Complex Discharges

Performance remains variable but continues to perform well against the target and was at 90.5% in April.

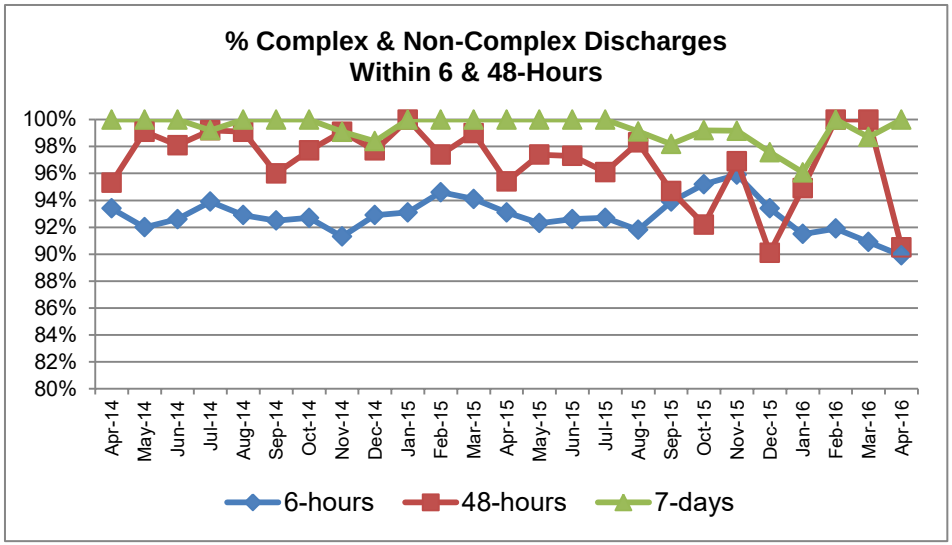
Performance across the Region demonstrates a significant level of variation with year-end cumulative assessment of SHSCT 92%; No Trust of Residence 88%; NHSCT 86%; WHSCT 81%; SEHSCT 78%; and BHSCT 54%.

Regionally 2015/2016 demonstrated a total of 1756 complex patients waiting than 7 days for discharge. The SHSCT accounted for 3% (48) of these, which was the lowest in the Region.

The Trust will continue working closely with multi-disciplinary teams including mental health services and services in the community as part of a proactive discharge planning process to meet the access standards for complex and non-complex discharges.

Actions to Address:

- Review of all actions to promote timely discharge will be undertaken as part of the Unscheduled Care Operational Improvement Group work plan.



Monthly Position:	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	Cum Assess	Trend
% of Coded Delayed Discharges – Trust*	60.7%	63.4%	66.2%	69.2%	60.6%	63.9%	93.2%	96.2%	95.3%	98%	97.2%	96.1%	96.8%	A	↑
6-hours**	92.7% (1632 out of 1770)	91.8% (1816 out of 1979)	93.9% (1967 out of 2095)	95.2% (1972 out of 2072)	95.9% (1621 out of 1690)	93.4% (1742 out of 1866)	91.5% (2587 out of 2826)	91.9% (2691 out of 2928)	90.9% (2787 out of 3065)	89.9% (2688 out of 2989)	91.5% (2715 out of 2967)	95.5% (2870 out of 3088)	91.2% 2629 out of 2882)	A	↓
48-hours**	95.4% (103 out of 108)	97.4% (111 out of 114)	97.3% (107 out of 110)	96.1% (122 out of 127)	98.4% (119 out of 121)	94.7% (196 out of 207)	92.2% (141 out of 153)	96.9% (93 out of 96)	90.1% (73 out of 81)	94.9% (74 out of 78)	100% (68 out of 68)	100% (71 out of 71)	90.5% (57 out of 63)	G	↓
7-days**	100% (108 out of 108)	99.1% (113 out of 114)	98.2% (108 out of 110)	99.2% (126 out of 127)	99.2% (120 out of 121)	97.6% (202 out of 207)	96.1% (147 out of 153)	100% (96 out of 96)	98.8% (80 out of 81)	100% (78 out of 78)	100% (68 out of 68)	100% (71 out of 71)	100% (63 out of 63)	G	↔

***Note** - % of coded discharges revised further to HSCB clarification on definitions April 2015 – January 2016
****Note** – data updated April 2015 – March 2016 (April 2016)

CP 22: MENTAL HEALTH SERVICES: Lead Director Mr Bryce McMurray, Acting Director of Mental Health & Disability

By April 2015, no patient waits longer than 9-weeks to access Child and Adolescent Mental Health Services; 9-weeks to access Adult Mental Health Services; 9-weeks to access Dementia Services; and 13-weeks to access Psychological Therapies (No change in target