demand management / SLCG review and ongoing need to develop alternative pathways*
** Focus on ED paeds and older people*
** Focus on creating assessment capacity in short medium and longer term; however interim need for additional bed capacity*
** Workforce/ability to create surge capacity (medical staffing additionality essential)*
** Reduced flexible bed capacity with decant works in DHH/DHH issues*
** Ongoing community issues (stability of social care sector)*

- Cancer services

Breast
Heather to provide brief update on
- support from other Trusts/number of patients transferred
- Update on plan for non-urgent patients
- Number of routines and max wait time

** Routines anticipated to be waiting 37-weeks at the end of September*
** 774 over 9-weeks at the end of August with longest wait 35-weeks*

Red flags & urgents back to 14 – 16 days currently: back to 100% October
** Trust has secured a level of additional capacity from other Trusts to provide support to this service area during the Summer period.*
** More formal networking arrangements are required to manage this service in the medium term.*

** A scoping exercise is being undertaken with GP colleagues establish if they can provide additional capacity from GPs with Specialist Interest in the management of routine patients. Results from this exercise are awaited.*
** An Expression of Interest is being drafted to test the Independent Sector market for availability of breast assessment capacity.*

- Mental health and learning disability services

9 weeks to access Adult Mental Health Services

**** The number of patients waiting in excess of 9-weeks continues to demonstrate an increase. Volumes in excess of 9-weeks has increased by 241% from end of March to end of August 2016.***
**** The service have evidenced an increase in demand, 10% cumulatively, over the last 3-years. This increased demand, compounded by vacancies, is demonstrated in the growing volume of patients waiting in excess of 9-weeks.***
**** Realignment of Consultant Psychiatrists and Psychology has the potential to increase practitioner workload and reduce time available to triage***

Actions -
• IS provider capacity has been increased from 60 to 100 per month for Step 2 referrals.
• On-going recruitment to permanent/temporary and bank for PMHC along with internal expressions of interest for additional hours.
• Analysis of referrals accepted to PMHC and finalisation of Urgent criteria.
• Development of triage and assessment centre model on-going (anticipated late 2016).
• Roll-out of 'Talking Therapies Hubs' to all localities, subject to receipt of additional funding (anticipated in 2017).

** 81 patients >9-weeks @ March – 276 >9-weeks @ August*
** longest wait 32-weeks @ March (IS) – 20-weeks @ August*

Update provided by Bryce for previous meeting.
For the past 3 years the Directorate has repeatedly referenced in the Trust TDP that achieving this target would only be possible if there was no surge in demand and/or a loss of capacity to meet demand.
During the 3rd quarter of 15/16 the service experienced a surge in demand by 20% compared to the same period in the previous year, combined with a loss of capacity through an increased number of practitioners on long-term sick leave.
The division focused on meeting all urgent referrals and in doing so this extended the waiting times for routine referrals beyond the 9 week target. There is also a direct correlation between extended waiting times and a subsequent increase in urgent referrals, as some GP's attempt to circumvent waiting times greater than 9 weeks.

The division has worked hard to address the waiting time issue by:

- *Diverting agreed referrals to an independent sector provider (note contract procured and awarded to Praxis – although currently in formal performance management procedures to address underperformance)*

- *Additional clinics – small in number and having only a minimal impact*
- *Ongoing audit of DNA rates with systemic and practitioner level initiatives to reduce DNA rates and increase capacity lost.*

The situation is improving although the Division recognises that the volatile relationship between demand and capacity can combine to extend the waiting times at any point during the year.

Psychological Therapies – 13 week Target

Has improved but waiting times are likely to increase again given the number of vacant psychology posts and the difficulties associated with recruiting and retaining staff. The division will take forward plans to realign the remaining psychology staff and focus this measure on those most in need.

** 10 patients >9-weeks @ March – 83 >9-weeks @ August*
** Longest wait 21-weeks @ March – 34-weeks @ August*

4. *Serious Adverse Incidents – Outstanding Review Reports*

Update for HSCB Board Directors Meeting (Margaret Marsall

Outstanding SAI Reports (Slide 21 of HSCB presentation)

*Updated position for outstanding SAI Reports shows an improvement from **44** (reported in information received from HSCB) reviews to **28** outstanding as of 20th September 2016.*

Present Position

	HSCB Report	*New Position 21/09/16*	*Acute Outstanding*	*CYP Outstanding*	*MHLD Outstanding*
Level 1	*24*	*16*	*12*	*3*	*1*
Level 2	*20*	*12*	*7*	*2*	*3*
TOTAL	*44*	*28*	*19*	*5*	*4*

Please see attached updated position for SAI Reports which shows a decrease from 44 as per HSCB position at 31/7/16 to 28 as of today 20/9/16

Improvement Plan

Increased focus on strengthening our response to Adverse Incidents

A key element of the Trust's clinical and social care governance work programme for 2016/17 is to review how adverse incidents are managed to identify how we can further develop and strengthen a culture of safety within the Trust
In order to do this we need to promote and build on the fundamental purpose of patient safety investigation, which is to learn and improve. This work will provide a foundation for continuous improvement in the way we identify, investigate and learn from adverse incidents in order to minimise avoidable harm in the future.

Key areas of work

- *Incident screening and apportioning of investigation resources*

- *Recommendations and Action Planning following Adverse Incident investigations*
- *Communicating Learning from Adverse Incidents*
- *Challenge and scrutiny of the Adverse Incident Process*

The Trust are also sharing this work regionally through the Quality 2020 work streams

Regional Work streams

The Trust are also contributing to a range of regional projects to improve on our management and response to SAI's.

- *RQIA/GAIN learning from SAI's*
- *Quality 2020 work streams – BHSCT work*
- *Regional Governance Leads Forum*

Successful changes in approaches which will positively impact on our responsiveness and timescales for completion of reports

- *Introduction of Child Death process*
- *Introduction of Regional MM process*
- *Falls review process*
- *Trust Training programme in place for staff – SAI investigations/incident investigations*

5. Update on TDP

(Aldrina as per letter to DS attached)

6. Service delivery risks (if not picked up on agenda)

- *Corporate/Cross Directorate*
  - *On-going workforce issues affecting range of services – specific any individual issues to be raised*
  - *IS regulated social care services*
    - *On-going challenges/performance management issue with IS regulated social care capacity.*
    - *Stability of sector/ability to meet unscheduled care demands*
  - *Capital Planning; thresholds /timing and impact on PALS performance*

- *Directorate specific challenges*
  - *Acute Services*
    - *Endoscopy demand; inability to reduce access times*
    - *Radiology workforce/reporting capacity; impact on reporting/scanning and impact in period of unscheduled care*
    - *Breast services; access times and current arrangements/management of risk*
  - *Older people and primary care*
    - *GP Out of Hours*

7. Reform and modernisation

(Aldrina – update on pathway reform)

8. AOB

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

FRIDAY 24 JUNE 2016

11.00am – 1.00pm

Conference Room 3, 2nd Floor, HSCB, Linenhall Street

AGENDA

1. Welcome and introductions

2. Overview of 2016/17 performance meetings

3. 2016/17 CPD standards/targets – Reference Trust Board Monthly Performance Report for May (to follow)

- Elective care (Esther)

(SBA performance year end report attached – SBA improvement plans all submitted only risk is with delivery of General Surgery IP/DC which will not return to profile – work ongoing to review this position)

SBA - Any emergent issues associated with manpower will be escalated at end of quarter 1)

£700k non recurrent investment for long waits/safety issues in place and ongoing; non-recurrent also in place for Endoscsopy (Trust formally assessing max levels it can deliver and will respond formally) and diagnostics

- Unscheduled care (Esther)

4-hour/12 hour position

- Cancer services (Esther)

14 –day breast/31/62 day position

- Mental health and learning disability services (Lesley) –

Reference brief from Bryce McMurray (attached)

- HCAI (Richard)

4. Children's services

- Unallocated cases (Lesley) _

Reference Update from Paul Morgan copy of our internal Unallocated Cases report for May 16 which goes to Trust Board. As you will see:-

5. Service delivery risks

- GP OOH (Angela) – Brief attached as per Health Committee
- Manpower (Aldrina /Richard/Angela) brief attached as per Health Committee
- Daisy Hill – Richard (brief attached as per Health Committee)

6. Reform and modernisation

- Unscheduled Care (Aldrina)

7. AOB

Performance meeting – Agenda item 3 (mental Health)

Performance – Mental Health & Disability – June 2016

1. 9 weeks to access Adult Mental Health Services - RED

For the past 3 years the Directorate has repeatedly referenced in the Trust TDP that achieving this target would only be possible if there was no surge in demand and/or a loss of capacity to meet demand.
During the 3rd quarter of 15/16 the service experienced a surge in demand by 20% compared to the same period in the previous year, combined with a loss of capacity through an increased number of practitioners on long-term sick leave.
The division focused on meeting all urgent referrals and in doing so this extended the waiting times for routine referrals beyond the 9 week target. There is also a direct correlation between extended waiting times and a subsequent increase in urgent referrals, as some GP's attempt to circumvent waiting times greater than 9 weeks.

The division has worked hard to address the waiting time issue by:

- Diverting agreed referrals to an independent sector provider (note contract procured and awarded to Praxis – although currently in formal performance management procedures to address underperformance)
- Additional clinics – small in number and having only a minimal impact
- Ongoing audit of DNA rates with systemic and practitioner level initiatives to reduce DNA rates and increase capacity lost.

The situation is improving although the Division recognises that the volatile relationship between demand and capacity can combine to extend the waiting times at any point during the year.

2. Psychological Therapies – 13 week Target – RED
Has improved but waiting times are likely to increase again given the number of vacant psychology posts and the difficulties associated with recruiting and retaining staff. The division will take forward plans to realign the remaining psychology staff and focus this measure on those most in need.

3. Dementia Services - RED
Current revisions to screening clinics are having a positive impact on waiting times with a projected return to the 9 week target in the next few months. Additional Psychiatrist of Age will complete a number of additional clinics commencing September which will aid the current situation.

4. Carers Assessments - AMBER
Mental Health Services secured additional funding for carers short breaks from the SLCG in 2015/16. An administrative access process was put in place which was underpinned by the submission of completed carers assessments. During 2015/16 ad additional 221 short breaks for carers were funded. Further work is required to ensure that credit for all of this additional work and performance is captured in the appropriate performance reports

5. Direct Payments - AMBER
Direct Payments in MHD has remained relatively static. Population in MHD is also relatively static.

6. Patient Discharge - Learning Disability – AMBER / Mental Health GREEN

There continues to be a consistently small number of delayed discharges from acute mental health and learning disability impatient services. While progress for individuals is made, a new population continues to emerge.

The main issue remains a constant throughout, in that there remains a dearth of appropriately supported community accommodation that can care for the complexity of need, especially in relation to behaviours that challenge services. The Directorate continues to work with the independent sector to provide for this client group, although progress can be slow. It should be noted that the Southern Trust no longer has access to long-stay hospital provision.

Agenda item 4 (childrens)

Reference Unallocated cases report attached

- We have consistently been below the regional average over the last 6 months.
- We have no unallocated child protection cases
- All child protection referrals are seen and spoken to within 24 hours (the Regionally agreed timescale)
- We have a clear pathway for referrals and allocation, that we constantly review and refine (eg applying GAIN Audit/Methodology)
- We have robust monitoring and review systems in place at Team Manager, Head of Service and AD level. Also regular scrutiny at Trust Board.
- Our longest waiting was 22 weeks for March; 25 weeks for April and under 20 weeks for May 16. Again this is favourable for the region, with the exception of WT and NT (18 & 15 weeks).

Agenda Item 5

Service pressures/issues –

The Southern Trust's key challenges in 2016/17

1. Workforce
    a. Medical
    b. Nursing
    c. Other staff groups
2. GPOOH
3. Elective Care / Access
4. Unscheduled Care Demand

1a .Medical Workforce – Recruitment Difficulties

The Southern Trust is experiencing difficulties with service provision in a number of 'hard to fill' specialties, especially at consultant and middle grade level. Some of these specialties now appear in the Government's UK shortage occupation list.

In addition, the Northern Ireland Medical and Dental Agency (NIMDTA) have notified that there is likely to be a significant number of unfilled junior doctor posts in core medicine from August 2016. Following round 1 recruitment, there are currently two vacant posts in Craigavon and two vacant posts in Daisy Hill in core medicine.

The following specialties are currently presenting significant challenges for the Trust in terms of medical vacancies:

- Dermatology – NI has a relatively small number of Dermatology training posts and consequently this leads to a small number of trainees coming through for consultant posts.

- Consultants & Specialty Doctors in Emergency Medicine - significant difficulties recruiting to Emergency Medicine – particularly for Daisy Hill. During 2015, the Trust advertised on four occasions for Consultants and on nine occasions for SAS doctors. Three SAS doctors were appointed, however one of the doctors has since resigned and another is not able to take up post until she completes her training in August 2016. There have been a number of resignations from senior staff in Emergency Medicine since the beginning of 2016. Four consultants have resigned. This includes the Associate Medical Director, the Clinical Director and the Lead Consultant in Daisy Hill. A permanent Specialty Doctor has also resigned in Daisy Hill. More recently we have managed to successfully appoint three consultants; however two of the consultants were not willing to commit to Daisy Hill, due to the lack of SAS (middle grade) support. They have since accepted posts in CAH. The third consultant is unable to take up post until October/ November 2016.

- Consultant Radiologists – The gap in Consultant Radiologist numbers is now included in the Government's shortage occupation list. A regional recruitment initiative is currently under way to try to attract Consultant Radiologists. The Trust has actively pursued recruitment and has successfully appointed a number of Consultant Radiologists in recent years. However, some have since left to take up posts in other Trusts. The situation remains unstable, mainly because all Trusts are competing against each other for a relatively small number of eligible doctors

The Trust is currently engaged with A-Team Healthcare Recruitment Ltd in a campaign to source European Doctors for a number of hard to fill specialties including Emergency Medicine. In addition, the Trust also committed to a recruitment campaign during 2015 with medical recruitment specialists in England who undertake recruitment project work for NHS Trusts and Health Boards on behalf of Doctors.net.uk. This was unsuccessful in securing additional appointments.

1b. Nursing Workforce – Recruitment Difficulties

In line with the UK wide shortage of registered nurses there are currently approximately 98 vacant posts (*across all branches of nursing*) remaining unfilled within the Southern Trust. The area with the highest shortage is in Adult Nursing as shown below:

- 55 vacant posts in adult nursing (35 Non-acute, 13 Acute medicine, 5 surgery, 2 ATICS)
- 11 vacant posts in childrens nursing
- 31 vacant posts in Mental Health and
- 1 vacant post in Learning Disability services

In addition to permanent vacancies, the Trust has experienced significant difficulty in securing additional flexible 'temporary' staff to support period of peak pressures including additional bed capacity and cover for temporary vacancies.

The Trust welcomes the announcement of additional pre-registration places however, given the scale of vacancies across the region, this number falls well short of required numbers ,with global shortage expected to peak in 2020.

During 2016/17, the Trust will be taking forward an increase in nurse training numbers via Open University to 23. The Trust has also progressed a range of innovative approaches to recruitment including a radio/online/social media/universities advertising campaign, one- stop recruitment days, and the Trust is leading the region in local, regional and national recruitment activities and is actively involved in work to progress International nurse recruitment. Whilst, significant progress (c. 40 posts) has been made in respect of international recruitment, it is likely to be 9-11months before any additional nursing staff will be in place.

The Trust also has a problem with availability of specialist nurses eg Parkinson's, Heart Failure and Palliative care etc. There are workforce issues around lead in training time, and problems with backfill difficulties, particularly for sole postholders.

1c. Other Workforce Challenges

- Mental Health services continue to face challenges linked to the availability of trained adult mental health nurses & also qualified Clinical Psychologists. Insufficient numbers of specialist staff are being trained annually and Trusts are competing to offer posts.
- Geriatric Medicine: shortage of Consultant Geriatric Medical staff; impacting Acute Care at Home
- Domiciliary Care Service: need to recruit 120 new staff each year to replace leavers.
- Day Care (MH & LD): 25 vacancies across the Trust, recent advertisements have been unsuccessful.

2. GP Out of Hours

GPs employed in the service work during the day in local GP practices where there is already a shortage. There is no contractual obligation to work within GPOOHs. Aligned with active promotion via social media of the 'Choose Well' campaign, the Trust has in place a GPOOH Action Plan to address challenges within this service and has included for example:

- Offering GPs additional flexibility in shifts/ bases of work
- Worked with HSCB to develop a LES for GPOOH
- Implementation of a 'Home Triage' pilot
- Utilisation of Nurse Triage and Nurse Practitioners in OOH including contracting with Dalraida to triage between 6pm and 8am
- Implementing additional cover (3rd red eye shift) Dec 15- End of April during peak periods over weekends to Monday
- Use of clinical pharmacists in the OOH
- Development of additional payments scheme

The main issues contributing to the difficulties in securing medical cover include:

- Training of GPs – 100 need to be trained annually to fill the vacancies in general practice. Currently maximum of 65 completing training and high levels opting for P/T working
- Recruitment of new GPs to OOH – From Jan 16, 3 new GPs however, others reducing their shifts
- Maternity/ sick/career breaks/ resignations - Small pool of hard working GPs significant difficulty providing cover. Sick leave and 2 GPs taking career breaks impacting on 'red eye' shift

- Indemnity costs – increased costs a disincentive to work over the hours agreed with the medical defence organisations
- Take home pay - GPs claim this is reduced due to indemnity, higher superannuation and loss of tax free allowances
- Day time GP role – increasing demand for GPs in hours

Any reduction in service cover has potential to increase risk and increase numbers of people choosing to attend Emergency Departments.

3.Elective Care/ Access:

Regional estimates indicate an increase in elective referrals of 6% year on year. In the context of on-going financial constraints the Southern Trust will experience significant challenges in delivering elective access targets. Key challenges include:

- Demand exceeding commissioned
- Recurrent investment insufficient to address capacity gap
- Limited non-recurrent funding will mean there is likely to be significant additional capacity provided this year.

The Trust will continue to take the following actions to manage lists:

- Monitoring access for red flag and urgent cases and prioritising capacity to meet this demand
- Strict chronological management of routine patients
- Actively working to limit lost capacity through DNAs or cancellations on the day
- Monthly information provided to GPs on waiting time for specialties.

4. Unscheduled Care Demand

The Trust experienced an increase of over 10% in ED attendances in the 5 years prior to 2015/16. In addition, there were 6,000+ additional attendances in 15/16 from 14/15 representing an overall increase of 4%. Of these attendances, 81% were triaged as Category 1 – 3 (Immediate, very urgent or urgent).

This increased demand and overreliance on hospital services had resulted in 'winter' pressures now being experienced as sustained peak pressures throughout the year with no flexible bed capacity and / or available workforce to respond. 2016/17 Southern Trust will be increasingly challenged in respect of achieving effective patient flow. May 2016 has seen the highest ED attendances from April 2015 across Craigvon and Daisy Hill ED and South Tyrone MIU.

Key challenges include:

- The Trust has low bed flexibility/ tolerance levels and needs to ensure the level of discharges is in balance with admissions.

- Quality and Safety concerns - on- going requirement to manage governance and patient experience issues re: outliers etc
- Inability to open additional bed capacity due to manpower constraints.
- Requirement to continue to maintain contingency options to flex existing bed stock with subsequent impact on elective care /cancellations.
- Reduction in community capacity to enable effective discharge particularly in rural areas e.g. Domiciliary care and nursing home care providers and capacity for specific beds e.g. EMI.

DHH Strategic Oversight Group

Summary of Key Points (June 2016)

Context:

A Senior Trust Oversight Group is in place to monitor USC pressures especially relating to senior medical cover in DHH ED, DHH Medicine and DHH Surgery

Medical staffing levels:

- Operational ED medical staffing levels in CAH and DHH are well in excess of funded staff levels
- Operational ED Consultant numbers fall well short of College of Emergency Medicine guidelines
- Information in PHA Emergency Medicine workforce document shows an inequitable share of medical staffing across Trusts with Southern having the fewest

Recruitment difficulties:

- Despite numerous trawls we struggle to secure appointments at consultant and middle grade level in ED and other specialties
- A Team project will help produce some doctors at 'SHO' level but this will not help with senior cover in any of the key specialties

Locum expenditure:

- Due to underlying problem with staffing levels and problems with recruiting, there is an increasing reliance on locum cover at all levels
- The expenditure on ED locums has almost doubled in 2015/16 to £2.3m across CAH and DHH
- This is unsustainable

College standards for cover during OOHs period

- Various college standards cite the need for senior cover (ST3 or above) during the out of hours period
- Trust are currently unable to meet this standard in DHH ED and only partially meet this standard in Medical and Surgery in DHH

Unscheduled Care Briefing **–** Southern Area 2015/16

Key Points:

- Demography – growth 10% higher than NI average, Growth in older people population
- Trust has optimised efficiency performance - CHKS 'top 40', triage performance, low ED conversion, lower ALOS etc.
- GPOOH – significant workforce pressures/ RQIA quality and safety
- Emergency admissions (>75 yrs) increased by 14% from 2013/14 to 2014/15 - has remained static this past year in 2015/16 – *potential impact of AC@H re: admission avoidance/ capacity c. proxy one acute ward.*
- 4 hour target: 80.1% in 2015/16. April 16 (CAH 69%, DHH 77%), May 16 (CAH 67%, DHH 75%)
- 60% of attendances triaged as Category 1-3 (immediate, very urgent or urgent)
- Increasing trend since January in ED attendances with increased peaks in consecutive days with volumes outside the normal levels for same period in previous years
- 12 hours target: 93 in 2015/16. April 16: 83 (CAH 77/DHH 5. The Daily SitRep Report indicated that the position regionally varied by site ranging from +30 - +160 during April). May16: 56 (CAH 53, DHH 3).
- May 2016 saw highest ED attendances over the past 14months (from April 2015) in all our sites: (CAH – 7305, DHH 4923, STH MIU – 2706)
- Bed State – by HSCB/ Alamac indicated - 20 beds capacity gap. This reflects low bed flexibility/ tolerance and need to ensure level of discharges in balance with admissions. In addition, requirement to maintain quality and safety standards further impacting on need to ensure IPC, lysis and T&O c. 6 + beds.
- Quality and Safety concerns - on- going requirement to manage governance and patient experience issues re: outliers, use of inappropriate beds versus 12 hour target.
- Inability to open additional bed capacity due to manpower constraints. Trust continues to maintain contingency options to flex existing bed stock with impact on elective care – theatre/ recovery. Elective cancellations continued in April (83 cases), May (47 cases).
- Reduction in community capacity - Domiciliary care provider and Nursing home care– capacity and cost pressures in this sector. Net loss of 26 beds from 4 Seasons closure of Donaghcloney PNH, capacity for bed requirements – EMI beds
- General increase in weekly charges levied by PNH that are above the regional tariff. Requiring 3rd party arrangements

DHH

- DHH ED seeing 50,069 New/Unplanned attendances (up 10%) with 11,228 non-elective admissions (via ED and direct)
- Conversion to admission continues to be good – 18%
- DHH ED seeing increasing number of patients being referred by GPs with a letter – 5,444 (up 17%)
- DHH ED are seeing increased numbers referred by GP OOH Service – 1,229 (up 17%)
- Direct admissions to DHH have reduced significantly as activity has increased. This is due to high occupancy and means patients therefore have to attend ED
- DHH ED seeing increased numbers from SET catchment – for example numbers from Down LGD have doubled to 2,016. This can be tracked to service change in Down and Lagan valley EDs
- ROI attendances to DHH and CAH EDs are not increasing

CAH

- CAH ED seeing 81,005 new/unplanned attendances (up 4.5%) with 23,528 non-elective admissions (via ED and direct)
- Conversion to admission continues to be good – 24%
- CAH ED seeing large numbers referred by GP with letter – 11,383
- CAH ED are seeing increased numbers referred by GP OOH Service – 3,851 (up 5%)
- CAH ED seeing large number of patients brought by police / prison staff – 391 (up 50%)
- CAH ED seeing large numbers from Northern Trust – 4,638

Previous actions to address pressures / mitigate risk:

Oversight group involving PHA/HSCB/LCG agreed a range of actions to address pressures and mitigate risk as follows:

- Additional ENPs in DHH ED
- Moving towards 24*7 band 6 cover in DHH ED
- Establishment of small number of observation beds in DHH (surgery) for borderline admissions including non-specific abdominal pain
- Ongoing trawls for middle grade and consultant appointments for DHH ED
- Ongoing trawls for middle grades for DHH Medicine and DHH Surgery
- Acceptance that there would be a significant reliance on locums in the interim
- Review of further elective activity in CAH that could move to DHH
- Contingency planning in the event that cover cannot be sourced for DHH ED

Unscheduled Care Reform:

- USC Regional/ Locality structures put in place. Operational Improvement Group – Trust level specifically focused on patient flow. Key workstreams:
    - Community Pathways – GPOOH, AC@H , Rapid Assessment models and NIAS Alternative pathways
    - ED – Ambulatory services, senior decision making and flow/ communications within ED,
    - Patient Flow – ward based management of flow re: medical / MD fit, discharge planning and implementation of SAFER bundle, Daily assessment (red / green days re: patient journey), discharge to assess, ward based pharmacy.
    - Technology – maximising use of flow, IMMIX, clinical noting, Directory of Services (launch 20th June)
    - Medical Handover process
    - Bed Modelling – across acute , sub-acute, and virtual (AC@H) hospitals,
- Key analysis through locality network being undertaken to review activity over the past years – this is looking at data for acute, community and primary care. This will confirm where the pressure points are and support action planning

In summary:

Despite all efforts to date, the Trust continues to be extremely concerned with cover in DHH ED and on-going increase in USC pressures across the system.

This is further compounded by the significant increase in activity going to DHH ED.

Quality/Safety/Finance – note: 'winter' beds remain open (no funding source) as at 14th June 2016.

GP Out of Hours Summary Overview Report

GP OOH – Contacts April 2014 – March 2016

Ended at	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Total
Home	618	601	465	523	551	498	455	546	524	574	545	496	**6396**
Base	4195	4126	3162	3194	3041	2974	3276	3818	4005	3588	3073	3218	**41670**
Advice	4811	4536	4041	3868	3881	3280	3375	3902	4917	4521	4306	4525	**49963**
Total	**9624**	**9263**	**7668**	**7585**	**7473**	**6752**	**7106**	**8266**	**9446**	**8683**	**7924**	**8239**	**98029**

Ended at	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total
Home	429	479	401	450	429	385	467	411	491	494	291	423	**5150**
Base	3057	3539	2660	2838	2695	2688	2888	3122	3469	3353	2664	3292	**36265**
Advice	4421	4851	3800	3822	4082	3393	4176	4310	5170	5327	4501	5683	**53536**
Total	**7907**	**8869**	**6861**	**7110**	**7206**	**6466**	**7531**	**7843**	**9130**	**9174**	**7456**	**9398**	**94951**

GP OOH Vacant Shift Report January – May 2016

	Jan-16		Feb-16		Mar-16		Apr-16		May-16	
Base	***Vacant Shifts***	***Vacant Hrs***	***Vacant Shifts***	***Vacant Hrs***	***Vacant Shifts***	***Vacant Hrs***	***Vacant Shifts***	***Vacant Hrs***	***Vacant Shifts***	***Vacant Hrs***
Armagh	34	144	57	245	24	102	22	92	20	87
Craigavon	48	247	74	374	63	329	35	184	28	145
Dungannon	57	307	85	424	55	302	23	118	38	197
Newry	48	238.5	57	292	39	197	35	187	35	181
Kilkeel	22	66	27	82	28	84	26	79	26	80
Total	209	1002.5	300	1417	209	1014	141	660	147	690
	Shifts	**Hours**	**Shifts**	**Hours**	**Shifts**	**Hours**	**Shifts**	**Hours**	**Shifts**	**Hours**
Total Available	645	3370	608	3107	622	3219	535	2824	561	2990
% Vacant	32%	30%	49%	46%	34%	32%	26%	23%	26%	23%
% Filled	68%	70%	51%	54%	66%	68%	74%	77%	74%	77%

Workforce Overview Report

Flexible Workforce – Overtime, Bank, Agency & Locum

Comparison of 2011/12, 2012/13, 2013/14 and 2014/15 Staff Levels (WTE), Overtime, Bank, Agency and Locum Costs and 2015/16 Costs to Date as % of YTD Total Salary Bill

Staff Levels WTE (HRMS/HRPTS) and Costs (£)	HRMS WTE		HRPTS WTE			Variance Staff WTE March 2012 and Current Month	Monthly Average Flexible Workforce Costs						2015/16 Costs to date as % of YTD Total Salary Bill
	Baseline Position				2015/16 to date as at 29 February 2016		2011/12	2012/13	2013/14	2014/15	2015/16	2011/12 Baseline & 2015/16 YTD Variance	
	Mar-12	Mar-13	Mar-14	Mar-15									
Staff Levels WTE (HRMS/HRPTS)	7,712.59	7,908.82	7,830.25	8,040.02	8,332.82	620.23							
Overtime Cost (£)	£2,378,447	£2,742,442	£2,405,219	£2,418,263	£2,658,221		£198,204	£228,537	£200,435	£201,522	£241,656	£43,453	0.81%
Bank Cost (£)	£7,988,757	£9,427,543	£10,316,793	£8,880,496	£8,524,348		£665,730	£785,629	£859,733	£740,041	£774,941	£109,211	2.59%
Agency Cost (£) (including M&D Agency Costs)	£4,951,745	£9,232,951	£8,244,487	£7,805,354	£10,383,243		£412,645	£769,413	£687,041	£650,446	£943,931	£531,286	3.16%
Locum Cost (£) (M&D Locum Staff employed by SHSCT)	£395,736	£428,785	£444,839	£664,870	£797,737		£32,978	£35,732	£37,070	£55,406	£72,522	£39,544	0.24%
Total Costs	**£15,714,685**	**£21,831,721**	**£21,411,338**	**£19,768,983**	**£22,363,549**		**£1,309,557**	**£1,819,310**	**£1,784,278**	**£1,647,415**	**£2,033,050**	**£723,493**	**6.81%**

SHSCT WTE Staff in Post Baseline Figures for March 2012, 2013, 2014, 2015 and 2016 Variance Information

Personnel Area	WTE as at:					Variance Between:								WTE of Personnel Area as a % of Total Staff as at March 16
						Mar 12 & Mar 16		Mar 13 & Mar 16		Mar 14 & Mar 16		Mar 15 & Mar 16		
	Mar 12	Mar 13	Mar 14	Mar 15	Mar 16	WTE	%	WTE	%	WTE	%	WTE	%	
Admin & Clerical	1,382.55	1,465.40	1,426.40	1,424.53	1,476.86	94.31	6.82%	11.46	0.78%	50.46	3.54%	52.33	3.67%	17.7%
Estates	106.04	98.26	97.43	101.43	105.36	-0.68	-0.64%	7.10	7.23%	7.93	8.14%	3.93	3.88%	1.3%
Support Services	703.82	671.26	623.10	595.52	563.06	-140.76	-20.00%	-108.20	-16.12%	-60.04	-9.64%	-32.46	-5.45%	6.7%
Nursing & Midwifery	2,890.22	2,995.90	2,941.18	3,089.65	3,222.28	332.06	11.49%	226.38	7.56%	281.10	9.56%	132.63	4.29%	38.6%
Social Services	1,089.24	1,083.93	1,110.42	1,164.58	1,257.23	167.99	15.42%	173.30	15.99%	146.81	13.22%	92.65	7.96%	15.1%
Professional & Technical	1,025.77	1,071.67	1,107.10	1,110.23	1,159.31	133.54	13.02%	87.64	8.18%	52.21	4.72%	49.08	4.42%	13.9%
Medical & Dental	514.95	522.40	524.63	554.09	561.81	46.86	9.10%	39.41	7.54%	37.18	7.09%	7.72	1.39%	6.7%
Total:	**7,712.59**	**7,908.82**	**7,830.25**	**8,040.02**	**8,345.91**	**633.32**	**8.21%**	**437.09**	**5.53%**	**515.66**	**6.59%**	**305.89**	**3.80%**	**100.0%**

Medical Workforce – Specific Detail

- Difficulties with service provision in a number of 'hard to fill' specialties, especially at consultant and middle grade level. Some of these specialties now appear in the Government's UK shortage occupation list.
- Northern Ireland Medical and Dental Agency (NIMDTA) notification that there is likely to be a significant number of unfilled junior doctor posts in core medicine from August 2016. Following round 1 recruitment, there are currently two vacant posts in Craigavon and two vacant posts in Daisy Hill in core medicine. NIMDTA have still to undertake CT1-2 LAT interviews and complete the 'combined specialty training' option, however it is understood that numbers are small so this is unlikely to have a significant impact on vacancies.
- The following specialialites are currently presenting significant challenges for the Trust in terms of vacancies:

Consultant Dermatologists

- A meeting with the HSCB commissioners is being planned to review the Dermatology service
- Recognised shortage of trained Dermatology Consultants in the UK. NI has a relatively small number of Dermatology training posts and consequently this leads to a small number of trainees coming through for consultant posts. One trainee recently achieved CCT; however she has since taken up a post in the Belfast Trust.
- Dermatology trainees have not been required to rotate through SHSCT as part of their training, so local trainees are more inclined to take up posts in Belfast where they are more familiar. It has now been agreed that one registrar will rotate to Craigavon every Thursday, so this should help.
- Two retired consultants continue to undertake some waiting list initiative clinics for Dermatology. There has also been an expansion in nurse led clinics in Dermatology.
- Trust advertised for Consultant Dermatologists on 4 occasions during 2014. One person applied to the first advert. This doctor was offered the post but declined. No further adverts were raised during 2015 on the advice of management in Dermatology as there were no suitable doctors available at the time.

Consultants & Specialty Doctors in Emergency Medicine

- Significant difficulties recruiting to Emergency Medicine – particularly for Daisy Hill. During 2015, the Trust advertised on four occasions for Consultants and on nine occasions for SAS doctors. These posts were based in Daisy Hill or there was a requirement to rotate to Daisy Hill as part of the job plan. There were no consultants appointed. Three SAS doctors were appointed, however one of the doctors has since resigned and another is not able to take up post until she completes her training in August 2016
- Many of the above adverts were placed in the Sunday Independent and the Irish Medical Journal in the Republic of Ireland, as well as the British Medical Journal and normal recruitment channels.
- There have been a number of resignations from senior staff in Emergency Medicine since the beginning of 2016. Four consultants have resigned. This includes the Associate Medical Director, the Clinical Director and the Lead Consultant in Daisy Hill. A permanent Specialty Doctor has also resigned in Daisy Hill.
- More recently we have managed to successfully appoint three consultants; however two of the consultants were not willing to commit to Daisy Hill, due to the lack of SAS (middle grade) support. They have since accepted posts in CAH. The third consultant is unable to take up post until October/ November 2016.
- The Trust is currently engaged with A-Team Healthcare Recruitment Ltd in a campaign to source European Doctors for a number of hard to fill specialties including Emergency Medicine.

- In addition to the recruitment campaigns detailed above, the Trust also committed to a recruitment campaign during 2015 with medical recruitment specialists in England who undertake recruitment project work for NHS Trusts and Health Boards on behalf of Doctors.net.uk. This campaign included targeted listings, display banner adverts and direct emails to doctors. Over 205,000 UK GMC registered doctors were members of Doctors.net.uk at the time and the company stated there were further connections to around 100,000 doctors across Europe. Only one doctor registered interest in a post in Daisy Hill, however the doctor subsequently withdrew.

Consultant Radiologists

- Gap in Consultant Radiologist numbers and Clinical radiology is now included in the Government's shortage occupation list. A regional recruitment initiative is currently under way to try to attract Consultant Radiologists
- Trust has successfully appointed a number of Consultant Radiologists in recent years; however some have since left to take up posts in other Trusts – mainly for personal reasons. In Feb 2015 the Trust appointed four permanent Consultant radiologists. One candidate withdrew, however the other three took up posts in August 2015.
- Four Consultant posts have recently been advertised – Breast Imaging (2 posts), Neuroradiology and Gastroenterology/Urology. Adverts closed on 17th May 2016. There is currently only one applicant. This is for the Neuroradiology post. Interview is scheduled for 27th June 2016.
- The situation remains unstable, mainly because all Trusts are competing against each other for a relatively small number of eligible doctors
- The Associate Medical Director post in radiology is currently vacant following the passing of Dr Hall.

Psychology

- There are current difficulties with maintaining and recruiting psychologists. Band 7 staff leave our services to uptake posts in other trusts where they can obtain higher banding. The Trust is looking at current structures to try to redress the balance and offer more career development and opportunity.

GP Out of Hours

- The Trust continues to experience significant difficulties with medical cover in its GP OOHs service – regional shortage of GP's for in hours, therefore impacting on numbers willing/available to work out of hours.

Geriatric Medicine

- Shortage of Consultant Geriatric Medical staff – will impact on initiatives such as Acute Care at Home.

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

TUESDAY 30 MAY 2017

2.00pm – 4.00pm

Conference Room 3/4, 2nd Floor, HSCB, Linenhall Street

DRAFT AGENDA – WITH TRUST PREP NOTES (INTERNAL USE)

1. **Welcome and introductions**

2. **Actions from last meeting (1.2.17)**

- *Additional information on CAMHS ID sent to Fionnuala McAndrew 1/May*

3. **2016/17 CPD standards/targets**
   - Elective care

IS and Elective additionality

- Wash through 15/16 – only remaining patients waiting in IS should be outpatient reviews. HoS chasing up close down of these – formal update requested from acute team: any remaining patients in IS from this period will be a financial risk for Trust in 17/18
- 16/17 – additional funding all utilised (not formally reconciled but no major risk identified)
- 17/18 - £375k allocated (372 scopes, 18,000 plain films, OP new and review) = no risk to spend before end of June
- Question – Are we getting £375k or similar level of elective additional non recurrent funding for Q2 – we need to be in the planning cycle for this now if we are to secure additional activity
- Elective Plan – how does a Q2 allocation sit with the elective plan
- Question – are we getting allocation for recurrent diagnostics – plain film reporting and ultrasound – will this be a full year allocation (some of these posts may already be approved and in the training programmes at risk – so need clarity)

Waits >52; need to ensure visiting services are removed from Trust waits in HSCB information (this was previously included)

	March 16	March 17	Variance
OP	756	2224	+ 1468 (+194% excluding visiting services ophthalmology etc – ICATS data not available for March)
IP/DC	446	1014	+568 (+127%)

Biggest growth areas

OUTPATIENTS (INCL. ICATS)	Mar-16	Mar-17	Variance
Endocrinology	122	162	+40
Gastroenterology	1	573	+572
General Surgery	3	249	+246
Neurology	39	501	+462
Ortho-Geriatrics	3	60	+57
Orthopaedics	54	161	+107
Rheumatology	129	321	+192
Urology	392	195	-197

Longest wait March 2016 72-weeks Endocrinology; March 2017 103-weeks Orthogeriatrics

IN-PATIENTS/DAY CASES	Mar-16	Mar-17	Variance
General Surgery	55	51	-4
Orthopaedics	98	342	+244
Pain Management	70	276	+206
Urology	223	343	+120

Longest wait March 2016 120-weeks Urology; March 2017 165-weeks Urology

SBA / Core performance

Improvement plan being progressed – should be submitted by Friday to target areas underperforming last year

SBA year end full report available

20170403_LIVE_
March 2017 Month En

Diagnostics

Waits over 26 weeks

March 16 - 118 (10 radiology, 41 cardiac investigations/urodynamics, 67 scopes)
March 17 - 634 (476 radiology; (330 CT 104 Dexa, 34 MRI); 84 cardiac investigations/urodynamics; 74 scopes)
Longest wait March 2016 67-weeks Urodynamics; March 2017 52-weeks CT Cardiac

Endoscopy

Waits over 9 and 26 weeks
March 16 over 9 = 718, over 27 = 67 longest wait 45 weeks
March 17 over 9 = 512 , over 26 = 74: longest wait 72 weeks

SBA - Endoscopy

March 16; total number seen 7255 in core, 1875 IHA, 582 IS (9692) (-8% on SBA total DC scopes including bowel screening and symptomatic)
March 17; total number seen 7068 in core, 1779 IHA, 795 in IS (9642) (-20% (-1816) on SBA total DC scopes including bowel screening and symptomatic

Point of note - Need to clarify we cannot accept an SBA uplift for 17/18 of 1125 and will be responding on this basis to request (investment made for staff, not G&S)

AHP –

Waits over 13 weeks
March 16 – 3469, March 17 – 5277 (March position reflecting a decreasing trend, from peak of 6068 in January with additional staff in post)

Unscheduled Care –

- ED 4-hour performance has remained relatively static in March and April, 74% and 73.4% respectively. Cumulative performance for 2016/2017 demonstrated 75.1% against the 4-hour OGI, which was 5% points below the cumulative performance for 2015/2016. However, this is set in the context of 2016/2017 attendances (166,232) 6% (8,838) higher than in 2015/2016 (157,394).
- ED attendances in March and April were significantly increased in comparison to February on CAH; DHH; and STH sites. 2016/2017 trend demonstrated an increase in attendances across all three sites in comparison to 2015/2016 with STH showing the largest increase: CAH +2.9% (+2,321); DHH +6.8% (+3,401); and STH +11.8% (+3,116).

- ED attendances in April 2017 have shown the highest level of attendances compared to April 2016 and April 2015. Total attendances, across the three sites, demonstrates a 5% year on year increase in April: April 2015 13,043; April 2016 13,708; and April 2018 14,327.
- In March 2017, 149 patients waited in excess of 12-hours reflecting a slightly deteriorate position to February 2017 (130). The Region demonstrated a total of 585 breaches of the 12-hour OGI, with the SHSCT accounting for 25% of this. April 2017 demonstrates a further deteriorated position of 222 breaches (no Regional information available).

Cancer Services –

Current performance:
PTL from 24 May 2017;
Longest active waits currently

- D277 (Urology 'look back' patient (bladder) – for MDM discussion 25 May)
- Total of 1 patients on pathway in excess of D85.
- Urology (14 patients) ranging from D277 to Day 87
- Breast D92 (waiting on vacuum biopsy – kit broken) – ? date not yet secured ? is there an alternative plan for this
- Initiative for ST to assist BT with nephrectomy patients (due to staffing issues) – ST has now 4 patients from SET transferred to ST for urology surgery (waiting between Day 272 – Day 100)

31-Day cumulative performance for 2016/2017 98.98%
62-Day cumulative performance for 2016/2017 84.2%

April breaches – longest wait – Urology 'look back' (prostate) – opened on CAPPS D238 and closed Day 317 (79-days)
D137 upper GI (days lost in first apt and pet scanner + complex pathway with 3 x MDM)

May breaches – longest wait confirmed to date – Day 147 Lower GI

Urology look back– all 19 patients completed; 4 confirmed cancers (1 bladder and 3 prostate) + patient zero (bladder). All being treated as individual SAI (Day of close:

Breast

Refer to HSCB regional discussion and current actions

See dashboard below

Mental Health and Learning Disability Services –

4. Champion Wards – update from Trust and discussion **(Esther to provide)**

5. Delivering Age Appropriate Care – admitting children <16 years to paediatric wards

(see attached previous correspondence sent in relation to this issue)

HSCB seeking a general update – LL has asked HSCB to confirm with Joanne McClean what is specifically required and we will provide a written update on this. Nothing as at 26/5

6. Reform and Modernisation

- Daisy Hill Hospital emergency services

7. Service Delivery Risks

Note – consider alerting risk around Radiology – plain film backlog

- *2 x plain film reporting contracts in place with is (RRO and Fourways)*
- *Lost capacity due to another contract ending(Medica) and timeline for re-procurement and consultant leaving Trust who did a high volume of IHA (Dr Menier).*
- *Plain film reporting now out 6-7 weeks wait (Heather Trouton to clarify if chests still within 28 days)*
- *Working with PALS for another IS provider; (some cost to be accrued in accessing a new framework)*

8. Potential GP Practice Closures – Trust's contingency plans **(Lesley obo Angela)**

9. AOB

- Dementia Services – Trust seeking some information on commissioning intent around <65 cohort in particular and update on regional pathway review

Week Ending	Total Breast Symptomatic Referrals received	2ww Referrals Received	New Patient Slots Availabile (per rota)	Patients Seen	Patients Sent to Other Trust	Patients refusing offer of transfer to other Trusts	Lost Slots	Reasons for Lost Slots	2ww %	2WW Patients on target	2ww Patients breaching target	Total 2ww Patients Seen	2ww Volumes on Waiting List with Date	2ww Volumes on Waiting List without Date	Total 2WW Volumes	2ww Longest Waiter at point of booking (in days)	Volumes on Routine Waiting List	Longest Routine Waiter (weeks waiting)	TOTAL Breast OP Waiting List Volumes
6/05/2017	61	39	32	32	0	0	52	17 - BH 10 - reductions 25 - 4th clinic	***30.0%***	9	21	30	44	176	220	35	1264	55	1484
3/05/2017	92	66	47	53	50	0	41	16 - temp reductions x 3 clinics 25 - 4th evening clinic	***17.3%***	9	43	52	35	205	240	35	1434	56	1674
0/05/2017	78	55	32	32	0	0	52	17 - BH 10 - reductions 25 - 4th clinic	***10.9%***	3	25	28	53	215	268	42	1243	56	1511

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 **Month No:** 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)

KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				March 2016		March 2017	CUMULATIVE ACTIVTY (INTERNALLY RE-DIRECTED RESOURCES) 2016-17
				APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	2015/16 SBA Position (for comparison) %	2015/16 SBA Position (for comparison) Variance	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	
100 In-Patient	1529	General Surgery (including Haematuria) IP	127	75	88	92	74	91	104	113	100	56	60	73	106	1032	1529	-497	-33%	-19%	-296	91 weeks	0
		Variance		-52	-39	-35	-53	-36	-23	-14	-27	-71	-67	-54	-21								
		Variance %		-41%	-31%	-28%	-42%	-29%	-18%	-11%	-22%	-56%	-53%	-43%	-17%								
100 Day Case	4301	General Surgery (including Haematuria) DC	358	326	277	316	262	251	348	301	289	178	223	217	312	3300	4301	-1001	-23%	-13%	-565	83 weeks	0
		Variance		-32	-81	-42	-96	-107	-10	-57	-69	-180	-135	-141	-46								
		Variance %		-9%	-23%	-12%	-27%	-30%	-3%	-16%	-19%	-50%	-38%	-39%	-13%								
100 TOTAL	**5830**	**GENERAL SURGERY IPDC COMBINED**	**486**	**401**	**365**	**408**	**336**	**342**	**452**	**414**	**389**	**234**	**283**	**290**	**418**	**4332**	**5830**	**-1498**	**-26%**	**-15%**	**-861**		**0**
		Variance		-85	-121	-78	-150	-144	-34	-72	-97	-252	-203	-196	-68								
		Variance %		-17%	-25%	-16%	-31%	-30%	-7%	-15%	-20%	-52%	-42%	-40%	-14%								
100C In-Patient	299	Breast Surgery IP	25	16	16	30	8	17	20	17	19	17	16	14	25	215	299	-84	-28%	-21%	-64	29 weeks	0
		Variance		-9	-9	5	-17	-8	-5	-8	-6	-8	-9	-11	0								
		Variance %		-36%	-36%	20%	-68%	-32%	-20%	-32%	-24%	-32%	-36%	-44%	0%								
100C Day Case	101	Breast Surgery DC	8	11	4	11	10	18	19	16	21	13	14	16	8	161	101	60	59%	71%	72	33 weeks	0
		Variance		3	-4	3	2	10	11	8	13	5	6	8	0								
		Variance %		31%	-52%	31%	19%	114%	126%	90%	150%	54%	66%	90%	-5%								
100C TOTAL	**400**	**BSUR IPDC COMBINED**	**33**	**27**	**20**	**41**	**18**	**35**	**39**	**33**	**40**	**30**	**30**	**30**	**33**	**376**	**400**	**-24**	**-6%**	**2%**	**8**		**0**
		Variance		-6	-13	8	-15	2	6	0	7	-3	-3	-3	0								
		Variance %		-19%	-40%	23%	-46%	5%	17%	-1%	20%	-10%	-10%	-10%	-1%								
101 In-Patient	1056	Urology IP	88	71	86	69	68	77	70	66	57	42	48	58	75	787	1056	-269	-25%	63%	362	165 weeks	0
		Variance		-17	-2	-19	-20	-11	-18	-22	-31	-46	-40	-30	-13								
		Variance %		-19%	-2%	-22%	-23%	-13%	-20%	-25%	-35%	-52%	-45%	-34%	-15%								
101 Day Case	3142	Urology DC (Excludes OPP New & Review)	262	294	264	306	243	290	323	288	338	262	333	298	295	3534	3142	392	12%	-14%	-623	152 weeks	0
		Variance		32	2	44	-19	28	61	26	76	0	71	36	33								
		Variance %		12%	1%	17%	-7%	11%	23%	10%	29%	0%	27%	14%	13%								
101 TOTAL	**4198**	**UROLOGY IPDC COMBINED**	**350**	**365**	**350**	**375**	**311**	**367**	**393**	**354**	**395**	**304**	**381**	**356**	**370**	**4321**	**4198**	**123**	**3%**	**-5%**	**-261**		**0**
		Variance		15	0	25	-39	17	43	4	45	-46	31	6	20								
		Variance %		4%	0%	7%	-11%	5%	12%	1%	13%	-13%	9%	2%	6%								
110 In-Patient	965	Orthopaedics IP	80	52	79	85	33	59	62	81	74	4	66	71	76	742	965	-223	-23%	-9%	-91	111 weeks	0
		Variance		-28	-1	5	-47	-21	-18	1	-6	-76	-14	-9	-4								
		Variance %		-35%	-2%	6%	-59%	-27%	-23%	1%	-8%	-95%	-18%	-12%	-5%								
110 Day Case	754	Orthopaedics DC	63	66	80	76	50	65	61	52	54	30	56	41	69	700	754	-54	-7%	12%	93	104 weeks	1
		Variance		3	17	13	-13	2	-2	-11	-9	-33	-7	-22	6								
		Variance %		5%	27%	21%	-20%	3%	-3%	-17%	-14%	-52%	-11%	-35%	10%								
110 Total	**1719**	**ORTHOPAEDICS IPDC COMBINED**	**143**	**118**	**159**	**161**	**83**	**124**	**123**	**133**	**128**	**34**	**122**	**112**	**145**	**1442**	**1719**	**-277**	**-16%**	**0%**	**2**		**1**
		Variance		-25	16	18	-60	-19	-20	-10	-15	-109	-21	-31	2								
		Variance %		-18%	11%	12%	-42%	-13%	-14%	-7%	-11%	-76%	-15%	-22%	1%								
120 In-Patient	1460	EAR, NOSE & THROAT IP	122	45	61	48	57	68	82	63	60	32	38	56	64	674	1460	-786	-54%	-47%	-693	44 weeks	0
		Variance		-77	-61	-74	-65	-54	-40	-59	-62	-90	-84	-66	-58								
		Variance %		-63%	-50%	-61%	-53%	-44%	-33%	-48%	-51%	-74%	-69%	-54%	-47%								
120 Day Case	1390	EAR, NOSE & THROAT DC	116	131	165	158	109	172	178	168	132	127	127	139	170	1776	1390	386	28%	28%	390	39 weeks	0
		Variance		15	49	42	-7	56	62	52	16	11	11	23	54								
		Variance %		13%	42%	36%	-6%	48%	54%	45%	14%	10%	10%	20%	47%								
120 Total	**2850**	**EAR, NOSE & THROAT IPDC COMBINED**	**238**	**176**	**226**	**206**	**166**	**240**	**260**	**231**	**192**	**159**	**165**	**195**	**234**	**2450**	**2850**	**-400**	**-14%**	**-11%**	**-303**		**0**
		Variance		-62	-12	-32	-72	3	23	-7	-46	-79	-73	-43	-4								
		Variance %		-26%	-5%	-13%	-30%	1%	9%	-3%	-19%	-33%	-31%	-18%	-1%								
191 Day Case	550	Pain Management DC	46	40	62	44	25	31	25	61	54	56	73	61	47	579	550	29	5%	14%	78	126 weeks	63
		Variance		-6	16	-2	-21	-15	-21	15	8	10	27	15	1								
		Variance %		-13%	35%	-4%	-45%	-32%	-45%	33%	18%	22%	59%	33%	3%								
300 In-Patient	117	General Medicine IP	10	8	3	11	7	6	8	4	9	5	8	9	11	89	117	-28	-24%	-36%	-42		0
		Variance		-2	-7	1	-3	-4	-2	-6	-1	-5	-2	-1	1								
		Variance %		-18%	-69%	13%	-28%	-38%	-18%	-59%	-8%	-49%	-18%	-8%	13%								
300 Day Case	1738	General Medicine DC	145	68	97	91	93	104	174	116	136	140	116	91	134	1360	1738	-378	-22%	-50%	-862	10 weeks	0
		Variance		-77	-48	-54	-52	-41	29	-29	-9	-5	-29	-54	-11								
		Variance %		-53%	-33%	-37%	-36%	-28%	20%	-20%	-6%	-3%	-20%	-37%	-7%								
300 Total	**1855**	**GENERAL MEDICINE IPDC COMBINED**	**155**	**76**	**100**	**102**	**100**	**110**	**182**	**120**	**145**	**145**	**124**	**100**	**145**	**1449**	**1855**	**-406**	**-22%**	**-49%**	**-904**		**0**
		Variance		-79	-55	-53	-55	-45	27	-35	-10	-10	-31	-55	-10								
		Variance %		-51%	-35%	-34%	-35%	-29%	18%	-22%	-6%	-6%	-20%	-35%	-6%								
301 In-Patient	17	Gastroenterology (Non-Scopes) IP	1	2	1	3	0	0	1	1	0	1	3	3	1	16	17	-1	-6%	12%	2		0
		Variance		1	0	2	-1	-1	0	0	-1	0	2	2	0								
		Variance %		41%	-29%	112%	-100%	-100%	-29%	-29%	-100%	-29%	112%	112%	-29%								
301 Day Case	188	Gastroenterology (Non-Scopes) DC	16	93	95	84	81	100	66	118	91	78	66	69	85	1026	188	838	446%	482%	906	23 weeks	0
		Variance		77	79	68	65	84	50	102	75	62	50	53	69								
		Variance %		494%	506%	436%	417%	538%	321%	653%	481%	398%	321%	340%	443%								
301 Total	**205**	**GASTROENTEROLOGY (NON-SCOPES) IPDC COMBINED**	**17**	**95**	**96**	**87**	**81**	**100**	**67**	**119**	**91**	**79**	**69**	**72**	**86**	**1042**	**205**	**837**	**408%**	**443%**	**908**		**0**
		Variance		78	79	70	64	83	50	102	74	62	52	55	69								
		Variance %		456%	462%	409%	374%	485%	292%	597%	433%	362%	304%	321%	403%								
303 In-Patient	100	Haematology (incl. Cancer Haem.) IP	8	4	4	4	11	9	3	7	5	1	2	2	5	57	100	-43	-43%	-52%	-52		0
		Variance		-4	-4	-4	3	1	-5	-1	-3	-7	-6	-6	-3								
		Variance %		-52%	-52%	-52%	32%	8%	-64%	-16%	-40%	-88%	-76%	-76%	-40%								
303 Day Case	1050	Haematology (incl. Cancer Haem.) DC	88	119	129	146	123	160	150	145	147	138	149	113	140	1659	1050	609	58%	40%	417	17 weeks	0
		Variance		32	42	59	36	73	63	58	60	51	62	26	53								
		Variance %		36%	47%	67%	41%	83%	71%	66%	68%	58%	70%	29%	60%								

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 **Month No:** 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)

KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				March 2016		March 2017	CUMULATIVE ACTIVTY (INTERNALLY RE-DIRECTED RESOURCES) 2016-17
				APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	2015/16 SBA Position (for comparison) %	2015/16 SBA Position (for comparison) Variance	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	
303 Total	1150	HAEMATOLOGY (INCL. CANCER HAEM.) IPDC COMBINED	96	123	133	150	134	169	153	152	152	139	151	115	145	1716	1150	566	49%	32%	365		0
		Variance		*27*	*37*	*54*	*38*	*73*	*57*	*56*	*56*	*43*	*55*	*19*	*49*								
		Variance %		*28%*	*39%*	*57%*	*40%*	*76%*	*60%*	*59%*	*59%*	*45%*	*58%*	*20%*	*51%*								
330 In-Patient	115	Dermatology IP	10	0	0	0	0	0	1	0	0	0	0	0	0	1	115	-114	-99%	-100%	-115		0
		Variance		*-10*	*-10*	*-10*	*-10*	*-10*	*-9*	*-10*	*-10*	*-10*	*-10*	*-10*	*-10*								
		Variance %		*-100%*	*-100%*	*-100%*	*-100%*	*-100%*	*-90%*	*-100%*	*-100%*	*-100%*	*-100%*	*-100%*	*-100%*								
330 Day Case	981	Dermatology DC	82	140	115	146	77	117	134	141	143	102	114	111	127	1467	981	486	50%	53%	523	29 weeks	30
		Variance		*58*	*33*	*64*	*-5*	*35*	*52*	*59*	*61*	*20*	*32*	*29*	*45*								
		Variance %		*71%*	*41%*	*79%*	*-6%*	*43%*	*64%*	*72%*	*75%*	*25%*	*39%*	*36%*	*55%*								
330 Total	1096	DERMATOLOGY IPDC COMBINED	91	140	115	146	77	117	135	141	143	102	114	111	127	1468	1096	372	34%	37%	408		30
		Variance		*49*	*24*	*55*	*-14*	*26*	*44*	*50*	*52*	*11*	*23*	*20*	*36*								
		Variance %		*53%*	*26%*	*60%*	*-16%*	*28%*	*48%*	*54%*	*57%*	*12%*	*25%*	*22%*	*39%*								
340 In-Patient	10	Thoracic Medicine IP	1	2	3	2	0	3	1	4	1	0	2	0	2	20	10	10	100%	70%	7		0
		Variance		*1*	*2*	*1*	*-1*	*2*	*0*	*3*	*0*	*-1*	*1*	*-1*	*1*								
		Variance %		*140%*	*260%*	*140%*	*-100%*	*260%*	*20%*	*380%*	*20%*	*-100%*	*140%*	*-100%*	*140%*								
340 Day Case	490	Thoracic Medicine DC	41	40	38	44	44	47	41	42	40	30	39	37	39	481	490	-9	-2%	13%	63	3 weeks	0
		Variance		*-1*	*-3*	*3*	*3*	*6*	*0*	*1*	*-1*	*-11*	*-2*	*-4*	*-2*								
		Variance %		*-2%*	*-7%*	*8%*	*8%*	*15%*	*0%*	*3%*	*-2%*	*-27%*	*-4%*	*-9%*	*-4%*								
340 Total	500	THORACIC MEDICINE IPDC COMBINED	42	42	41	46	44	50	42	46	41	30	41	37	41	501	500	1	0%	14%	70		0
		Variance		*0*	*-1*	*4*	*2*	*8*	*0*	*4*	*-1*	*-12*	*-1*	*-5*	*-1*								
		Variance %		*1%*	*-2%*	*10%*	*6%*	*20%*	*1%*	*10%*	*-2%*	*-28%*	*-2%*	*-11%*	*-2%*								
361 In-Patient	34	Nephrology IP	3	1	1	1	0	4	3	2	1	1	0	1	0	15	34	-19	-56%	-65%	-22		0
		Variance		*-2*	*-2*	*-2*	*-3*	*1*	*0*	*-1*	*-2*	*-2*	*-3*	*-2*	*-3*								
		Variance %		*-65%*	*-65%*	*-65%*	*-100%*	*41%*	*6%*	*-29%*	*-65%*	*-65%*	*-100%*	*-65%*	*-100%*								
361 Day Case	70	Nephrology DC	6	14	8	5	11	11	19	23	14	12	22	28	17	184	70	114	163%	349%	244	<13 weeks	0
		Variance		*8*	*2*	*-1*	*5*	*5*	*13*	*17*	*8*	*6*	*16*	*22*	*11*								
		Variance %		*140%*	*37%*	*-14%*	*89%*	*89%*	*226%*	*294%*	*140%*	*106%*	*277%*	*380%*	*191%*								
361 Total	104	NEPHROLOGY IPDC COMBINED	9	15	9	6	11	15	22	25	15	13	22	29	17	199	104	95	91%	213%	222		0
		Variance		*6*	*0*	*-3*	*2*	*6*	*13*	*16*	*6*	*4*	*13*	*20*	*8*								
		Variance %		*73%*	*4%*	*-31%*	*27%*	*73%*	*154%*	*188%*	*73%*	*50%*	*154%*	*235%*	*96%*								
400 Day Case	390	NEUROLOGY DC	33	46	31	42	32	42	38	41	46	34	53	41	69	515	390	125	32%	26%	103	9 weeks	0
		Variance		*14*	*-2*	*10*	*-1*	*10*	*6*	*9*	*14*	*2*	*21*	*9*	*37*								
		Variance %		*42%*	*-5%*	*29%*	*-2%*	*29%*	*17%*	*26%*	*42%*	*5%*	*63%*	*26%*	*112%*								
410 In-Patient	10	RHEUMATOLOGY IP	1	0	1	0	0	0	1	2	0	0	0	0	0	4	10	-6	-60%	-80%	-8		0
		Variance		*-1*	*0*	*-1*	*-1*	*-1*	*0*	*1*	*-1*	*-1*	*-1*	*-1*	*-1*								
		Variance %		*-100%*	*20%*	*-100%*	*-100%*	*-100%*	*20%*	*140%*	*-100%*	*-100%*	*-100%*	*-100%*	*-100%*								
410 Day Case	2899	RHEUMATOLOGY DC	242	310	245	275	218	275	325	289	291	231	277	258	305	3299	2899	400	14%	9%	255	16 weeks	12
		Variance		*68*	*3*	*33*	*-24*	*33*	*83*	*47*	*49*	*-11*	*35*	*16*	*63*								
		Variance %		*28%*	*1%*	*14%*	*-10%*	*14%*	*35%*	*20%*	*20%*	*-4%*	*15%*	*7%*	*26%*								
410 Total	2909	RHEUMATOLOGY IPDC COMBINED	242	310	246	275	218	275	326	291	291	231	277	258	305	3303	2909	394	14%	8%	247		12
		Variance		*68*	*4*	*33*	*-24*	*33*	*84*	*49*	*49*	*-11*	*35*	*16*	*63*								
		Variance %		*28%*	*1%*	*13%*	*-10%*	*13%*	*34%*	*20%*	*20%*	*-5%*	*14%*	*6%*	*26%*								
420 In-Patient	80	Paediatric Medicine IP	7	2	8	10	7	7	6	7	7	7	8	7	10	86	80	6	8%	-8%	-6		0
		Variance		*-5*	*1*	*3*	*0*	*0*	*-1*	*0*	*0*	*0*	*1*	*0*	*3*								
		Variance %		*-70%*	*20%*	*50%*	*5%*	*5%*	*-10%*	*5%*	*5%*	*5%*	*20%*	*5%*	*50%*								
420 Day Case	40	Paediatric Medicine DC	3	0	0	0	0	0	0	0	1	0	2	3	2	8	40	-32	-80%	-58%	-23	N/A	0
		Variance		*-3*	*-3*	*-3*	*-3*	*-3*	*-3*	*-3*	*-2*	*-3*	*-1*	*0*	*-1*								
		Variance %		*-100%*	*-100%*	*-100%*	*-100%*	*-100%*	*-100%*	*-100%*	*-70%*	*-100%*	*-40%*	*-10%*	*-40%*								
420 Total	120	PAEDIATRIC MEDICINE IPDC COMBINED	10	2	8	10	7	7	6	7	8	7	10	10	12	94	120	-26	-22%	-24%	-29		0
		Variance		*-8*	*-2*	*0*	*-3*	*-3*	*-4*	*-3*	*-2*	*-3*	*0*	*0*	*2*								
		Variance %		*-80%*	*-20%*	*0%*	*-30%*	*-30%*	*-40%*	*-30%*	*-20%*	*-30%*	*0%*	*0%*	*20%*								
502 In-Patient	1281	Gynaecology IP	107	70	81	86	73	79	103	78	74	69	59	68	71	911	1281	-370	-29%	-20%	-250	33 weeks	0
		Variance		*-37*	*-26*	*-21*	*-34*	*-28*	*-4*	*-29*	*-33*	*-38*	*-48*	*-39*	*-36*								
		Variance %		*-34%*	*-24%*	*-19%*	*-32%*	*-26%*	*-4%*	*-27%*	*-31%*	*-35%*	*-45%*	*-36%*	*-33%*								
502 Day Case	1411	Gynaecology DC	118	148	118	106	116	133	127	125	133	101	105	115	129	1456	1411	45	3%	11%	154	25 weeks	0
		Variance		*30*	*0*	*-12*	*-2*	*15*	*9*	*7*	*15*	*-17*	*-13*	*-3*	*11*								
		Variance %		*26%*	*0%*	*-10%*	*-1%*	*13%*	*8%*	*6%*	*13%*	*-14%*	*-11%*	*-2%*	*10%*								
502 Total	2692	GYNAECOLOGY IPDC COMBINED	224	218	199	192	189	212	230	203	207	170	164	183	200	2367	2692	-325	-12%	-4%	-96		0
		Variance		*-6*	*-25*	*-32*	*-35*	*-12*	*6*	*-21*	*-17*	*-54*	*-60*	*-41*	*-24*								
		Variance %		*-3%*	*-11%*	*-14%*	*-16%*	*-5%*	*3%*	*-10%*	*-8%*	*-24%*	*-27%*	*-18%*	*-11%*								
620 Day Case	1746	COMMUNITY DENTISTRY DC	146	130	122	129	116	124	118	118	127	104	129	122	127	1466	1746	-280	-16%	-17%	-295	23 weeks	0
		Variance		*-16*	*-24*	*-17*	*-30*	*-22*	*-28*	*-28*	*-19*	*-42*	*-17*	*-24*	*-19*								
		Variance %		*-11%*	*-16%*	*-11%*	*-20%*	*-15%*	*-19%*	*-19%*	*-13%*	*-29%*	*-11%*	*-16%*	*-13%*								
130 Day Case	699	OPHTHALMOLOGY (VISITING SERVICE)	*58*	*33*	*23*	*23*	*48*	*53*	*22*	*19*	*20*	*15*	*19*	*22*	*20*	317	699	-382	-55%	-20%	-143	51 weeks	N/A
		Variance		*-25*	*-35*	*-35*	*-10*	*-5*	*-36*	*-39*	*-38*	*-43*	*-39*	*-36*	*-38*								
		Variance %		*-43%*	*-61%*	*-61%*	*-18%*	*-9%*	*-62%*	*-67%*	*-66%*	*-74%*	*-67%*	*-62%*	*-66%*								
IP	7073	INPATIENT TOTAL	589	348	432	441	338	420	465	445	407	235	310	362	446	4649	7073	-2424	-34%	-19%	-1268	165 weeks	106
		Variance		*-241*	*-157*	*-148*	*-251*	*-169*	*-124*	*-144*	*-182*	*-354*	*-279*	*-227*	*-143*								
		Variance %		*-41%*	*-27%*	*-25%*	*-43%*	*-29%*	*-21%*	*-25%*	*-31%*	*-60%*	*-47%*	*-39%*	*-24%*								
DC	21900	DAYCASE TOTAL	1825	2009	1873	2002	1658	1993	2168	2063	2077	1651	1917	1782	2095	23288	21900	1388	6%	4%	970		
		Variance		*184*	*48*	*177*	*-167*	*168*	*343*	*238*	*252*	*-174*	*92*	*-43*	*270*								
		Variance %		*10%*	*3%*	*10%*	*-9%*	*9%*	*19%*	*13%*	*14%*	*-10%*	*5%*	*-2%*	*15%*								

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 **Month No:** 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)				2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				*March 2016*		March 2017	CUMULATIVE ACTIVTY (INTERNALLY RE-DIRECTED RESOURCES) 2016-17
KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	*2015/16 SBA Position (for comparison)* %	*Variance*	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	
Total	28973	INPATIENT & DAYCASE TOTAL	2414	2357	2305	2443	1996	2413	2633	2508	2484	1886	2227	2144	2541	27937	28973	-1036	-4%	-1%	-298		
		Variance		*-57*	*-109*	*29*	*-418*	*-1*	*219*	*94*	*70*	*-528*	*-187*	*-270*	*127*								
		Variance %		*-2%*	*-5%*	*1%*	*-17%*	*0%*	*9%*	*4%*	*3%*	*-22%*	*-8%*	*-11%*	*5%*								

HSCB excludes the following: Endoscopy (now on separate tab)

HSCB includes the following: (in red font) - BHSCT Visiting Services - Ophthalmology

INPATIENTS/DAYCASE VALIDATION - UPDATE AS OF 06/05/2022 BY VALIDATION ADMINISTRATIVE TEAM

UROLOGY In-patients Admin Validation (FINAL AS OF 06/05/2022)									
	Task	Total	Remain on WL	Remove from WL					No Answer
				Surgery elsewhere	Deceased	Removed by URO Sec/Consultant	Very ill/elderly	Other	
UROLOGY In-patients Admin Validation	Urgents	584	489 (83.73%)	23 (3.93%)	1 (0.17%)	7 (1.19%)	2 (0.34%)	3 (0.51%)	60 (10.27%)
			24 patients requested to be removed - emailed to URO Sec on 20/04/22 for Consultants' review and action.	21 removed on PAS and 2 emailed to Matthew re hermitage (not sure if these have been removed or not on PAS)	Recorded as deceased on PAS	all patients have been removed on PAS	1 patient has been removed on PAS and 1 emailed to URO Sec	Emailed to URO Sec - not been removed on PAS yet	Validation Officer took initiative to made numbers of attempted calls to get an update from patients without avail.
	Routines	240	209 (87.08%)	6 (2.50%)	0 (0%)	2 (0.83%)	1 (0.42%)	0 (0%)	22 (9.16%)
			23 patients requested to be removed - emailed to URO Sec on 20/04/22 for Consultants' review and action.	all patients have been removed on PAS	Recorded as deceased on PAS	all patients have been removed on PAS	Emailed to URO Sec - not been removed on PAS yet		Validation Officer took initiative to made numbers of attempted calls to get an update from patients without avail.
TOTAL		824	698	29	1	9	4	3	82

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

Quality Care - for you, with you

6 January 2022

Mr Raymond MacSorley
Managing Director
3FiveTwo Medical Limited
Unit 1 Channel Wharf
21 Old Channel Road
Belfast
BT3 9DE

SENT VIA E-MAIL to: [redacted] Personal Information redacted by the USI

Dear Mr MacSorley,

Contract Award Letter: Provision of Urology Services

Further to recent discussions with the Southern Trust in relation to the provision of urology services, I am pleased to confirm that the contract award is proceeding, subject to the conditions outlined on Page 2.

Attached is a contract for 800 Urology first outpatient assessments and subsequent condition management procedures, inclusive of where appropriate surgical procedures and post-operative management. Those requiring surgical procedures and post-operative surgery management are required to have these activities completed by the 31 March 2023.

The contract period will run from the contract award date until 31 March 2023 with the option to extend for further periods until 31 December 2023.

The Trust also reserves the right to increase service volumes should additional funding become available to spend in this way and against this contract (This is **not** a guarantee of additional volumes of activity for completion).

Please note that the full number of procedures must be completed within the timescale detailed above and that DNAs and / or cancellations will not count as completed activity.

The Trust also requires in line with 14.1 of the Terms and Conditions of Contract a copy of your Contingency Emergency Transfer Arrangements. I would be grateful if you could forward to me at your earliest opportunity.

The attached contract must be signed and returned, prior to commencement of the service provision.

The contract documentation includes the following:

- Service Specification
- Terms and Conditions of Contract
- Health Professional Staff – Summary Sheet

To expedite the contracting process I have attached the contract in an electronic format which should be returned by e-mail in the first instance. Therefore, I would be grateful if you would review the contract and confirm that you are willing to accept the terms by printing, signing (original signature), scanning and returning **the signatory page only (Page 89) via email before 12:00 noon on 7 January 2022 to Mrs Barbara Joyce at** [redacted] **.**

Two signed hard copies should subsequently be forwarded in the post to Mrs Claire McAdam at the address on the bottom of this letter (Each with an original signature). An original signed copy of the entire contract will be sent back to you for your records.

As previously noted the award of this contract is conditional upon the following:

- **Health Professional Staff - Trust Approval of CVs**

  Thank you for forwarding CV's and the annex B for the number of Health Care professionals that you are proposing to engage to work on this contract. As you are aware the Trust has reviewed and approved these and I have attached the correspondence indicating the confirmation of this process. If at any time you need to engage further Health Care professionals in the provision of this contract, then in line with the contract requirements you must have written approval from the Trust prior to engagement in service delivery.

- **Location of Service Delivery**

  A valid leasing agreement must be in place if using premises not registered to 3FiveTwo Healthcare Ltd and a copy of this agreement must be provided to the Trust.

  I would therefore be grateful if you would confirm the location(s) for service delivery and provide the agreement noted above if required.

- **Data Protection**

  The Data Protection Agreement will be amended by the Trust to reflect the outcome of the Trust's data mapping / audit and assessment of the capacities of the parties (i.e. Controller, Processor or Joint Controller), the detail of the specific Personal Data Processing activities under the Contract, those Personal Data Processing activities to which Part A, B or C shall apply, and the outcome of the Trust's Data Protection Impact Assessment (DPIA) to include but not limited to any risk mitigation steps arising from the DPIA, as required.

By signing this Contract, you are acknowledging this and agreeing that in respect of any contract that is entered into, the attached contract terms will be amended in respect of this matter.

For the purpose of submitting the documentation / information requested in this letter, can you please forward it to the email addresses noted below:

- Personal Information redacted by the USI
- Personal Information redacted by the USI
- Personal Information redacted by the USI

I will be the operational contact for the contract and can be contacted at Personal Information redacted by the USI or Personal Information redacted by the USI. The ability to provide safe and effective treatment for these patients is critical to the Trust's achievement of its elective performance standards and therefore can I emphasise the importance of robust communication processes with prompt escalations of any issues to me in order that this contract can be initiated swiftly and without delay for our patients.

I will be in touch shortly to discuss referrals, administrative responsibilities and other operational issues.

If you have any queries in the meantime please do not hesitate to contact me directly.

Many thanks for your interest in providing this service and we look forward to working with you.

Yours sincerely

Personal Information redacted by the USI

_____

Wendy Clayton
ACTING HEAD OF SERVICE FOR ENT, UROLOGY, OPHTHALMOLOGY & OUTPATIENTS

Cc Sue-Ann Collins, Head of Contract Management Governance
Lynn Lappin, Head of Performance

Enc:

- Service Specification
- Terms and Conditions of Contract
- Consultants Approval Correspondence

2019/20 PERFORMANCE IMPROVEMENT TRAJECTORY

Delivery of Core - New Outpatients

Trust: Southern

PIT Lead: Ronan Carroll, Assistant Director ATICS & SEC; Barry Conway, Assistant Director CCS & IMWH; Anne McVey, Assistant Director MUSC; Julie McConville, Assistant Director CYPS; Roisin Toner, Assistant Director OPPC

Date Submitted (HSCB): 14 June 2019

Comments/escalations: Cumulative performance for the total OP trajectory (23 specialties) demonstrates +1% (+486) above the projected levels of activity: 2 specialties (9%) are assessed as Red - **Cardiology** demonstrates -21% (-353) against the projected levels to date; **Chemical Pathology** (single-handed Consultant clinic) demonstrates underperformance of -12% (-10 patients). **1 specialty (17%) is assessed as Amber** - **Pain Management** demonstrates cumulative underperformance of -8% (-50 patients) - this has been quantified by the service and includes loss of clinics due to Consultant-on-call (on-site overnight, so OPD cancelled next day) in August & September; also more Consultant A/L taken in August and September; higher patient DNAs than anticipated. However, the trajectory shows significant improvement in Octonber, and the service advise that they envisage pulling back the trajectory before year-end.
ACTIONS: For those trajectories which are currently underperforming, Operational Teams have been requested to advise of the actions being taken to ensure the trajectories get back on track. **Cardiology** previously advised they had identified actions to be undertaken to improve the trajectory including - reworking specialty doctors job plans to optimise capacity at clinics, and confirmed 1 additional NOP clinic per week for Arrhythmia - effective November 2019. The Head of Service anticipates that this trajectory will be pulled back by the end of the year. **Chemical Pathology** - the service had advised that they were looking at options to increase capacity, including nurse-led clinics due to commence in January 2020. The Head of Service has also confirmed that a Specialty Doctor has been appointed to fill the gap left by the GP with Specialtist interest who left the Trust in Qtr 1 of 2019/20. the service anticipate being back on track by March 2020. **Geriatrics** - there are 4 sub-specialties, of which 3 are underperforming: *Ortho-Geriatrics* (ASD) advised that they will pull back by end of the year as 2 additional clinics have been set up for a period of 3 months initially from September. *Geriatric Medicine* (OPPC) and *Geriatric Acute* (ASD) had indicated that it is unlikely that the trajectories will recover by the end of the year - responses remain outstanding.

Reduce the percentage of funded activity associated with elective care services that remains undelivered

Month: 7 (Oct. 2019)

Specialty	SBA		2018/19 outturn against SBA			2019/20 Forecast Activity to be Delivered v Outturn (Actual)													Performance Against Trajectory Volume					Performance Against Agreed SBA Volume				
	2018/19	2019/20	Delivered 2018/19 (nn)	Variance 2018/19 (nn)	Variance 2018/19 (%)	2019/20 SHSCT Operational Trajectory Volume	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2019/20 Cumulative Volume (to date)	2019/20 Cumulative Expected Volume (to date)	Variance	% Variance	RAG status	2019/20 Cumulative SBA (to date)	2019/20 cumulative expected SBA	Variance	% Variance	RAG status
Breast Family History	218	218	215	-3	-1%	210	0	24	20	13	15	20	18	20	16	21	22	21										
Breast Family History Actual activity							**0**	**25**	**27**	**8**	**13**	**28**	**24**						**125**	**110**	**15**	**14%**		**125**	**127**	**-2**	**-2%**	**Y**
Breast Surgery	4,205	4,205	4,035	-170	-4%	3965	321	364	319	354	337	254	373	342	256	361	352	332										
Breast Surgery actual activity							**374**	**369**	**343**	**332**	**269**	**326**	**317**						**2330**	**2322**	**8**	**0%**		**2330**	**2453**	**-123**	**-5%**	**A**
Cardiology	2,415	2,415	2,693	278	12%	2739	223	251	247	205	170	261	297	280	177	200	211	217										
Cardiology actual activity							**179**	**231**	**212**	**120**	**110**	**214**	**235**						**1301**	**1654**	**-353**	**-21%**		**1301**	**1409**	**-108**	**-8%**	**A**
Chemical Pathology	140	140	175	35	25%	140	10	15	14	8	8	15	15	10	8	15	10	12										
Chemical Pathology							**8**	**12**	**13**	**4**	**9**	**15**	**14**						**75**	**85**	**-10**	**-12%**		**75**	**82**	**-7**	**-8%**	**A**
Dermatology (Cons-Led only)	7,322	7,322	8,337	1,015	14%	8066	560	750	800	630	630	550	850	830	495	814	597	560										
Dermatology (Cons-Led only) actual activity							**583**	**609**	**630**	**641**	**630**	**637**	**835**						**4565**	**4770**	**-205**	**-4%**		**4565**	**4271**	**294**	**7%**	**G**
Diabetology	418	418	507	89	21%	470	36	37	40	38	37	41	40	44	35	40	42	40										
Diabetology actual activity							**42**	**37**	**31**	**43**	**32**	**37**	**46**						**268**	**269**	**-1**	**-0.4%**		**268**	**244**	**24**	**10%**	**G**
Endocrinology	537	537	815	278	52%	725	63	65	69	40	59	62	60	65	60	65	57	60										
Endocrinology							**102**	**84**	**94**	**87**	**104**	**72**	**91**						**634**	**418**	**216**	**52%**		**634**	**313**	**321**	**102%**	**G**
ENT	9,463	9,463	9,170	-293	-3%	8828	603	653	688	383	731	794	850	1,021	733	816	806	750										
ENT actual activity							**774**	**710**	**821**	**633**	**685**	**843**	**776**						**5242**	**4702**	**540**	**11%**		**5242**	**5520**	**-278**	**-5%**	**A**
Gastroenterology	2,006	2,006	2,129	123	6%	2020	160	186	140	180	120	174	200	200	172	200	158	130										
Gastroenterology actual activity							**161**	**177**	**166**	**150**	**115**	**168**	**192**						**1129**	**1160**	**-31**	**-3%**		**1129**	**1170**	**-41**	**-4%**	**Y**
General Medicine	487	487	326	-161	-33%	216	17	17	16	15	20	20	18	19	17	18	19	20										
General Medicine							**17**	**25**	**21**	**28**	**30**	**31**	**30**						**182**	**123**	**59**	**48%**		**182**	**284**	**-102**	**-36%**	**R**
General Surgery	9,839	9,839	7,096	-2,743	-28%	7159	543	639	607	535	610	555	745	605	500	575	600	645										
General Surgery Actual activity							**589**	**643**	**507**	**435**	**349**	**732**	**912**						**4167**	**4234**	**-67**	**-2%**		**4167**	**5739**	**-1572**	**-27%**	**R**
Geriatric Medicine (combined)	1,912	1,912	2,231	319	17%	2190	166	200	188	170	162	193	218	181	142	217	172	181										
Geriatric Medicine actual activity							**164**	**186**	**179**	**163**	**158**	**174**	**220**						**1244**	**1297**	**-53**	**-4%**		**1244**	**1115**	**129**	**12%**	**G**
Gynae Colposcopy	1,354	1,354	974	-380	-28%	960	70	90	95	80	50	80	105	85	80	75	80	70										
Gynae Colposcopy							**98**	**67**	**88**	**84**	**54**	**93**	**96**						**580**	**570**	**10**	**2%**		**580**	**790**	**-210**	**-27%**	**R**

Gynae Fertility	137	137	210	73	53%	145	10	10	10	10	10	20	20	15	10	10	10	10								
Gynae Fertility							19	14	13	10	13	12	9						90	90	0	0%		90	80	10	13%	G
Gynae Urodynamics	400	400	123	-277	-69%	129	0	0	12	6	6	12	12	12	9	18	24	18								
Gynae Urodynamics							3	10	9	9	7	9	10						57	48	9	19%		57	233	-176	-76%	R
Neurology	2,790	2,790	3,006	216	8%	2806	233	234	220	240	260	264	233	260	240	212	190	220								
Neurology Actual activity							258	231	288	209	244	249	316						1795	1684	111	7%		1795	1628	168	10%	G
Obs and Gyn (Gynaecology)	6,853	6,853	6,792	-61	-1%	6445	517	517	650	470	530	601	570	640	470	570	420	490								
Obs and Gyn (Gynaecology) actual activity							496	561	514	664	339	545	622						3741	3855	-114	-3%		3741	3998	-257	-6%	A
Paediatrics	2,600	2,600	2,763	163	6%	2550	185	195	199	185	201	215	231	231	227	227	227	227								
Paediatrics actual activity							219	226	232	155	223	287	274						1616	1411	205	15%		1616	1517	99	7%	G
Pain Management	1,190	1,190	1,138	-52	-4%	1138	80	90	88	72	102	108	123	111	72	80	104	108								
Pain Management actual activity							78	86	95	94	51	90	119						613	663	-50	-8%		613	694	-81	-12%	R
Rheumatology	1,692	1,692	1,648	-44	-3%	1692	125	139	157	120	111	147	164	164	125	149	141	150								
Rheumatology actual activity							127	133	151	130	126	139	154						960	963	-3	-0.3%		960	987	-27	-3%	Y
Thoracic Medicine	1,724	1,724	1,809	85	5%	1782	140	160	169	130	135	162	157	169	133	145	145	137								
Thoracic Medicine actual activity							158	199	158	113	147	166	177						1118	1053	65	6%		1118	1006	112	11%	G
Trauma and Orthopaedics (Orthopaedics)	2,872	2,872	2,598	-274	-10%	2247	146	225	217	119	133	112	216	247	181	253	199	199								
Trauma and Orthopaedics (Orthopaedics)actual activity							147	221	231	143	92	197	236						1267	1168	99	8%		1267	1675	-408	-24%	R
Urology	3,591	3,591	3,841	250	7%	2866	292	361	364	202	251	157	289	260	157	239	147	147								
Urology actual activity							347	239	240	242	265	355	264						1952	1916	36	2%		1952	2095	-143	-7%	A
Total	64,165	64,165	62,631	-1,534	-2%	59,488	4,500	5,222	5,329	4,205	4,688	4,817	5,804	5,811	4,315	5,320	4,733	4,744								
TOTAL ACTUAL ACTIVITY							*4,943*	*5,095*	*5,063*	*4,497*	*4,065*	*5,419*	*5,969*	*0*	*0*	*0*	*0*	*0*	*35051*	*34565*	*486*	*1%*		*35051*	*37430*	*-2379*	*-6%*	A

Key:

Await response from Services RE: underperformance

RAG Status:

	Operational trajectory on track or better
	Underperformance of up to 5% against operational trajectory
	Underperformance of 5% - 10% against operational trajectory
	Underperformance of 10% or more against operational trajectory/behind plan

RAG status:

G	• SBA at 0% and above
Y	• SBA underperformance between -0.1% & -4.9%
A	• SBA underperformance between -5% & -9.9%
R	• SBA underperformance of -10% or more

KEY RISKS AND MITIGATIONS TO DELIVERY OF PLAN

Risk Description	Risk Rating	Mitigations	Risk Owner

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

2019/20 PERFORMANCE IMPROVEMENT TRAJECTORY

Delivery of Core - Inpatient/Daycase

Trust: Southern

PIT Lead: ATICS & SEC - Ronan Carroll; CCS & IMWH - Barry Conway; MUSC - Anne McVey; CYPS - Julie McConville; OPPC - Roisin Toner

Date Submitted (HSCB): June 2019

Outturn against SBA		
2017/18	2018/19	2019/20 (planned)
-10.0%	-5.2%	-8.5%

Comments/escalations: Whilst cumulative performance for the total IP/DC trajectory (15 specialties) demonstrates +8% (+1129) above the projected levels of activity:
- **2 specialties (13%) are assessed as Red** - **General Medicine** demonstrates -18% (-203) against the projected levels of activity - though this should be considered along with Gastroenterology which demonstrates an over-performance of 53% associated with inpatient coding backlog. *Operational response for this underperformance remains outstanding* ; **Orthopaedics** demonstrates -11% (-124 patients) against the projected levels of activity - the service have quantified the underperformance which is primarily attributed to an increase in trauma cases being undertaken in Ortho lists during the first 7 months of 2019/20, with elective orthopaedic slots displaced during the first half of the year due to an influx of trauma cases, but more significantly in September and October when more slots were lost than predicted. April to September demonstrated 69 slots lost due to an increase in trauma cases; Consultant sick leave in May; performance impacted by more A/L being taken in August than was originally anticipated. However, 52 slots were lost in October alone - there were more trauma cases undertaken in ortho elective lists (40) than in any other month, resulting in a loss of 25 elective slots. In addition, 4 elective sessions were converted to trauma all-day sessions to meet trauma demand; 4 sessions were lost due to inability to backfill 4 middle grades; 2 Consultants were on sick leave resulting in a loss of 4 further elective sessions during October. **ACTIONS: All Operational Teams have been asked to review their assumptions where the trajectory has gone off-track. If trajectories are underperforming, the service is requested to inform the Performance Team in writing of the quantified reasons and the estimated timescales and actions to be taken to ensure that this gets back on track. Services are also to advise urgently if there is anything which was not previously considered as part of their projections which may have an impact on the ability to deliver the 2019/20 volumes - with a view to re-submission to HSCB if necessary before the window of opportunity to do this closes.**
***Early alert*: the Orthopaedics service advised (in November) that performance against the trajectory will be further impacted as there will be no elective activity on the CAH site in December due to the reduction in theatre nursing staff. This will result in a loss of 107 elective patients.**

Reduce the percentage of funded activity associated with elective care services that remains undelivered

Month: 7 (Oct 2019)

Specialty	SBA Volume		2018/19 Outturn against SBA			2019/20 Forecast Activity to be Delivered v Outturn (Actual)													Performance Against Trajectory Volume						Performance Against Agreed SBA Volume				
	2018/19 SBA	2019/20 SBA	Delivered 2018/19 (nn)	Variance 2018/19 (nn)	Variance 2018/19 (%)	2019/20 SHSCT Operational Trajectory Volume	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	2019/20 Cumulative Volume (to date)	2019/20 Cumulative Expected Volume (to date)	Variance	% Variance	RAG status		2019/20 Cumulative SBA (to date)	2019/20 cumulative expected SBA	Variance	% Variance	RAG status
Breast Surgery	400	400	449	49	12%	410	37	32	34	33	31	32	32	36	32	40	35	36											
Breast Surgery Actual activity							***39***	***25***	***33***	***50***	***28***	***41***	***31***						***247***	***231***	***16***	***7%***			***247***	***233***	***14***	***6%***	G
Dermatology (Cons Led only)	1,066	1,066	1,253	187	18%	1263	98	96	94	86	119	129	129	90	127	102	97	96											
Dermatology Cons-Led only actual activity							***105***	***88***	***95***	***118***	***103***	***104***	***110***						***723***	***751***	***-28***	***-4%***			***723***	***622***	***101***	***16%***	G
Dermatology (Nurse Led only)	328	328	505	177	54%	483	33	37	55	30	30	50	48	48	30	44	39	39											
Dermatology Cons-Led only actual activity							***40***	***38***	***41***	***51***	***33***	***43***	***57***						***303***	***283***	***20***	***7%***			***303***	***191***	***112***	***58%***	G
ENT (Ear, Nose & Throat)	2,850	2,850	1,990	-860	-30%	1706	101	143	154	79	163	172	192	172	124	149	135	122											
ENT Actual activity							***158***	***177***	***192***	***131***	***143***	***188***	***193***						***1,182***	***1,004***	***178***	***18%***			***1,182***	***1,663***	***-481***	***-29%***	R
Gastroenterology (Non-Scopes)	205	205	1,164	959	468%	991	68	107	90	75	77	58	69	70	65	113	100	99											
Gastroenterology (Non-Scopes) Actual activity							***105***	***89***	***93***	***108***	***97***	***93***	***245***						***830***	***544***	***286***	***53%***		GMED & Gastro should be considered together	***830***	***120***	***710***	***594%***	G
General Medicine	1,855	1,855	1,839	-16	-1%	1906	139	152	158	148	174	172	181	162	157	177	136	150											
General Medicine Actual activity							***142***	***134***	***125***	***132***	***118***	***126***	***144***						***921***	***1,124***	***-203***	***-18%***			***921***	***1,082***	***-161***	***-15%***	R
General Surgery	5,830	5,830	4,127	-1,703	-29%	4013	268	343	326	234	275	368	394	364	298	535	303	305											
General Surgery Actual activity							***301***	***334***	***323***	***296***	***300***	***367***	***663***						***2,584***	***2,208***	***376***	***17%***			***2,584***	***3,401***	***-817***	***-24%***	R
Geriatric Medicine combined	10	10	60	50	500%	12	1	1	1	1	1	1	1	1	1	1	1	1											
Geriatric Medicine combined - Actual activity							***16***	***8***	***11***	***5***	***10***	***6***	***3***						***59***	***7***	***52***	***743%***			***59***	***6***	***53***	***911%***	G
Obs and Gyn (Gynaecology)	2,593	2,593	2,024	-569	-22%	1842	150	155	155	155	155	155	155	155	150	150	150	157											
Obs and Gyn (Gynaecology) - Actual activity							***131***	***136***	***147***	***185***	***170***	***150***	***184***						***1,103***	***1,080***	***23***	***2%***			***1,103***	***1,513***	***-410***	***-27%***	R
Paediatrics	120	120	113	-7	-6%	132	11	11	11	11	11	11	11	11	11	11	11	11											
Paediatrics actual activity							***15***	***18***	***17***	***17***	***20***	***25***	***10***						***122***	***77***	***45***	***58%***			***122***	***70***	***52***	***74%***	G

Pain Management	550	550	525	-25	-5%	511	60	54	54	30	30	45	40	42	30	42	42	42								
Pain Management actual activity							***61***	***47***	***54***	***41***	***22***	***53***	***50***						***328***	***313***	***15***	***5%***		***328***	***321***	***7***	***2%***	G
Rheumatology	2,909	2,909	3,074	165	6%	3062	271	288	300	224	224	283	243	278	214	239	245	253								
Rheumatology actual activity							***253***	***281***	***268***	***290***	***238***	***339***	***243***						***1,912***	***1,833***	***79***	***4%***		***1,912***	***1,697***	***215***	***13%***	G
Thoracic Medicine	500	500	442	-58	-12%	443	40	32	42	28	34	40	37	39	36	40	38	37								
Thoracic Medicine actual activity							***38***	***47***	***39***	***43***	***60***	***51***	***60***						***338***	***253***	***85***	***34%***		***338***	***292***	***46***	***16%***	G
Trauma and Orthopaedics	1,968	1,968	1,777	-191	-10%	1956	135	168	198	112	133	160	195	201	128	172	172	182								
Trauma and Orthopaedics actual activity							***124***	***154***	***164***	***132***	***120***	***144***	***139***						***977***	***1,101***	***-124***	***-11%***		***977***	***1,148***	***-171***	***-15%***	R
Urology	4,198	4,198	4,717	519	12%	4501	342	333	407	286	426	374	445	402	302	421	381	382								
Urology actual activity							***421***	***464***	***373***	***403***	***406***	***439***	***416***						***2,922***	***2,613***	***309***	***12%***		***2,922***	***2,449***	***473***	***19%***	G
Total - trajectory volume submitted	**25,382**	**25,382**	**24,059**	**-1,323**	**-5%**	**23,231**	**1,754**	**1,952**	**2,079**	**1,532**	**1,883**	**2,050**	**2,172**	**2,071**	**1,705**	**2,236**	**1,885**	**1,912**						**14,551**	**14,806**	**-255**	**-2%**	
Actual activity							***1,949***	***2,040***	***1,975***	***2,002***	***1,868***	***2,169***	***2,548***	***0***	***0***	***0***	***0***	***0***	***14,551***	***13,422***	***1,129***	***8%***		***14,551***	***14,806***	***-255***	***-2%***	y

Key:

RAG Status:

	Operational trajectory on track or better
	Underperformance of up to 5% against operational trajectory
	Underperformance of 5% - 10% against operational trajectory
	Underperformance of 10% or more against operational trajectory/behind plan

RAG status:

G	• SBA at 0% and above
Y	• SBA underperformance between -0.1% & -4.9%
A	• SBA underperformance between -5% & -9.9%
R	• SBA underperformance of -10% or more

KEY RISKS AND MITIGATIONS TO DELIVERY OF PLAN

Risk Description	Risk Rating	Mitigations	Risk Owner

Cancer Pathway Escalation Policy

1.0 Background

This policy is to inform Cancer Tracker/ Multi-Disciplinary Team (MDT) Co-ordinators, Clinicians and Divisional Management Teams of the escalation policy for Cancer Access targets.

The current cancer access standard targets are:
14 days – 100% for the 2 week wait breast symptomatic outpatient appointment
31 days – 98% date decision to treat to first definitive treatment
62 days – 95% date of receipt of referral to first definitive treatment

The purpose of this policy to illustrate the actions that may be required at specific points along the patient's pathway. These actions will be escalated from the first trigger point. (Please see Table 1)

2.0 General Principles of Escalation

General principles of escalation are as follows:

(a) The earlier the better.
It is easier to stand people down once the problem is resolved than to catch up lost time
(b) Try everything you know to resolve the problem
(c) Recognise that you can't solve all of the problems – but by escalating it will give others a chance to help find a solution.
(d) Record on the escalation proforma the steps you have taken
(e) Take action in a timely manner
Be clear of the timescale of escalation
If a response is not received from Consultant/Clinician within outlined timescale for escalation the relevant Chair of the MDT is to be notified.

3.0 Trigger Points for Escalation

For a patient to progress along the pathway, the Cancer Trackers will start the tracking process and be responsible for escalations throughout the pathway. In order for the Trackers to track they have been given the authority to expedite referrals (either appointments/diagnostics) within their own level of responsibility. While the Red Flag Appointments Team will escalate patients outside of expected 1st appointment timescales, the tracker will track the full cancer pathway.

In the event of delays in the patient pathway, as detailed in Appendix 1, the tracker will escalate to the Cancer Services Co-ordinator (CSC) or in her absence the Operational Support lead (OSL), who will in turn advise the Head of Cancer Service. The CSC will advise the relevant Head of Service (HOS) /OSL for that specialty, of any actions required to be taken or ongoing delays.

The HOS/OSL for the specialty will escalate patients who trigger key points on the pathways to the relevant Assistant Directors and Clinical leads as required.

Table 1 - Key trigger points on the Cancer pathway for escalation if patient not booked or completed

Key Trigger	Trigger Point	Escalate To	Further Escalation Point	Also Escalate To
First appointment	By day 10	>Head of Service >OSL	By Day 21	>Assistant Director for the Specialty >Director for Acute Services
Investigations/ Diagnostics	By day 17	>Head of Service >OSL	Greater than 10 days for diagnostic investigation or reporting	>Head of Service for Radiology >Assistant Director for Cancer & Clinical Services
MDM	By day 25	>Head of Service >OSL		
ITT	By day 28	>Head of Service >OSL		
Treatment	By day 31 or 62 (relevant to pathway	>Head of Service >OSL	Breaches of 31 or 62 day pathway	>Assistant Director for the Specialty

**please note that red flag appointments will escalate 1st out-patient appointment, the tracker will be responsible for liaising with red flag team if patient is not booked or on red flag out-patient waiting list for appointment.*

3.4 Delayed Escalation Response:

If the Cancer Trackers are awaiting a response for longer than 1 week regarding a management plan for a patient on a cancer pathway, and all relevant steps have been taken as per escalation policy, the relevant Multi Disciplinary Meeting Chair will be notified to avoid any further delays for the patient and copied to HOS for the specialty.

3.5 MDT Meetings:

The tracker will raise all on going risks at the Multidisciplinary meeting which will be minuted, and communicate the outcome and any unresolved issues to the CSC. If no solution is found, the risk will be escalated through a series of senior managers (see table 2) ultimately to the Clinical Lead for Cancer, who will inform the Chief Executive in the event of failure to resolve this issue.

3.6 Deferment from MDT:

If a patient is deferred from MDT discussion, this must be escalated to the releveant specialty HOS and OSL. It is the HOS and OSL responsibility to ensure the patient is discussed the following week and this is highlighted to the Chair of the MDT.

3.7 Inter-Trust transfers:

It is recognised good practice that where a potential breach or confirmed breach requires an Inter Trust Transfer (ITT), it is the responsibility of the Southern Trust's Executive Lead for Cancer to contact the Executive Lead for Cancer in the 'referred to' Trust to discuss delayed referrals (received after 28 days) and breach situations in order to understand reasons for delay and to agree "shared breaches".

Unfortunately, as pathways for some tumour sites continue to come under increased pressure, it may not always be practical for this level of contact/discussion to take place. The Trust will continue to liaise closely with the 'referred to' Trust in these circumstances to ensure patients receive treatment and care as quickly as possible on the pathway

4.0 Escalation Chain

Table 2 – Escalation chain for trigger points throughout cancer pathway

Escalation Chain	Role Responsible for Escalating	Escalation Point	Timescale for escalation	Cumulative Timescale for escalation
1.	Red Flag Appointments Team/ Cancer Tracker/MDT Co-ordinator	Cancer Services Co-Ordinator	24 hours	24 hours
2.	Cancer Services Co-ordinator	Head of Service for the Specialty Head of Service for Cancer copied to relevant OSLs	24 hours	48 hours
3.	Head of Service for the Specialty	Assistant Director for the Specialty Assistant Director for Cancer Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	3 days
4.	Assistant Director for the Specialty	Chair of MDM *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	4 days
5.	Chair of MDM	Executive Lead for Cancer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	5 days
6.	Executive Lead for Cancer	Director of Acute Services *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	6 days
7.	Director of Acute Services	Chief Executive Officer *Copied to Head of Service for Cancer and Cancer Services Co-ordinator*	24 hours	7 days

Note – these timescales are the longest periods expected.

Each Cancer Tracker/MDT Co-ordinator will be aware of individual patient pathways for each tumour site and the reasonable timescales expected. A generic pathway is attached as Appendix 1, specific site pathways are are also available.

Each step of the pathway is a potential weak link in the chain; and clear observation is required at all stages to ensure:

(a) patient appointment is booked
(b) patient attends appointment
(c) the next review appointment is booked
(d) treatment is commenced

The table above illustrates the escalation chain with each level escalating as required until the delay has been addressed.

Escalation reporting and actions taken will be noted by the tracker in the diary page of the Capps system.

Table 3 – Escalation Chain Roles and Contacts

Roles	Contact Name
Cancer Tracker/ MDT Co-Ordinator	Marie Dabbous Anne Turkington Hilda Shannon Wendy Kelly Shauna McVeigh Griania White Rachel McCartney Catherine Glenny Sinead Lee Sarah Moore
Cancer Services Co-Ordinator	Vicki Graham Angela Muldrew
Heads of Service	Fiona Reddick - Cancer Services Martina Corrigan - Urology/ENT Amie Nelson - UGI / LGI / Breast Kay Carroll – Derm / Lung Wendy Clarke – Gynaecology Louise Devlin - Gastroenterology
Operational Support Lead	Sharon Glenny – IMWH & CCS Wendy Clayton – SEC Lisa McAreavey - MUSC
Assistant Director	Barry Conway – IMWH & CCS Anne McVey – MUSC Ronan Carroll – SEC
Chair of MDM	Dr McCracken – Gynae Mr Neill – LGI Mr Glackin – Urology Dr Mathers – Breast Dr Convery – Lung Dr O'Hagan – Skin Dr Boyd – Haematology Dr McCaul – Head & Neck
Executive Lead for Cancer	Dr McCaul
Director of Acute Services	Esther Gishkori
Chief Executive Officer	Shane Devlin

5.0 Pathway Breaches

Breach reports will be commenced by the Cancer Tracker/MDT Co-ordinator where patients breach the targets, i.e. 14 day for breast, 28 day for inter–trust transfers, day 31 and day 62 breaches.

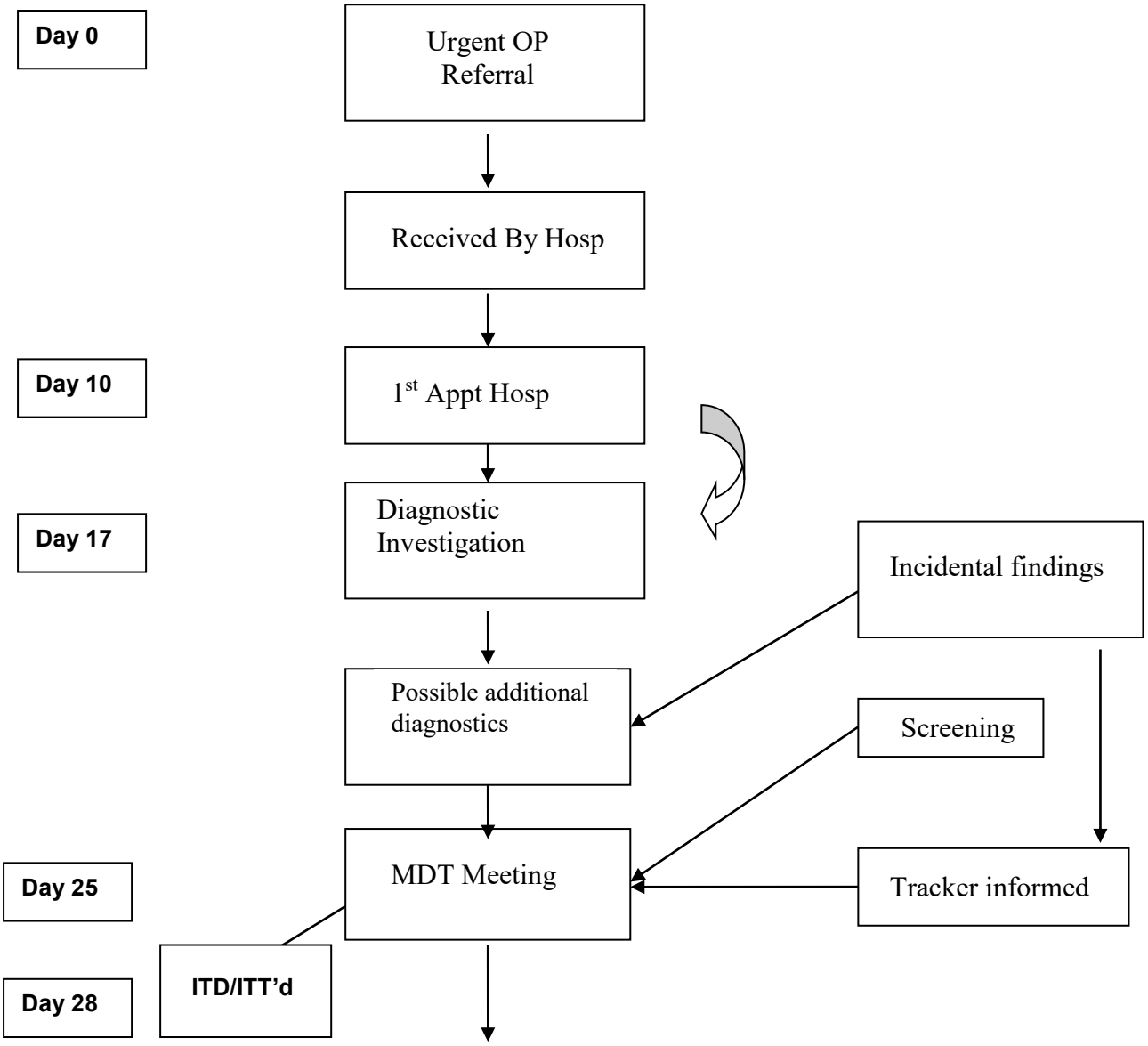
A copy of the breach report will be forwarded to the relevant Assistant Director, and the team's Clinical lead for action as appropriate.

Monthly breaches by tumour site will be discussed at the Cancer Monthly Performance Meeting and areas for improvement analysed.

This policy must be followed by all members of staff, in every event.
This policy is designed to ensure problems are resolved at the lowest level, but that an Executive Director is informed within 24 hours of any failure of the system that has not been resolved at lower organisational/divisional levels.

Appendix 1

PATIENT PATHWAY



31 day target:
Maximum 1 month wait from decision to treat to first treatment for all cancers

62 day target:
Maximum 2 month wait from an urgent GP referral to first treatment for all cancers

NEW REFERRAL PATHWAY UROLOGY SERVICES

OUTPATIENT REFERRAL SOURCE — NOTE

ED | Other Consultant | Other Hospital — NOTE | CCG e.g. Primary Care — NOTE

Referral Date Stamped and Registered on PAS and Priority Status Recorded
(1 Day)
On occasions it could be longer as clarification on referral is required

Referral Appears in NIECR automatically registers on PAS

NOTE: Additional steps may be requried for children, adults at risk, those with physical/learning difficulties and those who require assistance with language

NOTE NOTE

Consultant of Week for Triage
(Triaged within 3 days and Red flag daily during week)

Accept Referral — NOTE

No → Discharged back to Referer
Consultant Dictate letter or email Referer

Yes →

OUTPATIENT

DIAGNOSTIC PATHWAY

NOTE

RED FLAG TEAM
Should be seen first apt in pathway 14 days

NEW Urgent

NEW Routine

Once Referral has been Triaged PAS to be updated and Patient Added to WL as per Triage.
Acknowledgement letter sent to Patients/ within 1 Working Day
(most of the time) - electronic triage has helped this

Inappropriate Referrals returned to Referrer/Source immediately and Referral closed on PAS with reason for decline of referral recorded.

Validation reports (Triage Escallation Report) run weekly (*Most Weeks depending on capacity*) to pick up any outstanding referrals sitting over 3 working day period. This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

New Urgent WL
General List
+ Each Doctor has WL

(6 weeks)
HOS/OSL will give this information

New Routine WL
General WL
+ Each Doctor has WL

(9 Weeks)
HOS/OSL will give this information

Urgent Review WL
Each Doctor has WL

Routine Review WL
Each Doctor has WL

Out Patient
Stone Clinic/Treatment WL
Mr Young

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

PB1 apt letter sent out in first instance - Patients should receive minimum of 3 weeks (6 weeks indicated in IEAP) notice and 2 appointment dates (within NI)
Patients are asked to contact Booking Centre to book a time slot

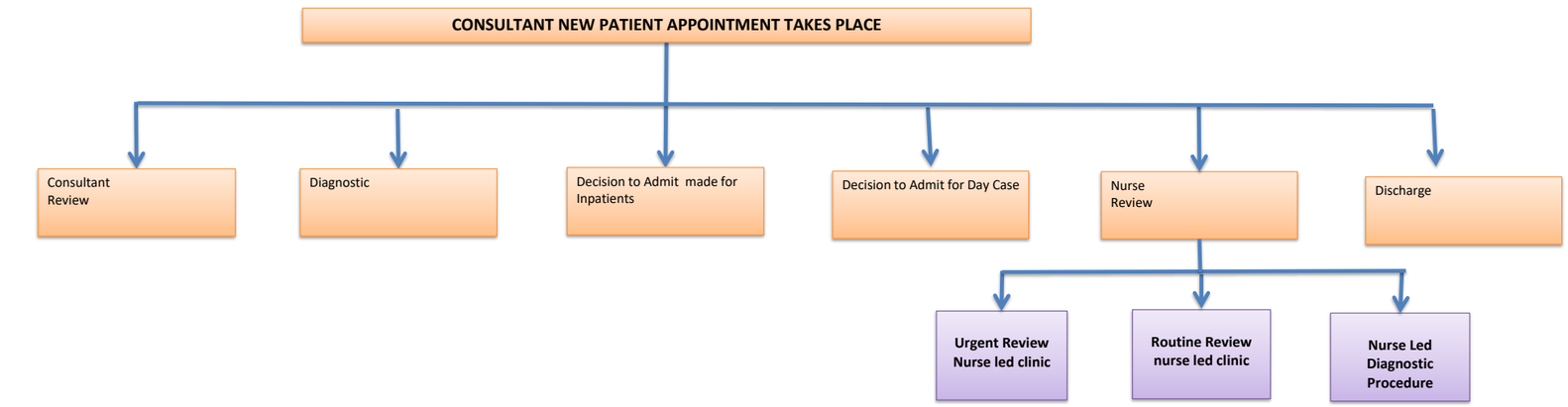
After 1 week PB2 sent out to patient. If there is no response following this appointment a letter to patient and referrer regarding Discharge from this clinic waiting list.

If patient refuses an appointment after being given a minimum 3 weeks notice - waiting time is cancelled.

As there is a delay with Clinic Templates - PB1 and PB2 letters are not always viable to use as in order to fill slots phone calls to patients have been happening to arrange appointments and 3 weeks notice is not given which means that after 2 appointment offered with less than 3 weeks notice means these patients remain on the WL and are unable to be discharged.

NOTE

NOTE



REDFLAG PATH REFERRAL PATHWAY UROLOGY SERVICES

REFERRAL SOURCE

NOTE

ED | **Other Consultant** | **Other Hospital** | **CCG e.g. Primary Care** NOTE NOTE

Red Flag Admin booking Team date stamp add on PAS + Added to Spreadsheet Daily Patients to be appointed within 14 days

Referral Appears in NIECR automatically registers on PAS

Any Mismatches go on a holding table in NIECR - Red Flag Staff check this a few times daily NOTE

NOTE: Additional steps may be requried for children, adults at risk, those with physical/learning difficulties and those who require assistance with language

Consultant of Week for Triage (Triaged daily during week)

Accept Referral

No

Discharged?

Consultant Dictates letter to Referer Medical Sedretary types and returns Referral to Referer RECORDED ON PAS BY MEDICAL

Yes

NOTE

Validation reports to show delayed triage run weekly (*Ideally this should be twice weekly)* to pick up any outstanding referrals sitting over 3 working day period. This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

This report is escalated to Operational Services Lead/HOS .

Once Referral has been Triaged PAS to be updated and Patient Added to WL as per Triage. by Red Flag Admin Team
Acknowledgement letter sent to Referer/ within 1 Working Day - (most of the time) - electronic triage has helped this

NOTE NOTE

DIAGNOSTIC
MRI, CT, Flexible Cystoscopy, Blood Test, PSA, Urine Test

MDM

NOTE

OUTPATIENTS

F2F / Virtual /OP Apats
Red Flag Urology

(One Waiting List which is booked to specialist clinics where required) Patients taken in chronological order)

Down Graded Referrals
New/Urgent Review
i.e. not red flag

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

Haematuria Apts

Prostate / Renal Apts

Consultant Led Urology

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

Nurse Led Urology LUTS

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

NOTE
NOTE

MDM
Takes Place Weekly
Thursday Afternoon

PATIENT SEEN
(REQUEST FOR DIAGNOSTICS OR MDM OR DISCHARGED)
Patients could then be downgraded from Red Flag to Routine (Routine Review List) or routine Diagnostic

MDM REview apt Following Discussion at MDM
This apt is booked by Medical Secretary

DECISION TO TREAT PATHWAY

NOTE

Priority status changed?

Yes

No

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Combined urogynae approach to Female LUTS

Mr. O'Donoghue

Jenny McMahon

Sabahat Hasnain

Current Urology Team

- Four consultants as permanent staff
- One locum consultant
- One consultant with expertise in female urology
- One specialty doctor and one urology nurse specialist working within benign service

Staff shortages!

NICE guidelines on urinary incontinence and pelvic organ prolapse (2019)

Local MDTs for women with primary stress urinary incontinence, overactive bladder or primary prolapse should include:

- 2 consultants with expertise in managing urinary incontinence in women and/or pelvic organ prolapse
- a urogynaecology, urology or continence specialist nurse
- a pelvic floor specialist physiotherapist and may also include:
- a member of the care of the elderly team
- an occupational therapist
- a colorectal surgeon.

Indications for referral to a specialist service in women with urinary incontinence include:

- persisting bladder or urethral pain
- palpable bladder on bimanual or abdominal examination after voiding
- clinically benign pelvic masses
- associated faecal incontinence
- suspected neurological disease
- symptoms of voiding difficulty
- suspected urogenital fistulae
- previous continence surgery
- previous pelvic cancer surgery
- previous pelvic radiation therapy.

Consideration

- **Are gynaecologists able to take all the women from our current urodynamics waiting list?**
- **Will that include initiating treatment plans?**

Patients requiring urological input:

1. Haematuria
2. Dysfunctional voiding
3. Previous urological surgery – augmentation cystoplasty, diverticulectomy, bladder repair, fistulae, autologous fascial slings in conjunction with gynae
4. Congenital urological conditions
5. Neurological patients
6. Urethral diverticulum
7. Urethral fistulae
8. Tapes – urinary tract erosion/ stones

Female LUTS service development:

Are you able to facilitate all female LUTS patients and have an agreed female LUTS pathway?

- That would include all appropriate referrals
- Standardisation of urodynamic practice between Gynaecology and Urology
- Potential for accreditation
- Potential for service development including
  - combined uro-gynae botox & PTNS lists
  - video urodynamics lists

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Clayton, Wendy

From: Corrigan, Martina <[redacted]>
Sent: 16 March 2016 13:45
To: Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Graham, Vicki; Carroll, Ronan; Trouton, Heather; Glenny, Sharon; Reddick, Fiona; Clayton, Wendy; McVeigh, Shauna
Subject: RE: Urology escalation

Dear all,

Has anyone anything sooner?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Clayton, Wendy
Sent: 15 March 2016 13:29
To: McVeigh, Shauna; Corrigan, Martina
Cc: Graham, Vicki; Carroll, Ronan; Trouton, Heather; Glenny, Sharon; Reddick, Fiona
Subject: RE: Urology escalation

Martina

See below escalation. RF circumcision & Biopsy not booked until the 4/4/16 – is there anything you can do to bring forward?

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: [redacted]
Mob: [redacted]

From: McVeigh, Shauna
Sent: 15 March 2016 13:20
To: Clayton, Wendy
Cc: Graham, Vicki
Subject: Urology escalation

Hi

Please see escalation, patient who is on day 21. Was seen in clinic on 03.03.16. Outcome was for RF circumcision and biopsy. Paulette had advised this was to be appointed for 04.04.16. Had asked if this could be performed any sooner, as patient would be at risk of breaching. She had advised nothing sooner. Patient will be on day 41 when biopsied.

Day	Date	Event
0	23/02/2016	Suspect Cancer 'Red Flag' referral from GP/Dentist referred to Craigavon
6	29/02/2016	CMYREG 03.03.16 D9
9	03/03/2016	First Seen at Craigavon
16	10/03/2016	Clinic outcome from 03.03.16 - On examination: glans penis has an erythematous area incorporating the majority of the dorsal aspect of the glans penis. ? CIS. I discussed the findings with Mr Personal Information redacted by the. He has agreed to the following plan: 1. A course of Canesten has been prescribed. 2. Red Flag circumcision and glans penis biopsy.
16	10/03/2016	Patient has been added to WL for RF Circumcision and biopsy of penis. Will email secretary for a date.
21	15/03/2016	Paulette advised that this has been booked for 04.04.16 - have emailed back to advise this is very late - can patient not be seen any sooner as that would be day 41 when performed. Await response.
21	15/03/2016	Secretary advised - Yes, earliest we can get ? nothing w/c 28.03.16 due to Easter. Will escalate patient to OSL as high risk of breaching if cancer is confirmed.

Thanks
Shauna

Clayton, Wendy

From: O'Brien, Aidan <[redacted]>
Sent: 23 August 2016 21:10
To: Corrigan, Martina; ONeill, Kate; Campbell, Dolores; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Carroll, Ronan; Reddick, Fiona; McVeigh, Shauna; Graham, Vicki; Clayton, Wendy; Glenny, Sharon
Subject: RE: Urology escalation

Martina at al,

I do not have any memory of having agreed to review this patient in John's absence, though my memory is not all it should be at times.
In the outcome of the MDM which I chaired on 21 July 2016, I stated that the patient was to be reviewed by Mr. O'Donoghue.
I certainly did not make any plans to review him.
In any case, I do not have a review clinic until 23 September 2016.
So, I cannot help with this one,

Aidan.

From: Corrigan, Martina
Sent: 23 August 2016 16:30
To: ONeill, Kate; Campbell, Dolores; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Suresh, Ram; Young, Michael
Cc: Carroll, Ronan; Reddick, Fiona; McVeigh, Shauna; Graham, Vicki; Clayton, Wendy; Glenny, Sharon
Subject: RE: Urology escalation

Dear all,

Please see below, can anyone see this patient in John's absence as his next review clinic will not be until 5 September.

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Glenny, Sharon
Sent: 23 August 2016 15:43
To: Corrigan, Martina
Cc: Carroll, Ronan; Reddick, Fiona; McVeigh, Shauna; Graham, Vicki; Clayton, Wendy
Subject: FW: Urology escalation

Hi Martina

Please see below urology escalation, unfortunately patient is a confirmed cancer at D39 of pathway. The patient is still awaiting a review appointment, are you able to help with getting this organised?

Thanks

Sharon

From: McVeigh, Shauna
Sent: 23 August 2016 15:04
To: Glenny, Sharon
Cc: Graham, Vicki
Subject: Urology escalation

Hi

Please see escalation of patient that is a confirmed cancer, he was discussed at MDM 21.07.16 and needed reviewed with Mr O'Brien, he needs MRI and bone scan requested and further MDM discussion. I have been chasing this review appointment up but it remains to be booked.
Patient belongs to Mr O'Brien. He was originally Mr O'Donoghue's but Mr O'Brien agreed to review in his absence.

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

Day	Date	Event
14	07/03/2016	First Seen at Craigavon
15	14/04/2016	PSA has been repeated and is still elevated - it was 8.27. Will advise consultant as clinic letter had stated that they might need TRUSB. Have cc Kate into email await response.
17	20/04/2016	No response from Mr O'Donoghue have emailed to ask how he would like to proceed with this patient - no requests on sectra and no pending appointments on PAS.
33	09/07/2016	TRUSB performed on 05.07.16 - for MDM 14.07.16 - pathology outstanding.
33	26/07/2016	Review with Mr O'Brien is outstanding - patient was discussed @ MDM on 21.07.16.
33	28/07/2016	Have chased review up with secretary - adjustment added following TRUSB.
33	02/08/2016	No response from secretary - she is of on leave. Will ask Mr O'Brien when he can review this patient.
33	16/08/2016	No date for review have checked with secretary - she was off on leave date awaited. MRI and bone scan to be requested.
33	17/08/2016	Suspension End : Suspension - Medical Following TRUSB
39	23/08/2016	Review remains to be booked post MDM - patient needs MRI and bone scan requested. Will escalate patient to OSL to try get review booked.

Shauna Mcveigh
Cancer tracker / MDT Co-ordinator
Extension - Personal Information redacted by

Clayton, Wendy

From: Corrigan, Martina <Personal Information redacted by the USI>
Sent: 06 September 2017 17:31
To: Jacob, Thomas; Glackin, Anthony; Haynes, Mark; O'Brien, Aidan; ODonoghue, JohnP; Young, Michael
Cc: Clayton, Wendy; McVeigh, Shauna; Reddick, Fiona; Glenny, Sharon; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Robinson, NicolaJ; Troughton, Elizabeth
Subject: RE: Urology escalation - Personal Information redacted by the USI

Good evening

Can anyone assist with a date for TURBT for this patient please?

Regards

Martina

From: Glenny, Sharon
Sent: 01 September 2017 16:12
To: Corrigan, Martina
Cc: Clayton, Wendy; McVeigh, Shauna; Reddick, Fiona
Subject: FW: Urology escalation - Personal Information redacted by the USI

Hi Martina

Please see urology escalation below – patient is currently D43 of pathway and requires date for surgery. Any assistance you can offer in relation to this would be greatly appreciated.

Thanks

Sharon

From: McVeigh, Shauna
Sent: 30 August 2017 11:23
To: Glenny, Sharon
Subject: Urology escalation - Personal Information redacted by the USI

Hi,

Please see escalation of patient that is on day 41 of his pathway delay with 1st appointment wasn't seen until day 33. He has been added to Mr O'Brien's WL for surgery. Have emailed secretary for a date. Could be at risk of breaching if cancer is confirmed which is likely from his CT report, and if surgery is not performed within target.

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

Day	Date	Event
	21/02/2012	Pathology : UGEB UPPER GI ENDOSC. BX ~
0	20/07/2017	Consultant Upgrade to 'Red Flag' referred to Craigavon
7	27/07/2017	1st apt 22/08/2017. Day 33. Escalated.
33	22/08/2017	First Seen at Craigavon
35	24/08/2017	Clinic outcome from 22.08.17 - Today flexible cystoscopy was performed which unfortunately revealed a solitary likely TCC at the bladder base, additionally the prostate was seen to be enlarged but non-occlusive. We will book him for a red flag TURBT in the near future.
41	30/08/2017	Patient is on WL for a date for surgery - added to Mr O'Briens list. Will email secretary for a date & escalate patient to OSL.

Thanks
Shauna

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

Clayton, Wendy

From: Clayton, Wendy < Personal Information redacted by the USI >
Sent: 22 September 2017 09:55
To: Glenny, Sharon; Graham, Vicki
Subject: FW: UROLOGY ESCALATION -

See below Vicki – can you action please

Wendy Clayton
Operational Support Lead
ATICS/SEC
Ext: Personal Information redacted by the USI
External number: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

EXT** Personal Information redacted by the USI **if dialling from Avaya phone.
***If dialling from old phone please dial** Personal Information redacted by the USI*

External No. Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 21 September 2017 17:39
To: Clayton, Wendy
Subject: RE: UROLOGY ESCALATION -

Can you ask for this to be added on as extra on any of the clinics next week please.

Regards

Martina

From: Clayton, Wendy
Sent: 21 September 2017 12:14
To: Corrigan, Martina
Subject: FW: UROLOGY ESCALATION -
Importance: High

See below ☹

Wendy Clayton
Operational Support Lead
ATICS/SEC
Ext: Personal Information redacted by the USI
External number: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

EXT** Personal Information redacted by the USI **if dialling from Avaya phone.
***If dialling from old phone please dial** Personal Information redacted by the USI*

External No. Personal Information redacted by the USI

From: Graham, Vicki
Sent: 21 September 2017 12:10
To: Glenny, Sharon
Cc: Clayton, Wendy
Subject: FW: UROLOGY ESCALATION -
Importance: High

Hi Sharon,

Please see below late referral that appears to have been overlooked with eTriage – On investigating this what appears to have happened is that it has been triaged by Mr O'Brien with a comment, but a member of staff in the appointment team has pushed the referral through but it has not been appointed. Sinead identified this yesterday when scrolling down through the tracking. When referrals are being booked from eTriage a referral letter should also be printed at the time the appointment is booked, so that this can be filed away, and also as a check that appointments are all booked. eTriage is unfortunately down at the minute (From 11-2pm) due to ongoing work so I am unable to check to see if any comments were added when pushing referral through as action completed. The appointment has now been booked for 05.10.17, Day 52. I will check with Martina is there would be anything sooner, but I just wanted to advise you of patient first.

Regards,

Vicki Graham
Cancer Services Co-ordinator
Red Flag Appointment Office
Tel. No. Personal Information redacted by the USI
Internal Ext: Personal Information redacted by the *(Note: if dialling from the old system please dial* Personal Information redacted by *in front of the extension)*

From: rf.appointment
Sent: 21 September 2017 11:05
To: Graham, Vicki
Subject: UROLOGY ESCALATION

Vicki,

Please see escalation below. This is the referral I noticed when checking the tracking part of CAPPS. It looks like this referral has ben overlooked.

Personal Information redacted by the USI

OP REG – 14/08/17 CMYTDU – 05/10/17 D52 Personal Information redacted by the USI (Upgraded referral)

Best

Sinéad Catherine Joanne Langley
Higher Clerical OfficerHR Assistant

✉ Southern Health & Social Care Trust
Red Flag Appointments Office
Main Building (Beside boardroom)
Craigavon Area Hospital
Lurgan Road, Portadown

Ext. Personal Information redacted by the Personal Information redacted by the USI

My Number has changed!
EXT Personal Information redacted by the USI if dialling from Avaya phone.
If dialling from old phone please dial personal information redacted by the USI

Clayton, Wendy

Subject: FW: Audit of charts re AOB 13/1/17

From: Corrigan, Martina <[redacted]>
Sent: 13 January 2017 16:41
To: Clayton, Wendy <[redacted]>; Carroll, Ronan <[redacted]>
Subject: RE: Audit of charts re AOB 13/1/17

Thanks Wendy

I have been working with Pamela Lawson on this and they have located 12 of these so far and they are now searching the Villas for these as I have provided her with the numbers so this will change.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

From: Clayton, Wendy
Sent: 13 January 2017 16:39
To: Carroll, Ronan; Corrigan, Martina
Subject: Audit of charts re AOB 13/1/17

Ronan/Martina

I have updated the below today 13/1/17:

Tracking code	Description	Longest date tracked to borrower	No. of charts tracked to AOB
CU2	Mr AOB O'Brien	August 2006	8
CAOBO	AOB office	June 2003	16
CURWDO	AO Brien Urology cl		0
CURWOB	AOB urology CAH		0
EURAOB	Enniskillen AOB urology	Dec 2016	11
Totals			**35 charts**

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: [redacted]
Mob: [redacted]

From: Clayton, Wendy
Sent: 23 December 2016 13:10
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Audit of charts re AOB

I have included longest date as requested that the chart has been tracked to the borrower:

Tracking code	Description	Longest date tracked to borrower	No. of charts tracked to AOB
CU2	Mr AOB O'Brien	August 2006	8
CAOBO	AOB office	June 2003	210
CURWDO	AO Brien Urology cl		0
CURWOB	AOB urology CAH		0
EURAOB	Enniskillen AOB urology	June 2014	147
Totals			**365 charts**

From: Clayton, Wendy
Sent: 23 December 2016 13:02
To: Carroll, Ronan; Corrigan, Martina
Subject: RE: Audit of charts re AOB

Ronan / Martina

I have ran a PAS query to see how many charts are tracked out to Mr O'Brien. I believe this will be useful for your meeting next Friday:

Tracking code	Description	No. of charts tracked to AOB
CU2	Mr AOB O'Brien	8
COABO	AOB office	210
CURWDO	AO Brien Urology cl	0
CURWOB	AOB urology CAH	0
EURAOB	Enniskillen AOB urology	147
Totals		**365 charts**

Happy to talk through.

Wendy

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

From: Clayton, Wendy
Sent: 23 December 2016 11:59
To: Carroll, Ronan; Corrigan, Martina
Subject: Audit of charts re AOB

Ronan

I have undertaken an audit of 11 SWAH clinics

There were 183 patients attended, I did a random audit on 98 charts and 55 were tracked to AOB = 56%

Do you want me to do anymore?

Regards

Wendy Clayton
Operational Support Lead
ATICS/SEC
Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

Clayton, Wendy

Subject: FW: outstanding charts for Mr O'Brien
Attachments: updated missing notes as per 16 jan 17.docx

From: Corrigan, Martina <[redacted]>
Sent: 16 January 2017 16:07
To: Carroll, Ronan <[redacted]>
Cc: Clayton, Wendy <[redacted]>
Subject: outstanding charts for Mr O'Brien

Ronan

As discussed, Health Records have done an extensive search of the missing charts that were tracked out to Mr O'Brien.

After this search the total outstanding is 13 charts and I have attached a list of these with comments against same.

If you need any more detail please let me know

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: [redacted]
Mobile : [redacted]

MDT SAI Recommendations Work Plan

Rec	From SAI Report
1	The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.
	How This Will Achieved From SAI Report
	This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.
Rec	**From SAI Report**
2	All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.
Rec	**From SAI Report**
3	The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight fortnightly agenda. There must be action on issues escalated.
Rec	***From SAI Report***
4	The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.
	How This Will Achieved From SAI Report
	This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans.This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).
Rec	**From SAI Report**
5	The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed
	How This Will Achieved From SAI Report

MDT SAI Recommendations Work Plan

	This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by fail-safe mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit / assurance. It is essential that current limited clinical resource is focused on patient care.
Rec	**From SAI Report**
6	The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.
	How This Will Achieved From SAI Report
	This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources.This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.
Rec	**From SAI Report**
7	The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
8	All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.
Rec	**From SAI Report**
9	The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
10	The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals.

MDT SAI Recommendations Work Plan

	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
11	The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Regional Guidance for Implementing a Lookback Review Process

July 2021

Contents

This policy should be read in conjunction with the Policy for Implementing a Lookback Review Process.

Regional Guidance for the Implementing of a Lookback Review Process

1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have been exposed/potentially exposed to a specific hazard in order to identify if any of those exposed have been harmed, and to identify the necessary steps to ameliorate the harm (e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service etc.).[1]

This Regional Guidance, along with the accompanying policy document, has been drafted in order to standardise and update the approach taken to Lookback Reviews by the HSC in Northern Ireland. It replaces HSS (SQSD) 18/2007, issued by the Office of the Chief Medical Officer on 8 March 2007.

A Lookback Review is a process consisting of four stages; immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s); the identification of the service user cohort through a service review or audit of records to identify those potentially affected; the recall of affected service users; and finally closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement (see summary diagram of Lookback Review Process (Diagram 1).

The triggering event or circumstances under which a Lookback Review would be considered include; faulty or contaminated equipment, missed/delayed/incorrect diagnosis relating to diagnostic services, failure of safety critical services or processes, competence issues with a practitioner(s) or identification of a practitioner with a transmissible infection or underlying health problem that may pose a serious risk to a service user following procedures undertaken (see also Policy on the Implementation of a Lookback Review Policy Section 1 for a more comprehensive list).[2]

[1] Health Service Executive (HSE) 'Guideline for the implementation of a Look-back Review Process in the HSE'. HSC National Incident Management and Learning Team, 2015. Section 7.1 Page 10.
[2] See also 'Policy for the Implementation of a Lookback Review Process' Section 1 Page 3.

The existence of a hazard exposing a number of people to a risk of harm is not always immediately apparent. The triggering event may have been raised as a concern by a service users and/or their family/carers or it may have been highlighted by a service review/audit or it may have come to light as a result of a concern expressed by a colleague or through a Serious Adverse Incident (SAI) Review or Thematic Review undertaken by the Regulation and Quality Improvement Authority. The triggering event will alert the Health and Social Care (HSC) organisation that a number of people may have been exposed to a hazard and the need to instigate a Lookback Review Process should be immediately considered.

1.1 What does a Lookback Review Process involve?

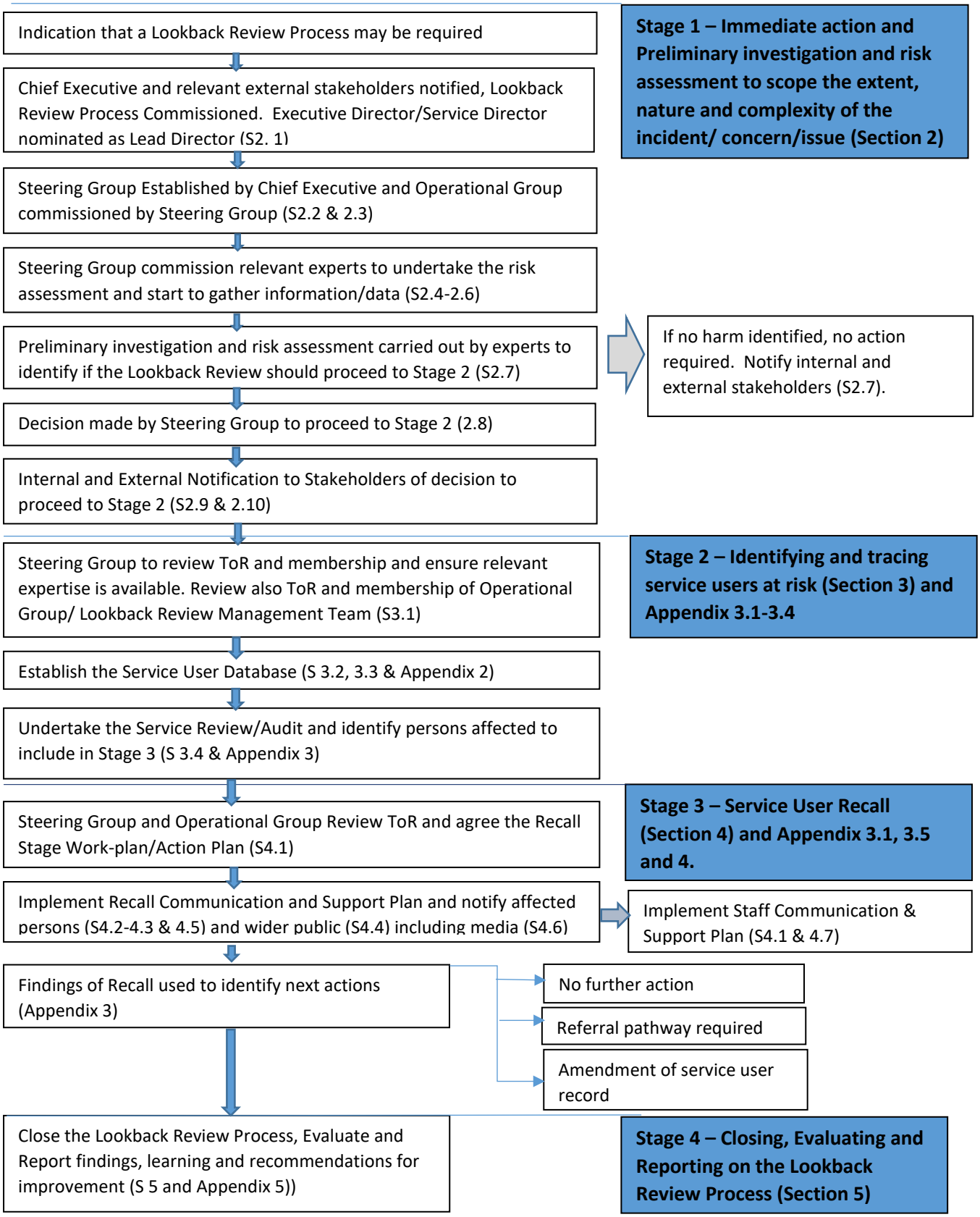
The Lookback Review Process involves:

- Identifying, tracing, communicating, and providing appropriate ongoing advice to, and/or management of, the group of service users who have been exposed or potentially exposed to a hazard and who may have been harmed, or are at risk of future harm or loss;
- Notification internally to Trust Board and to appropriate external stakeholders (see Sections 2.1, 2.9 and 2.10);
- Notification to the wider public as and when required. While openness and candour are guiding principles in a Lookback, it is essential that communication occurs at a time when clear messages can be conveyed whilst ensuring that the 'at risk' population has been identified and communicated with before the wider public is alerted. Relevant healthcare professionals including General Practitioners should also be identified and communicated with in advance of any public statements. This is essential to maintain public confidence and prevent unnecessary anxiety and to ensure that services can be focused on the correct group of people (See Section 4 below).

The following diagram (Diagram 1) provides a summary of each stage of the Lookback Review Process and may be used in conjunction with the Lookback Review Process Checklist (see Appendix 5). The Process, as laid out below is a step by step guide. It is important, however, that the primary focus should remain on harm and risk of harm to service users. Therefore, there will be occasions where it is

clear from the outset that a Lookback Review will be necessary and where the organisation effectively runs more than one of these stages consequently.

Diagram 1 Flowchart - Summary of Stages in a Lookback Review Process



1.3 Governance Arrangements

The HSC organisation should ensure that the Lookback Review Process is managed in line with extant Governance and Assurance Framework arrangements.[3] The Steering Group (Section 2.2) should be seen as a 'task and finish' group within the HSC organisation's Governance/Assurance Framework structure reporting to Trust Board through the Senior Management Team/ Executive Team of Trust Board. The Steering Group should commission an Operational Group or Lookback Review Management Team to take forward the operational aspects of the Review Process (unless the Lookback Review is anything other than limited in terms of nature, extent and complexity).

When scoping the nature, extent and complexity of the Lookback Review Process (Section 2.6 – 2.7) the Steering Group should evaluate and escalate the risk in line with the organisation's Risk Management Strategy. This will ensure that the risk(s) identified will be included in either the organisation's Board Assurance Framework, Corporate Risk Register or Directorate Risk Register and managed in line with the Risk Management Strategy.

The Lookback Review Process should be outlined in the mid-year Assurance and/or annual Governance Statement as required. The annual Governance Statement is the means by which the Accounting Officer provides a comprehensive explanation on the HSC organisations' approach to governance, risk management and internal control arrangements and how they operate in practice.[4] The Statement provides a medium for the Accounting Officer to highlight significant control issues which have been identified during the reporting period and those previously reported control issues which are continuing within the organisation.

1.4 Other Related Incident Management Processes including Investigations

As stated previously, Lookback Reviews are carried out in order to identify if any of those exposed to a hazard have been harmed, and to identify the necessary steps to take care of those harmed. The incident giving rise to the Lookback Review Process or issues identified as a result of the process may require review as a Serious

[3] DoH '*An Assurance Framework: a Practical Guide for Boards of DoH Arm's Length Bodies*.' April 2009.
[4] Department of Finance ' *Managing Public Money NI (MPMNI)*' AS.1

Adverse incident (SAI).[5] This will require a parallel (though interlinked) review which should be undertaken in line with Health and Social Care Board guidance [6] to identify key causal and contributory factors relating to the triggering event (see Sections 2.10 and Section 5). In some circumstances, a Lookback Review Process may have been prompted by a preceding SAI review.

The circumstances leading to a decision to implement a Lookback Review may require the HSC organisation to notify other statutory agencies such as the Coroners Service for Northern Ireland and/or the Police Service for Northern Ireland (PSNI). The reporting of the Lookback Review as an SAI to the Health and Social Care Board (HSCB) will work in conjunction with, and in some circumstances inform, the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Guidance.

A Memorandum of Understanding (MoU) has been agreed between the Department of Health (DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI).[7] The MoU applies to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the MoU apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

A Lookback Review Process may raise issues of professional competence/conduct. HSC organisations will then be required to instigate performance management, capability and disciplinary reviews or investigations in line with their internal Human Resource policies, procedures and relevant professional regulatory guidance for

[5] Health and Social Services Board (HSCB) 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents'. November 2016 Version 1.1.
[6] *Ibid.*
[7] DoH *'A Memorandum of Understanding' developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident'.* HSS (MD) 06/2006, February 2006.

example Maintaining High Professional Standards (MHPS).[8] These processes should run as a parallel process to the Lookback Review, although relevant information from one process may inform the other. In such circumstances, confidentiality in respect of the member of staff must be taken into consideration.

[8] DoH 'Maintaining High Professional Standards in the Modern HPSS'. HSS (TC8) 6/2005. November 2005.

2.0 Stage 1 – Immediate Action, Preliminary Investigation and Risk Assessment

Immediate action should be taken to ensure the safety and wellbeing of the service users.

2.1 Notification of the need to consider a Lookback Review Process

The Director of the service involved should be notified immediately that a hazard or potential hazard has been identified which may require the organisation to consider implementing a Lookback Review Process. The Director will report the issue(s) internally through the Chief Executive to the Board of Directors in line with the organisation's risk escalation processes. The relevant Director will also need to consider if the hazard might affect other HSC Organisations or private/ independent providers.

It is recognised that at this early stage there may be limited information available to the HSC organisation until information and intelligence is gathered and the risk assessment is undertaken (see Sections 2.6 and 2.7), however, in line with extant guidance, the Director should notify the DoH of the emerging issues by way of an Early Alert (see also Section 2.9).[9] The Early Alert should make clear, if the information is available, the details of other organisations/services potentially involved in NI or in other jurisdictions, the timeframe during which the issue may have been relevant and the potential volumes of services users who may be affected. The Director should also consider if the findings, given the potentially limited information could be considered as an SAI at this time (see Section 2.10). [10] If in doubt, the extant SAI guidance provides the opportunity for the organisation to declare the matter as an SAI, which can then be 'de-escalated' later.[11] The HSC Organisation will also have to consider possible notification of the event(s) to the Coroners Service for NI and/or the PSNI (see Section 1.4).

[9]Department of Health 'Early Alert System' HSC (SQSD) 5/19.
[10] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incidents. November 2016.
[11] *Ibid.,* Section 7.6 Page 21

It is also important to advise the organisation's Head of Communications/Communications Manager at an early stage so that a communication plan including media responses can be prepared in advance.

2.2 Establish Steering Group

A Steering Group should be convened as soon as possible after the disclosure of the issue of concern to develop an action plan and oversee its implementation. Depending on the extent, nature and complexity of the triggering event the Steering Group should be chaired by either the relevant Service Director or in some circumstances it may be chaired by the relevant Executive Director/Professional Lead.

If other investigation processes are in place (e.g. Capability/Performance Management Reviews) these should run as parallel processes, however, information from the other investigative processes, taking into account confidentiality and the information governance requirements that will apply to these parallel processes, may be used to inform the decision making of the Steering Group.

The Steering Group will need to meet on a regular basis to ensure that they receive feedback/ situation reports (SITREPS) from the Operational Group/Lookback Review Management Team and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared as required with internal stakeholders (Executive Team/Senior Management Team and Board of Directors) and external stakeholders i.e. HSCB, Public Health Agency (PHA) and DoH.

2.3 Composition of the Steering Group

The composition of the Steering Group will be dependent on the service involved and the nature and extent of the Lookback Review Process. The Steering Group should not normally involve personnel who may have been directly involved in the event/hazard that triggered the Lookback Review Process.

Depending again on the extent and nature of the Lookback Review the HSC organisation should consider the following as core members; a Non-Executive Director, the Director of service/speciality concerned, relevant professional Executive Director(s), Risk and Governance representative, Head of Communications, Information Technology manager, Medical Records manager and senior service

representatives with expertise (including clinical and/or social care) in the services/ processes which are the subject of the Review Process, a PHA representative and an HSCB representative (in the case where the Lookback Review has been identified as an SAI, the role on the Steering Group will be clearly identified to ensure that the independence of the PHA/HSCB is not jeopardised).

The organisation may also wish to consider a member of a relevant service user representative/advocacy group is included as a member of the Steering Group.[12] In these instances, a confidentiality agreement must be signed by the service user representative. The representative should not have access to service user identifiable data. Such an agreement should be proportionate and reflect the need of the organisation to protect the information of individuals and to ensure that information disseminated is accurate, proportionate and timely and that support mechanisms are in place for service users and staff.

The Steering Group should also commission an Operational Group or Lookback Review Management team which should report to and support the Steering Group in taking forward the operational aspects of the action plan e.g. establishing the service user database (Section 3.2) and supporting the Recall Stage (Section 4).

2.4 Role of the Steering Group

Within 24-48 hours from being established the Steering Group should decide on the immediate response which includes;

- Methodology to determine the size/magnitude, complexity and nature of the risk/harm to service users/carers in order to plan an appropriate Lookback Review Process e.g. risk assessment (see Section 2.7 below);
- Determine if the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations as well as the independent sector and organisations in other jurisdictions;

[12] The Patient and Client Council (PCC) is responsible for delivering and/or providing access to advocacy and support services as specified by the DoH and HSCB guidance in supporting families through a 'hub and spoke' model of service delivery working with providers of advocacy services. Other independent services may be accessed as required through the PCC, including the development of a network of available advisory services.

- Determine the extent of notifications to the DoH, HSCB and PHA that is required, if these notifications have not already been initiated (see Section 2.1 above and Sections 2.9 and 2.10);
- Address and manage notification internally through the Senior Management Team/Executive Team to the Board of Directors;
- Agree on the formation of an expert advisory sub group comprising experts in the area of concern, relevant clinicians, and department or directorate heads to undertake the risk assessment and service review or audit . Consideration should be given as to whether or not that expertise should come from outside the organisation;
- Agree on a service user communications plan. Communication with the service user/family is a priority and the organisation should be proactive in managing the manner and timing in which affected service users receive relevant information (see Section 4.2).
- Agree on a communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected.
- Agree on a media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries (see Section 4.6).[13]

2.5 Steering Group Terms of Reference and Action Planning

The Steering Group should develop and approve Terms of Reference and establish a Lookback Review Action Plan for Stage 1 of the Process. Both the Terms of Reference and action plan should be reviewed and revised as and when the Process proceeds to the next stages.

The action plan should include as a minimum; the management of immediate safety issues, identify those who may have been exposed to harm, care for those who may have been harmed/affected, actions to prevent further occurrences of harm, a communication plan, contingency planning for business continuity of the service and plans for potential service user follow-up.

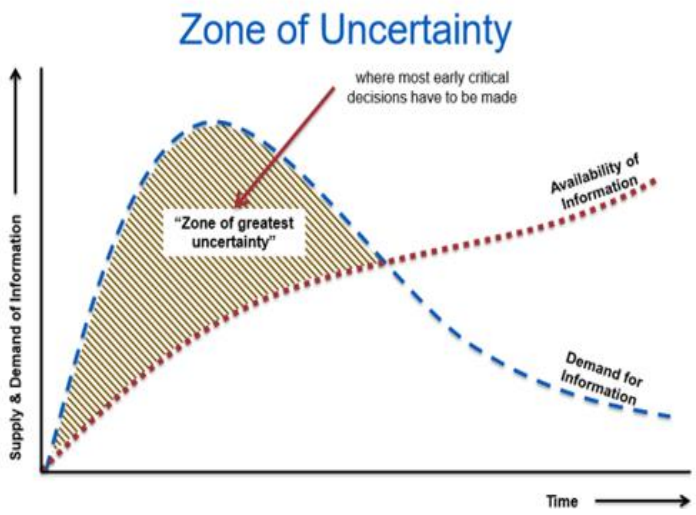
[13] New South Wales 'Lookback Policy Directive', Clinical Excellence Commission Safety & Quality, System Performance & Service Delivery, September 2007. Section 4 Page 5.

2.6 Gathering Information and Intelligence to Scope the Extent, Complexity and Nature of Harm

Key decisions have to be made at this early stage of the process when minimal information may be available to the Steering Group. Decision making should be based on a joint understanding of risk (see below) and shared situation awareness.[14] Situation awareness is having a common understanding of the circumstances, immediate consequences and implications of the triggering event along with an appreciation of the available capabilities and the priorities of the response.[15]

It is important that internal and external stakeholders are aware that the Steering Group may be required to make decisions during a time of uncertainty (or zone of uncertainty) about the level of risk or harm to service users (see Figure 1 below).[16] Depending on the extent, nature and complexity of the Lookback Review Process it can be difficult for the Steering Group to predict when it has gathered the optimum level of information to make decisions such as the decision to announce the Service User Recall stage.

Figure 1 Zone of Uncertainty



At the early stage, as above when limited information is available upon which the Steering Group will be required to make crucial decisions then a Decision Making Model, widely used amongst the emergency services as a tool, could be considered.

[14] Joint Emergency Services Interoperability Principles (JESIP) ' www.jesip.org.uk
[15] *Ibid*.
[16] *Ibid*

Tools to aid decision making include for example the Joint Decision Making (JDM) Model (Figure 2)[17] which helps bring together the available information, reconcile objectives and make effective decisions.

Figure 2 Joint –Decision Making Model

Further information and use of the JDM are available via the Joint Emergency Services Interoperability Principles (JESIP).[18]

All decisions should be recorded/logged, justified, seen to be reasonable and proportionate to the information available at the time. Therefore the Steering Group will require the services of an experienced minute-taker or 'loggist'[19] to ensure an accurate record of actions and decisions is maintained at each stage of the process.

2.7 Risk Assessment [20]

As indicated above, the first stage in the process is to undertake a risk assessment to determine whether the scope, size/magnitude, complexity and nature of harm

[17] Joint-Decision Making Model @ www.jesip.org.uk/joint-descision-model
[18] *Ibid*.
[19] A term used in Major Incident Planning a loggist is the person who is responsible for capturing, through decision logs, the decision making process that might be used in any legal proceedings following an incident ' www.epcresilience.com
[20] HSE. *Op.Cit* Section 7.6 Preliminary Risk Assessment Page 115-16.

arising from the triggering event should progress to the next stage(s) i.e. a service user lookback and potential service user recall. In order to do this, the Steering Group should commission relevant experts to undertake this risk assessment. As above (Section 2.3), the relevant experts may include but are not exclusive to: people with the clinical or social care expertise in the services/ processes which are the subject of the Lookback Review Process, Risk and Governance Managers, and a Public Health Specialist. This will be determined by the Steering Group on a case by case basis.

A decision to undertake the completed Lookback Review Process has significant implications for service users, providers and resources. The risk assessment, therefore, should provide a thorough assessment of the chance of harm and the seriousness of that potential harm. It must be conducted in a manner that balances the need to identify and address all cases where there might be safety concerns on the one hand, with the need not to cause any unnecessary concern to service users or to the public on the other.[21]

The risk assessment should look at:

- If the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations including the independent sector;
- The potential extent of the issue and the level of exposure to the hazard;
- Evidence of harm that has occurred;
- The likelihood of future harm occurring;
- The potential and actual (if relevant) outcomes of the issue e.g. missed diagnosis/ missed return appointments for follow up etc.;
- The potential impact of the issue;
- The potential cohort of service users affected (including service users of other HSC and non-HSC Organisations);
- The potential impact on other service users (not in the 'at risk' cohort) e.g. potential delays in treatment and diagnosis;

[21] *Ibid*. Appendix 1

- The manner in which harm would be ameliorated (e.g. repeat investigation/ onward referral for treatment).

The HSC Regional Risk Matrix and Impact Table may be used as guidance to evaluate the risk.[22] A template for undertaking a preliminary risk assessment is included in Appendix 1 of this Guidance.[23]

The Steering Group will use the information obtained from this assessment to decide if the Process should continue to the Service User Lookback and Recall stages (see Section 2.8). If there is no harm or risk to service users, the Lookback Review Process can be closed. The Steering Group will inform the relevant internal and external stakeholders. It is advised that the Early Alert is updated to indicate that the process has been closed, outlining clear reasons for the decision. The HSC organisation should consider the incident as a 'near miss' and undertake a systems analysis to establish contributory factors, learning and recommendations.

2.8 Decision to proceed to Stage 2 Service User Lookback and Stage 3 Service User Recall

The decision to proceed to the Service User Lookback and Recall stages is a difficult and complex one and should not be taken lightly. As above, the decision should only be considered in circumstances where it is indicated following careful risk assessment, which may necessitate external peer review and advice from senior decision-makers and/or others with knowledge and experience in the specialty in which the Process is being considered and with advice from those who have experience in conducting a Lookback Review Process (see Section 2.7 Risk Assessment).[24] The decision should also include consideration of the impact on other service users (i.e. not the 'at risk' cohort) for potential delays in diagnosis and treatment.

Lookback Reviews by their nature are often high-volume, involve high-complexity and high-cost (including opportunity cost which diverts time and resources from

[22] HSCB. *Op.cit*. Appendix 16.
[23] HSE. *Op.cit*. Preliminary Risk Assessment Stage pages 15 to 16 and Appendix 1.
[24] *Loc.cit*.

ongoing care.) As described above, they involve a number of stages and logistical challenges.

If a decision is taken to proceed to the Service User Lookback and Recall stages then the Chair of the Steering Group must inform the Chief Executive and Board of Directors and notify the relevant external bodies. The Early Alert should be updated (Section 2.9). If the Process has not already been reported as an SAI then the Steering Group should review the SAI criteria and take appropriate action (see Section 2.10).

The Steering Group should continue to consider any safety concerns that may arise at any stage of the Review Process which may need prompt action. Concerns may include the following:

- Taking preventative action such as the removal of the hazard [25];
- Consideration of the benefits and risks of suspending or transferring the service under review;
- Management of staff member(s)/service whose caseload is under review in line with Professional/Regulatory Guidance/HR/Occupational Health policy and procedure;
- Clinical and social care management of service users/ staff identified by the preliminary review and suspected of being adversely affected;
- Providing support to service users and staff involved.

The Steering Group should ensure that business continuity plans are considered and implemented, where necessary, including providing for additional health and social care demands which may arise as a consequence of the Lookback Review. The HSC organisation is responsible for securing service capacity and for ensuring that the necessary resources are allocated to conduct all the stages of the Review Process and subsequent follow-up processes. If the resources required exceed what is available then this should be escalated to the organisation's Board and if necessary to the Health and Social Care Board.

[25] If the hazard is associated with a medical device then the HSC organisation should report this in line with Norther Ireland Adverse Incident Centre (NIAIC) adverse incident reporting – guidance and forms. October 2018 ' www.health-ni.gov.uk.

The Steering Group should be prepared for the fact that when a full Lookback Review Process is being considered this information can often become publicly known at the planning stage and should have a contingency plan in place for notification of affected persons and the wider public if this should occur.

2.9 Early Alert Notification [26]

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services. Events should meet one or more of the following criteria;

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*
2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*
3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*
4. *The event may attract media attention;*
5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC Service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does <u>not</u> include any deaths routinely referred to the Coroner, <u>unless</u>:*
    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*

[26] Department of Health 'Early Alert System' HSC (SQSD) 5/19.

ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*

iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*

ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;*

iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*

iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

The next steps will be agreed during the initial contact/telephone call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at Annex C, and forwarded, within 24 hours of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net.

The Early Alert must provide a succinct description which clearly outlines the key issues and the circumstances of the event. Information contained within the brief is to include:

- urgency;
- determining who has been affected and how - physical and/or psychological harm, or no known harm;
- process for determining risks; and
- need for Department participation/involvement/oversight.

2.10 SAI Notification and Investigation

In some circumstances an SAI review may have triggered the Lookback Review Process (Section 1). However, often the Lookback Review will be triggered by a

concern that has been raised by a service user or their family/carers or a member of staff. The Steering Group should consider at an early stage if the findings of the Lookback Review meets any of the criteria for reporting the concerns as an SAI (see also Section 7.2.1). The criteria for reporting an SAI are defined within the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016 at www.hscboard.hscni.net [27]

[27] HSCB Loc. Cit Section 4

3.0 Stage 2 Identifying and tracing service users at risk

One of the most important stages of the Lookback Review Process is the accurate identification and tracing of the service user cohort who have been identified as being affected by the triggering event. The HSC organisation is responsible for the identification and tracing of the affected service users must allocate appropriate resources to ensure that this is undertaken.

In the context of the Lookback Review process, this Stage involves the review of care/ processes against explicit standards and criteria to identify those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria. [28]

3.1 Role of the Steering Group –Terms of Reference and Action Planning

The Steering Group should continue to ensure the management of immediate safety issues and care for those harmed or potentially harmed by the triggering event.

The Steering Group is responsible for ensuring the identification and tracing of the cohort of service users to be included in the service user lookback and recall phases of the Lookback Review Process. The Steering Group will need a clear definition of which service users should be recalled/ offered further tests/assessments, what they should be recalled for, how test/assessment outcomes will be categorised and how each category will be managed/followed-up (Sections 3.2 – 3.4 and Appendix 3).

The Steering Group should review their Terms of Reference and Group membership at this stage and consider if additional membership from the service area/support services and from service users advocacy services are required for either the Steering Group or the Operational Group/ Lookback Review Management Team if applicable (see Section 2.3). The extent and complexity of the Lookback Review Process will determine the resources and responses required.

The Steering Group should also review the Lookback Review Action plan (Section 2.5). As required, expert advice or linkages may be also made with resources such as relevant Professional Bodies and Faculties (e.g. Royal Colleges) to assist with this stage of the Lookback Review.

[28] HSE. *Op.Cit*. Section 7.7 Page 17

The Steering Group should also consider the service user recall methodology for the next stage and further develop the Communication Plan (including the formation of Helplines/Information Lines and use of the organisation's web page to provide general information and Frequently Asked Questions and responses Section 4.4).

The Steering Group will need to meet on a regular basis to ensure that they receive situation reports (SITREPS) and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared with internal stakeholders (Executive Team/Senior Management Team and Board) and external stakeholders i.e. HSCB, PHA and DoH.

3.2 Establish the Service User Database

The HSC organisation will need to develop a service user database to collate the details of the service users that have been identified for inclusion in the service review/ audit stage of the Process. It is important to consider the output from the service user notification database at the outset. The list of service users will be needed to:

- Generate letters to service users;
- Check if service users at risk have made contact;
- Keep track of who requires further review/testing;
- Record who has had results; and
- At the end of the Lookback Review Process to generate information on numbers of service users identified, further assessed and their outcomes.

The database needs to be updated, by administrative staff, on a regular, and at some stages at least on a daily basis. This will ensure the information held is the most up to date and reliable.

The database may already exist on one of the organisations Information Technology (IT) systems. In some circumstances (for example service users who have not been reviewed for a period of time), it may be necessary to check the service user details with the General Register Office for NI to identify if any of these service users have

since deceased.[29] Information Technology staff are essential members of the sub team to assist in accessing existing databases/establishing databases. Specific data variables, will be determined by the nature of the triggering event and the audit methodology to be applied. If a database of service user details does not already exist then a suggested core dataset for service users at risk has been outlined in Appendix 2.

The Steering Group should give special consideration in the Lookback Review Action Plan as to whether or not the cases of deceased persons meet the inclusion criteria, how their records should be handled and how best to communicate with their relatives.[30]

3.3 Establish the Process for the Identification of Affected Service Users[31]

The Steering Group should establish and record clear processes for the identification of the service users/ staff to be included in the Recall Stage. This will include the development/ agreement of the:

- Audit criteria (criteria as to what will be considered within acceptable practice limits, minor or major discrepancy, the clinical significance of these discrepancies, and actions to be taken in each category, guided by national and international best practice, faculty requirements etc.);
- Scope of Audit (including timeframes and definition of records to be reviewed);
- Audit Methodology;
- Audit Tool;
- Instructions to ensure consistent recording of audit results;
- Instructions for analysis of audit data;
- Procedures for ensuring the validity and reliability of the audit to ensure that all auditors interpret and apply audit criteria in the same way; and
- Process for the submission of audit outcomes to the Steering Group.

[29] General Register Office for Northern Ireland @ www.gov.uk.
[30] HSE. *Op.Cit.* Section 7.7.4, page 18.
[31] Ibid. Section 7.7.3 Page 17

The HSC organisation should take account of extant guidance in relation to maintaining service user confidentiality.[32] [33] [34] The audit of service user's healthcare records should be undertaken by the healthcare team who would ordinarily have the right to access the service user's healthcare records as part of the delivery of health and social care. However, if the audit team is extended to include healthcare personnel who would not have a right to access the service user's healthcare records, and consent has not been provided by the service user for these personnel to access their records, then these records must be sufficiently anonymised, such that an individual is not identifiable to those undertaking the audit.[35]

3.4 Undertaking the Audit

The Steering Group will commission the audit of the healthcare records of the affected service users as identified in Stage 1 (risk assessment). The audit methodology and tools will have been defined by the Steering Group (see Section 3.3).

The audit will involve clinical staff with the necessary skill and knowledge of the specialty involved. However, depending on the nature, extent and complexity of the Lookback Review the HSC organisation may need to commission relevant experts to undertake the audit or service review.

Again, depending on the nature of the Lookback Review the team may initially be required to screen the service users' notes/x- rays/test results etc. to establish if they are in the affected cohort. A system for the initial identification of the service users including flow charts, service review proformas and service user notification letters are contained in Appendix 3. These are examples only and are provided as reference material and should be adapted by the HSC organisation for the specific health and social care trigger event on a case by case basis.

Following initial screening and identification of service users affected, further assessment may be required.

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[32] General Data Protection Regulation ((EU) 2016/679) (UK GDPR) @ https://eugdpr.org
[33] Data Protection Act 2018 @ www.legislation.gov.uk .
[34] DoH 'Code of Practice for protecting the confidentiality of service user information' April 2019 @ www.health,n-i.gov.uk
[35] HSE. *Op.cit*. Section 7.7.3.

The service user database will be used to document the service users/ staff who are included and excluded following each stage of the Lookback Review Process (see Section 3.2 above). In general, it will be used to track persons affected and to record actions, interventions and outcomes.

Upon completion of the audit, the service review team will provide the Steering Group with the results of the audit which will inform the Steering Group of the persons affected to be included in the Recall Stage.

4.0 Stage 3 Service User Recall

4.1 Planning the Recall

Following completion of Stage 2, the Steering Group will move to the third stage, the Service User Recall Stage. The Steering Group and Operational Group should ensure that their Terms of Reference include the following; purpose of Recall, scope, method and timeframe.

The Steering Group will also establish the Recall Team(s) which will consist of experts in the subject area/ discipline which is the covered by the Lookback Review Process.

The Steering Group must agree with the Recall Team(s) a realistic work-plan with timelines that reflect the urgency and complexity of the Lookback Review Process.

The Steering Group will have to consider the following which will form the basis of the Operation Group/Lookback Review Management Team work-plan:

- Identify venue for the conduct of the Recall stage;
- Secure administrative support;
- Establish an appointment system including DNA management;
- Secure clinical and other specialist support e.g. laboratory/x-ray etc.;
- Arrange transportation of samples and results;
- Manage arrangements for assisting service users affected to attend the Recall Stage (for example car parking, site maps, signage/ 'meet and greet' arrangements, public transport, taxis, meals);
- Agree a system for recording of results;
- Ensure that counselling and welfare services are available to service users and to staff;
- Agree the communication and service user support arrangements (see Section 4.3); and
- Consider the arrangements for overtime/out-of- hours working for staff.

Ideally, a liaison person/team should be appointed to oversee the seamless conduct of each attendance a service user has as part of the Recall stage, whether they are clinic appointments or repeat tests/x-rays etc. Responsibilities would include; providing a point of contact, follow-up of DNAs , quality assurance of the Process (correct letter to correct person) and checking that any service user affected are referred into the 'system' for subsequent follow-up.[36]

Depending on the extent, nature and complexity of the Process, the Steering Group will have to meet on (at least) a daily basis to ensure they receive SITREPS and continue to have an accurate oversight of the Lookback Review at this Stage (see Section 3.1).

4.2 Service User Communication and Support

One of the most important areas of managing any Lookback Review Process is the communication with all the affected service users. When communicating it is equally important to be able to say who is not affected. The timing of any communication is critical and every effort should be made to notify the entire group simultaneously. The method of doing this will be dictated by the numbers of service users involved (see Section 4.3). Service user notification must be co-ordinated with public announcements made by the organisation. In an ideal situation service users should be contacted before a media announcement is made. However, this is not always possible given the nature/scale of some Lookback Review Processes or if there is a breach in confidentiality at an earlier stage. Where applicable, the Steering Group should identify any service user representative bodies/third sector and brief them.

The Steering Group should agree key messages to ensure consistent and accurate information to provide confidence in the process. The Steering Group should consider the person(s) best suited to communicating bad news with affected service users, their families and/or carers. A spokesperson, should be identified to act as the organisation's spokesperson and be available for interview by the media etc. Media training should be provided on a case to case basis (see also Section 4.6).

The following should be included in the service user communication and support plan:

[36] *Ibid.* Section 7.8.2 Page 22.

- access to professional interpreters as required;
- a designated point of contact for service users, their families and/or carers;
- regular and ongoing information updates provided to service users and families and/or carers;
- affected service users offered a written apology by the health service organisation;
- establishment of a Helpline/Information Line/website to ask questions and to obtain information (see Section 4.5 and Appendix 4 for practical guidance); and
- affected service users who need additional consultation have these appointments expedited to allay any anxieties or concern that they may have.

Communication and support of families should include:

- identifying immediate and ongoing management needs of service users, their families and/or carer;
- ensuring that service users understand the processes for ongoing management and have written advice/fact sheets concerning this;
- ensuring that relevant fact sheets containing information on the lookback review are published on the health service inter/intranet website;
- ensuring adequate resources are in place to provide the level of service required;
- provide counselling and welfare services; and
- initial communication should be direct, either face-to-face or via telephone, where the service user must be given the opportunity to ask questions.

4.3 Service User Notification by Letter

Depending on the extent of the Lookback Review Process notification may be by a letter sent to the service users affected by the issue. As above, the timing of service user notification must be carefully choreographed with any public announcement made by the organisation. If the Process has affected small numbers of service

users organisations may wish to consider alternative forms of direct communication e.g. telephone calls in first instance which should be supplemented by a follow-up letter containing the pertinent information. A sample of letters has been provided in Appendix 3 for reference/guidance.

The service user letter should be signed by the Chief Executive or a Director of the HSC organisation. Service user letters should be sent by first class post in an envelope marked “Private and Confidential -To be opened by addressee only” and “If undelivered return to... (*the relevant Trust*)...”

Letters to the service user should include the following if appropriate:

- Unique service user identifier number;
- Service user information leaflet/ fact sheet;
- The website/freephone helpline number(s) and hours of opening;
- Location map with details of public transport routes;
- Free access to parking facilities; and
- Arrangements for reimbursement of travelling expenses.

It can be helpful to include a reply slip with a pre-paid envelope to confirm that service users have received the letter. Alternatively, the organisation may consider using a recorded delivery service or hand delivering the letters if numbers are manageable.

Depending on the individual Lookback Review Process the HSC organisation may need to identify any service users under 16 and/or other vulnerable groups to write to their parent/guardian/ representative.

The Steering Group should plan for how service users who do not respond to an invitation and/or ‘lost to follow-up should be managed. The Steering Group should ensure that ‘every reasonable effort’ is made to contact all service users at risk for example by telephone or through General Practitioners. It is accepted that service users may have moved out of the region or abroad.

4.4 Public Announcement of the Recall Stage

The Steering Group will determine the timing of the Public Announcement of the Recall Stage of the Lookback Review Process. Communications management

throughout the Lookback Review Process should be guided by the principles of 'Being Open'[37] balanced with the need to provide reassurance and avoid unnecessary concern.

Recall Stage will be announced to the public by the relevant HSC organisation lead Director in line with the Communication Plan (Section 4.2 and 4.6). As stated in Section 4.3, it is vital that the Steering Group strive to ensure that the Lookback Review Process is not publicly announced until all of the persons affected have been notified and a clear public message can be given regarding the extent of the cohort and those that are not affected. This is not always possible, as breaches of confidentiality may occur and therefore the Communication Plan should be prepared for this eventuality at all times.

When it is determined that communication with the public is required it should not be announced until all of the service users affected have been notified. As above it is recognised that this is not always possible. Key principles of public announcements include:

- Being open with information as it arises from the Lookback Review Process;
- Ongoing liaison with the media throughout the Lookback Review Process;
- Preliminary notification being made public where a situation requires additional time for the discovery of accurate information to be provided to service users and the wider public.

It essential that the findings in relation to the Lookback Review Process should not be released into the public domain until the Process is complete, all the findings are known and all affected service users are informed of the implications of the findings for them.[38]

4.5 Setting up a Service User Helpline/ Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of enquiries from service users, their families and the general public. It is recommended that site-specific helplines are considered for

[37] DoH 'Saying sorry – when things go wrong'. January 2020.
[38] HSE *Op Cit* Page 20

persons affected and a more general information line for the wider public. Consideration should also be given to providing information on the Trust's website for example Frequently Asked Questions (FAQs) and responses. Planning at this stage is vital to ensure that public confidence in the service is not further eroded. Guidance on setting up a service user helpline/information line is contained in Appendix 4.

4.6 Communication with the Media

Adverse incidents, especially those involving a service user lookback generate intense media attention. Regardless of the nature or intensity of media inquiries, information given to them should never exceed that which has been shared with the service users affected.[39]

The Steering Group should consider developing a 'media pack' (see below). The Head of Communications/Communications Manager should take a lead on developing this strategy. Depending on the extent, nature and complexity of the Lookback Review Process the Head of Communications/Communications Manager will liaise with the DoH Communications branch to seek advice on the communication strategy for the media and general public.

As part of the Communications Plan for dealing with the media, the Steering Group should:

- nominate a spokesperson for public and media communications;
- minimise the delay in response to the public and the media;
- develop a media pack which should contain; and
    - key messages
    - frequently asked questions (FAQs) and answers
    - draft media statements for each phase of the review process.

Media statements in relation to the issue, should be accurate and not add to the anxiety of the service users and their families/carers. Media statements should not be released prior to notification of the Lookback Review Process (see Sections 4.3 and 4.4). In the circumstances where a media statement is released it should state that a Lookback Review Process is being carried out, and immediately limit the area

[39] *Ibid.* Section 7.11.2 Page 26

of concern to time period, region and service area within which the Process is being conducted. It should detail the numbers of persons affected being included in the recall stage of the process and the expected timeframe for the completion of the recall stage, if known.[40]

The media statement should note that all service users affected have been contacted (and method of contact) and that a Helpline/Information line/website has been established, giving the opening time(s) of the line and the contact details. The FAQs can be provided to the media as well as any additional briefing information such as an information leaflet.

All media statements and briefing notes should be ratified by the Steering Group.

4.7 Staff Communication and Support

While the public will need to be reassured that every effort is being made to conduct a full and thorough review, it is essential that the involved healthcare workers are protected and supported during this time. They need to be kept fully informed at all times during the exercise. Support from a peer and counselling should be offered by the employer. This is particularly important during the early stages of the lookback review process when there will be intense media interest. One point of contact, such as the Director of Human Resources should be identified to lead on this aspect throughout the process. In the case of an individual(s) being managed under the HSC organisation's capability/performance management/disciplinary procedures then the relevant HR policies should apply. These parallel processes are not included in the scope of this guidance (see Section 1.3).[41]

A communication and support plan should be devised for staff. This should include communication and support for:

- All staff who are managing the lookback process;
- All staff working in the area of concern; and
- All other staff that may be affected.

[40] *Ibid*. Page 27.
[41] DoH Policy for Implementing a Lookback Review Process Section 4.

5.0 Stage 4 Closing, Evaluating and Reporting on the Lookback Review Process

A Lookback Review Process Guideline Checklist has been included in Appendix 5. The Checklist is a memory aid only and must be used in conjunction with the guidelines.[42]

The Steering Group are responsible for formally closing the Lookback Review Process when all service users affected have been reviewed and the care of service users requiring further treatment and care management have been transferred to the appropriate service and all the service users have been written to with the outcome of the review.

At the end of any Look Back process it is the responsibility of the Lead Director/Chair of the Steering Group to evaluate the management of the Lookback Review to assess the efficiency and effectiveness of the process and to identify any lessons learned from the process. Key measures should be assessed and strategies for further improvement should be implemented and reported to the Chief Executive as required.

The findings should be included in a Look Back Review Report. The content will be unique to each Lookback Review Process. The report should be shared with all relevant internal and external stakeholders. This report should be used to form the basis of the Serious Adverse Incident Report (Section 2.10) to facilitate the dissemination of learning across the HSC as a whole.

For the purposes of a report on a Lookback Review Process the report should contain the following information:

- Introduction including:
  - Details of Terms of Reference(s) (include Terms of Reference(s) in the
  - Appendices section of the report)
  - Composition and roles of the Safety Incident Management Team
  - Composition and roles of the Audit Team
  - Composition and roles of the Recall Team
- Methodology applied to the Look-back Review Process including:

[42] HSE. *Ibid*. Appendix 8.

- Methodology applied to preliminary review/Risk Assessment
- Clear audit methodology for the Audit Stage including:
  - Audit Criteria
  - Scope of Audit
  - Audit Methodology
  - Audit Tool
- Procedures for ensuring the validity and reliability of the Audit stage to ensure that all auditors interpret and apply audit criteria in the same way
- Recall Stage methodology
- Communications Plan
- Information and Help Line Plan
- Plans for follow up for persons affected following both the Audit and Recall Stage

- Results/ Findings of Stage 1 Preliminary Findings/Risk Assessment;
- Results/ Findings of Stage 2 service review/ audit;
- Results/ Findings of the Recall stage;
- Actions taken to date to address findings; and
- Learning and further recommended actions to address findings.

Peer review publication of issues relating to the Lookback Review Process, for instance; the development of an audit tool, logistics and communication with service users/families and staff may be of benefit and should be encouraged.[43]

[43] HSE. *Op. Cit*. Section 7.10.

Glossary

Term	Definition
Adverse Incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Audit	In the context of the lookback review process, audit involves the review of care/processes against explicit standards and criteria to identity those who may not have received the required standard of care or where the procedure used did not adhere to explicit standards and criteria.
Clinical Review	A re-examination of a medical and or clinical process/es which has delivered results that were not to the expected quality standard.
Cohort	A group of people who share a common characteristic or experience within a defined period (e.g., are currently living, are exposed to a drug or vaccine or pollutant, or undergo a certain medical procedure) i.e. a sub-group selected by a predetermined criteria.
Contributory factor	A circumstance, action or influence which is thought to have played a part in the origin or development of an incident or to increase the risk of an incident.
Database	The ability to record information for retrieval at a later date. In this instance it may be on paper if the numbers involved are small. If the numbers are large, ITC equipment and competent administration staff may be required.
Harm	1 **Harm to a person**: Any physical or psychological injury or damage to the health of a person, including both temporary and permanent damage.

	2 **Harm to a thing**: Damage to a thing may include damage to facilities or systems; for example environmental, financial data protection breach, etc.
Hazard	A circumstance, agent or action with the potential to cause harm.
Lookback Review	A re-examination of a process (es) which has delivered results that were not to the expected quality standards.
Proforma	A page on which data is recorded. The page has predefined prompts and questions which require completing.
Quality Assurance	A check performed and recorded that a certain function has been completed. Negative outcomes must be reported and actioned.
Recall	An act or instance of officially recalling someone or something. In the context of the Lookback Review Process, the recall will involve the examination of the service user and/ or the review all relevant records in line with the Terms of Reference and will identify any deviations from required standards of care. Appropriate corrective actions will be identified as appropriate.
Risk	The chance of something happening that will impact on objectives.
Risk Assessment	A careful examination of what could cause harm to people, to enable precautions to be taken to prevent injury or ill-health.
Serious Adverse Incident	In the context of a Lookback Review Process an SAI is any event or circumstance that meet the specific criteria laid out within the HSCB Procedure for the Reporting and Follow up of SAIs 2016 at www.hscboard.hscni.net.

Service Review Team/expert advisory group	A specially selected group of individuals, competent in the required field of expertise, to perform the Lookback Review Process
Service User	Members of the public who use, or potentially use, health and social care services as patients, carers, parents and guardians. This also includes organisations and communities that represent the interests of people who use health and social care services.
Triggering Event	The initial concern(s) or adverse incident which lead to the HSC organisation considering the initiation of the Lookback Review Process.

Appendices

Template for Risk Assessment

Appendix 1

Information about the event or concern that has given rise to the need to consider a lookback review process (include information in relation to any actual harm that has been caused as a result of this issue)**:**

Information about the potential extent of the issue (include information about the number of people, number of HSC organisations that might be adversely affected by the issue)**:**

Information about the potential outcomes of the issue (include information about the potential consequences of the issue e.g. missed diagnosis / missed return appointments / harm from contaminated equipment):

Information about the risk level of the issue (include information about the severity of harm that might occur in the people adversely affected by the issue). Use the Regional Risk Matrix (Section 2.7) to evaluate the risk.

Please tick one:

Extreme	
High	
Medium	
Low	

Additional Details:

Information about the potential cohort of service users affected (number, gender, age range):

Details of Immediate Action Required

Recommendations to Steering Group regarding Stage 2 Lookback Review (include recommendations for the Terms of Reference for the Lookback Review including recommended inclusion and exclusion criteria; and for scoping audit(s) of service users that might fall within the inclusion criteria):

Details of personnel who undertook the Risk Assessment:

Name	Title

Date of Risk Assessment:

Establishing the Service User Database – Core Dataset Appendix 2

The data below is a minimum dataset, it is however subject to change depending on the individual situation. Ideally the use of an existing HSC organisation database(s) is preferred.

- Unique identifier number;
- Surname;
- Forename;
- Title;
- Date of birth;
- Sex;
- Address line one (House name, number and road name);
- Address line two (Town);
- Address line three (County);
- Postcode.

- GP name;
- GP address line one;
- GP address line two;
- GP address line three;
- Postcode.

- Named consultant;
- Date of appointment/procedure1;
- Date of appointment/procedure 2;
- Date of appointment/procedure 3;
- Procedure one description;
- Procedure two description;
- Procedure three description.

- Reviewer 1 description;
- Reviewer 2 description;
- Data entered by – identification;
- Data updated 1 by – identification;

- Data updated 2 by – identification;
- Data updated 3 – identification.

Appendix 3

Initial Identification of Service Users involved in the Service Review/ Audit Stage

See Flow Chart - Process for advising that all service users who may have been affected (Appendix 3.1 Section 1)

See Flow Chart - Process for advising all service users known to be the affected cohort (Appendix 3.1 Section 2)

The retrieval of notes/x-rays/test results must be co-ordinated with the support from Medical Records staff.

A Service Review Proforma (Appendix 3.2) is attached to each set of notes.

The service user database needs to be updated after completion of this Proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Service Review Proforma should be transferred from the front of the notes and filed into the service users' records.

Conducting Further Assessment (Notes/X-rays/Test Results etc.)

A Notes/X-ray/Test Results Review Proforma (Appendix 3.3) is attached to the front of each set of service user notes.

The service review team will undertake a further detailed audit of the notes to review the outcomes of previous assessment/scans/tests.

The service review team will then decide if previous outcomes/diagnosis were accurate.

The Proforma will be completed by the Service Review Team.

- A green or red sticker is placed on the pro forma. The **green** sticker identifies a positive outcome and that no further follow up is required - Letter D is sent to service user.

- A **red** sticker identifies a negative outcome that requires a further assessment – Letter E is sent to service user.

The service user database needs to be updated after completion of this pro forma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Notes Review Pro forma should be removed from the front of the notes and filed into the healthcare record.

Conducting Further Assessment (Clinical)

A Clinical Review Pro Forma (Appendix 3.4) is attached to the front of each set of healthcare record.

The service review team will undertake a clinical examination/test/scan etc. as appropriate to determine a positive or negative outcome. One must bear in mind that timescales for test/scan results may differ depending on individual situations.

The pro forma is then completed by the Service Review Team. A **green** or **red** sticker is placed on the pro forma.

- The **green** sticker identifies a positive outcome and that no further follow up is required - Letter F is sent to service user.

- A **red** sticker identifies a negative outcome that requires further treatment which should be managed within normal clinical arrangements – Letter G is sent to service user.

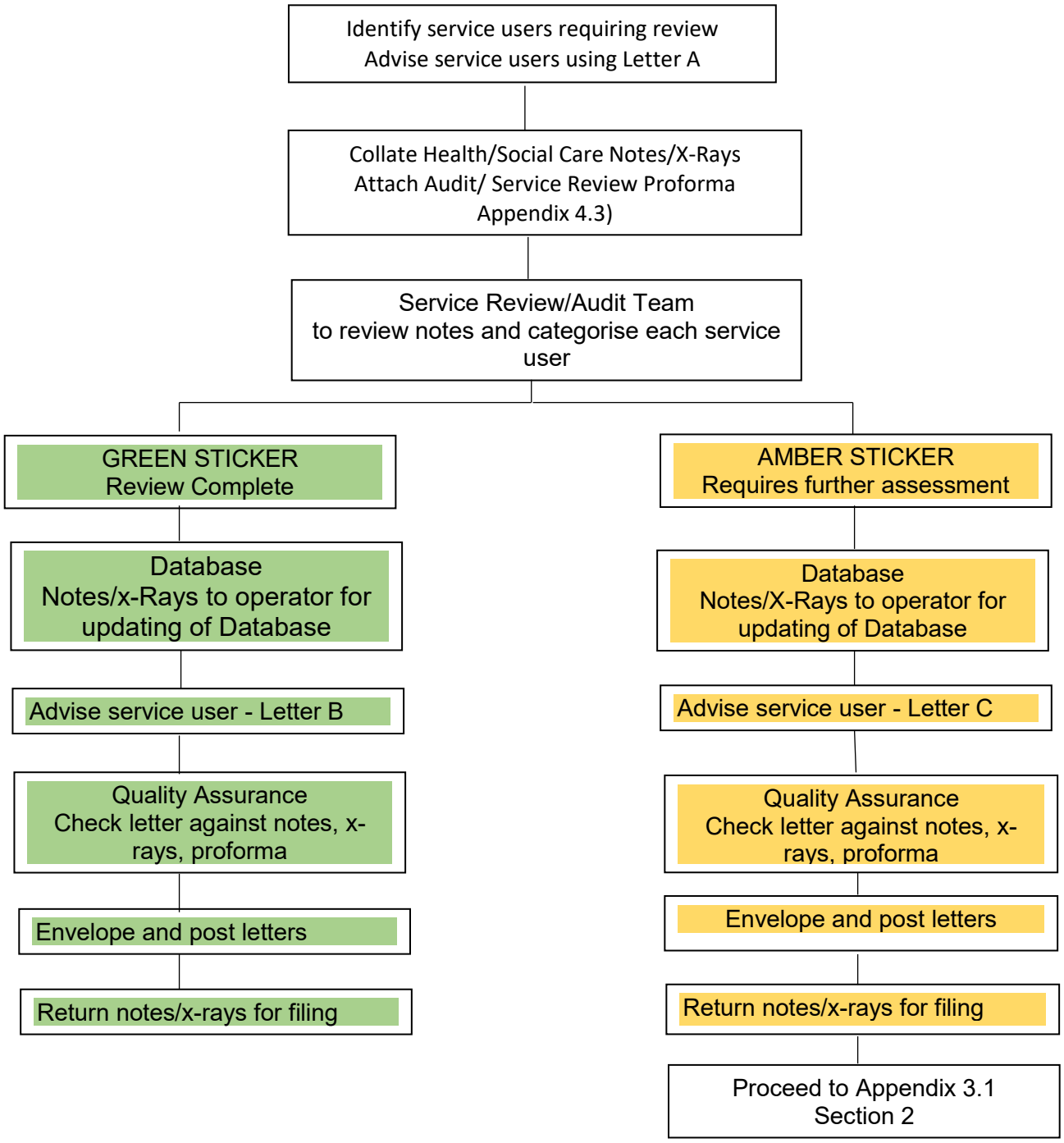
The service user database needs to be updated after completion of this proforma.

A quality assurance check is provided by Administration which is essential to ensure that the correct letter is sent to the correct service user.

The Clinical Review Pro Forma should be transferred from the front of the notes.

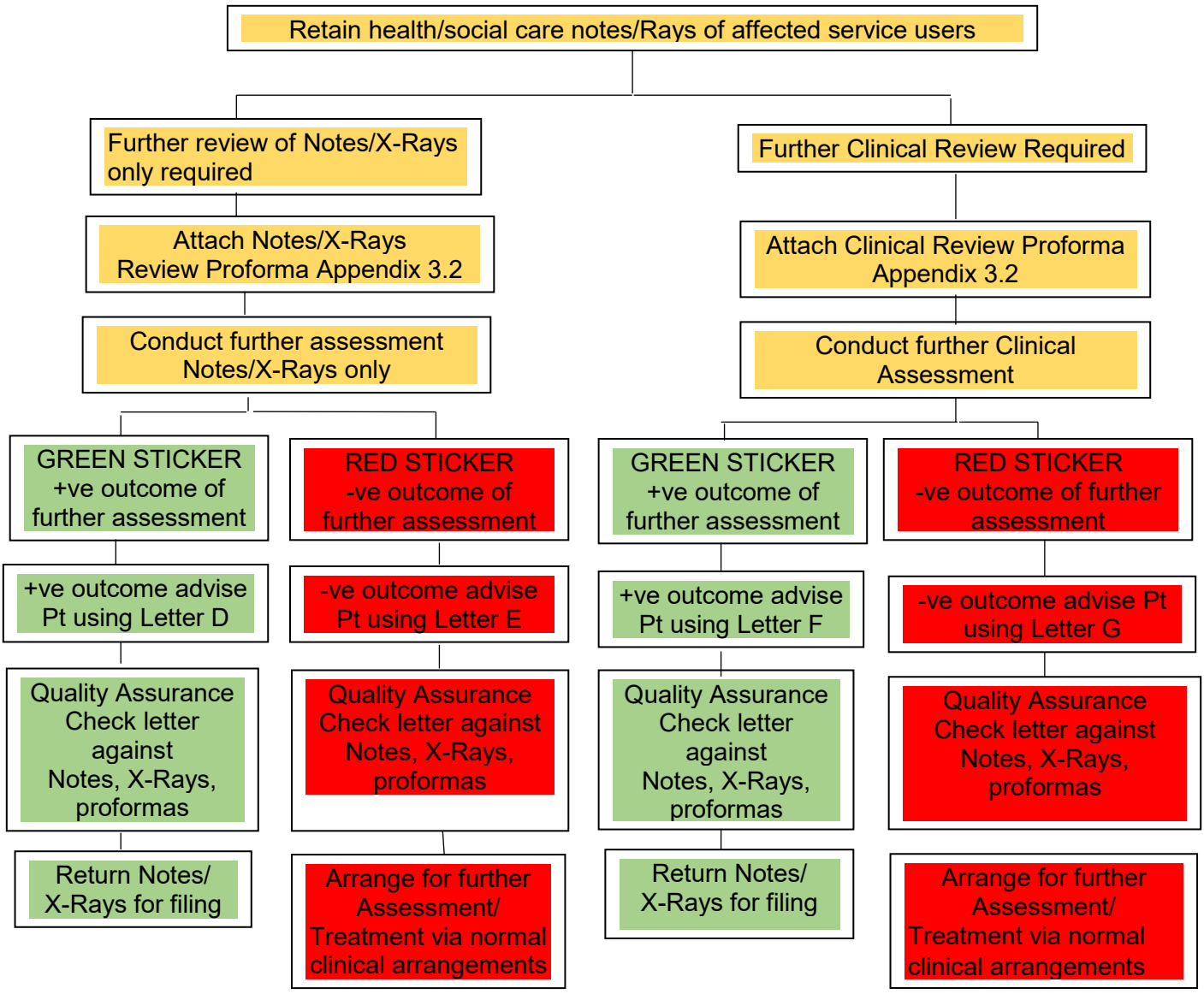
- If it has a **green** sticker attached: file into service user notes.
- If it has a **red** sticker attached: return service user notes and pro forma to admin support for processing within normal clinical arrangements.

Appendix 3.1 (Section 1) Advising service users who may be in the affected service user cohort



Appendix 3.1 (Section 2)

Process for Advising Service users known to be in the affected cohort.



Appendix 3.2 Service Review Proforma

SERVICE USER DETAILS (ATTACH LABEL)

CASENOTES REVIEWED ☐

X-RAYS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

(Give details)

DATE OF APPOINTMENT/SCAN/EXAMINATION REVIEWED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETE

AMBER STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.3 NOTES/X RAY REVIEW PROFORMA

SERVICE USER DETAILS (ATTACH LABEL)

ADDITIONAL INFORMATION

CASENOTES REVIEWED ☐

X-RAYS/SCANS REVIEWED ☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED ☐

ADDITIONAL TESTS/SCANS/X-RAYS REQUIRED ☐

CLINICAL REVIEW REQUIRED ☐

REVIEWER 1

Signature & date

REVIEWER 2

Signature & date

GREEN STICKER – REVIEW COMPLETED

RED STICKER – FURTHER FOLLOW UP REQUIRED

DATABASE UPDATED ☐ **(Signature & date)**

ADMIN QA CHECK ☐ **(Signature & date)**

LETTER SENT ☐ **(Signature & date)**

Appendix 3.4 CLINICAL REVIEW PROFORMA

DETAILS (ATTACH LABEL)

	OUTCOME +VE	-VE
CLINICAL EXAMINATION	☐	☐
TEST	☐	☐
SCAN/X-RAY	☐	☐
BIOPSY	☐	☐

OTHER MEDICAL DIAGNOSTIC/DATA REVIEWED
(Give details)

	YES	NO
FURTHER FOLLOW REQUIRED: PROCESS INTO NORMAL CLINICAL ARRANGEMENTS	☐	☐

CONSULTANTS SIGNATURE: _____DATE:_____

GREEN STICKER – REVIEW COMPLETED

AMBER STICKER – FOLLOW UP REQUIRED
PROCESS INTO NORMAL CLINICAL ARRANGEMENTS

RED STICKER - FOLLOW UP REQUIRED
REQUIRED URGENT REFERRAL

DATABASE UPDATED ☐ (Signature & date) _____

ADMIN QA CHECK ☐ (Signature & date) _____

LETTER SENT ☐ (Signature & date) _____

Appendix 3.5 DRAFT LETTERS

Although there will be one “master” letter, you will need to generate several variants from it for different circumstances e.g. when the service user is a child.

The following are provided for suggested content only.

LETTER A: Advising of a Lookback Review Process

LETTER B: No further follow up required

LETTER C (version 1): Further follow up is required – Notes only

LETTER C (version 2): Further follow up is required – Clinical

LETTER D: Positive outcome of further assessment – Notes only

LETTER E: Negative outcome of further assessment –Notes only

LETTER F: Positive outcome of further assessment – Clinical

LETTER G: Negative outcome of further assessment – Clinical

LETTER H: Letter to General Practitioner to advise them that the service user(s) are being included in the Recall Phase of Lookback Review Process

LETTER A: Advising of a service review/lookback review process

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear < Title>

<***Title of Lookback Review Process***>

It has come to the attention of <*HSC organisation*> that < *a healthcare worker/system*> has <brief outline of the incident>.

We have decided as a precautionary measure to review each of the cases with which this <*healthcare worker/system*> has been involved since <*date range*>.

Your case will be included in this review, which will be a substantial process <*involving…..*>. We have initiated a Service Review Process and will endeavour to deal with this as timely as possible.

I wanted to inform you directly about this rather than letting you hear it through another source and I believe it is important that you are kept fully informed of the review process. We will write to you immediately after your case has been reviewed to advise you whether or not it will be necessary for you to have <*a follow up appointment/test*>.

If in the interim you have any queries, a special telephone helpline has been set up on <*freephone/Tel: xxxxxxxx*> so that you can discuss any concerns. It is staffed from <*date and time to date and time*>. This line is completely confidential and operated by professional staff who are trained to answer your questions.

Although there are a large number of call handlers, there will be times of peak activity and there may be occasions where you may not get through. In this event I would ask you to please call again at another time.

<*Enclosed is a factsheet with more detailed information, which you may find helpful*>.

Please have your letter when you call the helpline, as you will be asked to quote the unique reference number from the top of the page.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER B: No further follow up required

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx / using the protocol*> and I am pleased to inform you that your <*case notes/assessment/test*> has now been reviewed and that **no further follow up is required.**

I fully appreciate that this has been a worrying time for you and I apologise for any upset this may have caused. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 1): Further follow up is required – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<Title of Lookback Review Process>

We had previously written to advise you that <HSC Organisation> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <*clinician/consultant*> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for <*name and grade of person*> to <*review notes/assessment*> and we will contact you again as soon as this is complete.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER C (version 2): Further follow up is required – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

We had previously written to advise you that <*HSC Organisation*> had decided, as a precautionary measure, to review your individual case.

Your case was reviewed <*by xx/using the protocol*> and the <clinician/consultant> has advised that **further follow up is required.** I must emphasise that this does not necessarily mean that <*illness/infection*> has been detected but that more investigation is required to reach a definite diagnosis.

I fully appreciate that this has been a worrying time for you and I deeply regret that your previous <*assessment/test/treatment*> has been found to be inadequate.

We have made special arrangements for you to be seen in <*where*> on <*date & time of appointment*>.

Our service review team will be available at this appointment to discuss the clinical aspects of your case. I have enclosed directions to <*xxxxxxx*> and information on parking arrangements.

If you are unable to attend this appointment please contact <*Tel xxxxxx*> to allow us to reorganise this for you.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER D: Positive outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

I am pleased to advise you that your case has been reviewed by <*name and grade of person*> and we would wish to reassure you that <*he/she*> is satisfied with the quality of your original <*assessment/investigation/test*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER E: Negative outcome of further assessment – Notes only

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Further to our letter dated <*date*> regarding the need for further assessment of your individual case.

Your case has been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that the quality of your original <*assessment/investigation/test*> was unsatisfactory.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER F: Positive outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are pleased to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **NEGATIVE**. This indicates that you have not been exposed to <*infection/illness*>.

We would however wish to offer you the opportunity to be reviewed by <*whomever*> at a forthcoming clinic. This will give us the opportunity to examine you and to help reassure you of the outcome of the Service Review Process we have undertaken.

If you wish us to arrange an appointment please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter.

Once again I would take this opportunity to apologise for the distress and anxiety caused by conducting this review. However, I am sure you will understand that, although the risk <*of missed diagnosis/contracting xx*> was thought to be very low, we had an obligation to remove any uncertainty.

Yours faithfully

(Chief Executive/Director of HSC Organisation)

LETTER G: Negative outcome of further assessment – Clinical

Healthcare Reference Number

Confidential Addressee Only

DD Month Year

Dear <*Title*>

<***Title of Lookback Review Process***>

Thank you for attending <*special clinic*> on <*date*> for follow up assessment.

Your results have been reviewed by <*name and grade of person*> and we are sorry to advise you that <*he/she*> has confirmed that your <*investigation/test*> result was **POSITIVE**. This indicates that you have been exposed to <*infection/illness*>.

As a result of this we have arranged for you to be seen by <*whomever*> at <*where*> on <*date and time*>. This will give us the opportunity to examine you and to assess what further treatment you may require.

If the appointment above is unsuitable, please contact <*Tel xxxxx*> quoting the unique reference number at the top of this letter, so that we may reorganise it for you.

I would take this opportunity to apologise for the distress and anxiety caused by this letter, I have enclosed a fact sheet which may help answer any further queries you may have ahead of your appointment.

Yours faithfully

(Chief Executive/Director of HSC Trust)

Letter H: Letter to General Practitioner (informing them of the inclusion of their patient(s) in the Recall Phase of the Lookback Review Process)

Service user name & address

Dear <*Doctor Name*>

<Title of Lookback Review Process>

<*Service Name*> recently reviewed <*Procedure*> undertaken at the hospital in <*Date(s)/Year(s*)>. This review was part of a quality assurance process as we were not satisfied with the quality of a number of <*Procedure(s)*> carried out. As a precautionary measure our medical advisors have recommended that a number of service users who attended for <*Procedure*> are offered a <*Specialty*> outpatients appointment.

Our records show that your patient <*Name*> previously attended <*name of location*> for <*name of procedure*>. We have written to your patient to advise them that their file was reviewed as part of this process and to offer them an outpatient appointment.

If you have any queries about this letter, please contact <*Name person and contact details*>.

Yours Faithfully

(Chief Executive/Director of HSC Organisation)

Appendix 4 Setting up a Service User Helpline or Information Line

Once it has been agreed that the Lookback Review process is to be publicly announced HSC organisations need to have in place a system to deal with potentially large numbers of calls from service users, their families and the general public. It is recommended that site specific helplines are considered for persons affected and a more general information line for the wider public.

The following points should be considered by the Steering Group:

- An individual, such as a senior manager should be identified to coordinate and implement the Telephone Help Line;
- A meeting needs to be convened with a small number of individuals, with the necessary knowledge of the speciality, to establish the necessary systems to support the helpline/information line. It may be that Lead and Specialist Nurses are ideally placed to assist at this crucial stage of planning;
- Information Technology staff are essential members of this team to assist in establishing databases and the necessary technology. A senior member of staff from the Telephone Exchange is invaluable at this stage in planning.

Identification of Venue for Helpline/Information Line

- Ideally the Helpline should not be isolated from the main hub of the organisation. Staff need to be able to access others to seek advice while the Helpline is operational. However, it does need to allow confidential conversations to take place and requires a dedicated space.
- Cabling to allow sufficient telephones is required. Once the media report on the issue is in the public domain then there is likely to be an influx of calls.
- Free phone telephone numbers need to be agreed with Telephone Exchange staff or relevant department.
- It is advisable to have a failsafe system to capture additional calls if the telephone lines become blocked with calls. This may involve agreeing with the Telephone Exchange staff to take details from those callers who are unable to get through quickly and ensure one of the Helpline staff return the call within an acceptable timeframe.

- Once the number of Helpline stations are agreed, personal computers are required for each to facilitate easy access to service user information. IT staff will assist in accessing the necessary cabling and hardware.

Briefing Paper for Helpline Staff

- It is important that those manning the Helpline should be trained and briefed. They should be provided with training and background information on the circumstances surrounding the Look Back exercise.
- Files should be prepared and updated daily with the initial press release and briefing notes on the subject (see Key Messages below).

Production of Algorithms

- Staff manning the Helpline will find it useful to have simple algorithms which assist in giving accurate information to callers. It may be that the caller has no reason to be alarmed when they are informed they are not within the affected group of service users.

Production of Key Messages

- Helpline staff need to be confident in the messages they are giving to callers. To assist this “key messages” should be agreed with the clinical teams and these are read to callers in response to specific questions. Helpline staff must not deviate from these messages.
- Some anxious callers will ring on many occasions and it is vital that if they speak to different Helpline staff they are being given a consistent message.
- Key messages will change as the review progresses. These then require to be updated in the individual files for Helpline staff.

Production of Proforma

- As each call is received it is important to maintain a record. A proforma should be designed to capture the relevant information. It should not be so detailed that the caller feels annoyed, however there needs to be sufficient to ascertain if follow up action is required.
- If the Helpline staff believe that follow up is required then a system needs to be agreed to segregate proformas, perhaps by identifying follow up calls with

a red dot. By the following day these need to have been actively followed up, probably by clinical staff in the speciality being reviewed.

- For completeness and post Look Back audit purposes a database of Helpline calls might be helpful.

Production of Rotas

- The Helpline opening times need to be agreed at the outset so that rotas can be produced. However as stated earlier the extent to which the matter is covered in the media will largely dictate when the calls might be made and some flexibility might be required. There is a strong correlation between media reports and number of calls made.
- In the early stages it will be essential to have staff with good communication skills. Staff will need to be released very quickly from their "normal" duties to assist with this work. There may need to be back filling of these posts to release these staff to assist.
- While staff should not be asked to work more than 6 hours at any one time on the Helpline, it is recognised that in the first few days resources may be stretched. On occasion some normal hospital business may need to be suspended temporarily. Overtime and out-of-hours arrangements should be considered and agreed through the Human Resources Department prior to the commencement of the Helpline.
- Ideally if new staff are coming onto the rota there should always be one member of staff who is familiar with the system and can advise others and co-ordinate overall. As far as possible the help lines should be staffed by experienced people with an understanding of the governance and duty of care responsibilities. Briefing on this area is helpful to understand the corporate responsibility.

Staff Briefing

- Briefing of staff, particularly in the early stages of the exercise is vital. A leader needs to be identified to take this role. This would normally be an Executive Director.

- Staff need to feel they are being listened to during the exercise. If they believe that the system could be improved they should have that opportunity to discuss their views at a daily staff briefing session.
- Catering arrangements should be in place for staff who assist in this work. Regular coffee breaks should be accommodated.

Appendix 5 Lookback Review Process Guideline – Process Checklist Template

	Look-back Review Process The purpose of the check-list is to act as an aide memoir to managers and staff to assist them to ensure compliance with the HSE Look-back Review Process Guidelines. The check-list must always be used in conjunction with the Lookback Review Process Guidelines. References to the relevant sections of the Guideline have been included in the check-list.	You should refer to the relevant Guideline Section(s) for guidance on each stage of the process.	Tick as appropriate		
1	Stage 1: Scoping the extent, nature and complexity of the Lookback Review	Section	Yes	No	N/A
1.1	Chief Executive notified that a Lookback Review Process may be required	**2.1**			
1.2	Chief Executive or nominated Director has established a Steering Group and Terms of Reference were agreed	**2.2 – 2.4**			
1.3	The Risk Assessment was commissioned by the Steering Group	**2.7**			
1.4	Using the information obtained from the Risk Assessment, the Steering Group made a decision to progress to the Service Review/ Audit and Recall stages of the Lookback Review Process	**2.7 – 2.8**			
1.5	The Chair of the Steering Group has notified the relevant bodies (DoH, HSCB, PHA) of the decision to progress with the Lookback Review Process	**2.9 – 2.10**			
2	Stage 2: Identifying and Tracing Service Users at Risk	Section	Yes	No	N/A
2.1	The Steering Group agreed the Scope and the Terms of Reference of the Service Review/ Audit and Recall stages of the Lookback Review Process	**3.1**			
2.2	The Steering Group developed a Lookback Review Action/Work Plan to inform the Audit and Recall Stages of the Lookback Review Process	**3 .1 – 3.2**			
2.3	A database was established to collate and track the information gathered by the Lookback Review Process	**3.2 – 3.3**			
2.4	The Service Review/ Audit was undertaken by nominated team or experts commissioned by the Steering Group	**3.4**			
2.5	The Service Review/Audit identified persons affected to be included in the Recall stage	**3.4**			
2.6	The Helpline/ Information Line was established by the Steering Group	**4.2 , 4.5 & Appendix 4**			

3	Stage 3: Recall Stage	Section	Yes	No	N/A
3.1	The Recall stage was announced by the relevant Director	4.3 – 4.4			
3.2	The Recall stage was announced after persons affected had been informed of their inclusion in the Recall stage of the Lookback Review Process	4.4			
3.3	The Recall Team(s) implemented the Recall stage as per the Steering Group Action Plan	4.1			
3.4	The Recall Team identified actions to be taken to address any deviations from required standards of care	4.1			
3.5	The Recall Team implemented actions and/ or communicated required actions to the Steering Group	4.1			
3.6	The Steering Group undertook an evaluation of the Lookback Review Process and developed an anonymised report with recommendations and learning	5			
3.7	The Chair of the Steering Group submitted the anonymised report to Chief Executive and relevant external bodies	5			

Notes from Urology Lookback Steering Group Meeting
20 December @ 8.30am Via Zoom

Present:
Melanie McClements
Ronan Carroll
Martina Corrigan
Mark Haynes
Dr Damien Gormley
Wendy Clayton
Sarah Ward
Dr O'Kane

Apologies
Kate O'Neill

Purpose of Meeting
Establishment of internal Monday morning 8.30am meeting to review the progress of Urology lookback exercise, plan going forward in line with Lookback guidance, maximise capacity to see patients and inform agenda/communication on regional meetings.

Welcome
- Minutes of last meeting shared. Nil comments returned and agreed by group.

Terms of Reference
- Internal TOR agreed after last meeting on 6.12.21
- External Assurance Group TOR discussed at last meeting and Caroline Cullen going to add to. These are to be shared at next meeting in Jan 2022

Matter arising
- Melanie asked if there was final agreement re using the 4 questions on clinical review form or 9 questions
- Martina advised that Prof Sethia is using the 9 questions as he is looking at historical care and these are appropriate for this. 4 questions was discussed in meeting with Caroline Cullen, Ronan & Sarah on Friday and aware we are going with 4 questions based on following:
  1. CMO questioned use of 9 when 4 deemed reasonable
  2. Buy in from Consultants in house and in IS for use of 4 rather than 9. 9 felt to be too tedious
  3. Allows in house Consultants to remain neutral and not comment on past. Focus on current care pathway
  4. The process is quicker- means we can get more patients seen in shorter timeframe.
- Prof Sethia to continue his process on the 9 questions.
- All members of group asked if in agreement to use 4 questions. All in agreement but recognised that Prof Sethia to continue with the 9 as he has been using this process and is very comfortable with it.

- June Turkington in DLS aware of 4 questions as these were shared with her with the draft specification for IS contract. Comments on spec but not on questions. Melanie asked that June is updated on the decision to use 4 questions to ensure clarity. **Action:** Sarah to email June and cc members of group in to advise of the decision to proceed with 4 questions
- Melanie asked regarding Section 21 notice upload. Martina advised all completed apart from MH which is being completed and then we are complete. All CNS have uploaded.
- Martina advised she has raised with PI team the challenges coming in January 22 with the next surge and the high likelihood of redeployment to support teams. Martina has asked for acknowledgement that there will be a need to extend timescales for potential next section notices in light of this situation.
- Dr Gormley also advised that for the SCRR team with Hugh Gilbert. Of the 8 originally identified medical staff, 1 has withdrawn and a further 2 have not responded to the request. Dr Gormley advised they are planning to meet with them to reassure and ensure they are aware this is being done for the Trust and not for the PI team.
- Next UAG scheduled for today has been cancelled. We submitted update anyway.

Update re Capacity to See Outstanding Patients

- Wendy and Sarah updated on the Urology Consultants and x3 (including MH) accommodating WLI to address the 503 patients waiting to be reviewed. Initially the 114 patients on waiting list were identified as those to go to IS. Wendy explained with down turn in theatre capacity in Jan 22 these sessions can be used to accommodate these patients. Communication going out today with the sessions available and the allocation. Aim to have these completed by Feb therefore still on track to have all patients reviewed by March 22.
- A 2nd CNS (Cancer) has had to go off sick due to knee injury and is unable to drive therefore with this gap there will be no resource to have CNS present at each of the AOB review clinics. CNS remaining will do the best they can.
- Wendy detailed the clinics completed so far from JOD and MY with MH starting this week
- Sarah shared the table we submitted to UAG detailing the volumes and dates.

Letters/ SCRR

- Sarah shared the table detailing that just over 100 letters (Letter A- record review and no issues) have all been completed and posted from last week.
- Sarah advised that the letters for RIP patients were 2nd checked by her to ensure correct NOK, H&C etc etc. Few issues but all rechecked after amendments and sent.

- Letters B & C (needs records reviewed & reviewed but need further review) have been in progress from last week. Some of these will have been posted as Matthews team have been working through these. Sarah to get update from Matthew from weekends activity as staff doing additional to get letters completed.
- SCRR letters completed for all patients we have screened (55 in total). Remaining 23 to be screened today. Sarah has prepped letters for some of the remaining 23 in advance of meeting to try and get ahead.
- The 55 patients screened have been contacted by Liaison (some have not responded) received call from daughter Friday asking as they know the plans for SCRR can they not receive the letter prior to xmas and get this after. Sarah asked for consensus on this as also noted Fiona Sloan the SCRR liason link is not available to ring remaining SCRR patients until this Wednesday (22nd Dec) and felt it too close to xmas for this. Also conscious that letters going out this week in Letter B & C groups may not get these until end of the week and therefore no one will be available on Info Line to support. Would like to delay ringing further SCRR patients and sending out remaining Letter B & C until next week.
- Group all asked individually of thoughts and all agreed that this was the most sensitive thing to do as these patients are all being told their care needs looked at. The patients who have received Letter A are assured there are no issues and therefore this would provide relief for xmas.
- Agreed that next wed 29th Dec we would start ringing the remaining SCRR patients as we finish screening today and aim to post letters to SCRR, Letter B & C groups on Friday 31st for them to arrive Monday 2nd and then have Info Line support available from 3rd after bank holiday.
- Aware inquiry team have written to the SAI patients at this time. No indication that any SCRR patients or any other patient has been contacted.
- Sarah advised that we have not yet had a steer on the continuation of the SCRR process. Dr O'Kane advised she has written to Lourdes and is awaiting guidance. As themes have been identified in current SCRR process felt we do not need to continue however aware that Governance HOS has asked about the screening of the previous patients. **Action:** Await feedback regarding continued SCRR screening process.
- Sarah advised all datix have been completed for the 77 SCRR Patients that have went through screening.
- Master spreadsheet has been updated to reflect datix number, patients seen at WLI clinics, outcomes, info line contact, letter type and date sent etc.

Next Meeting Scheduled for 8.00am Thursday 6th Jan 2022 via Zoom: Sarah will send out link for this one only and then continue with already scheduled 2 weekly Monday meetings.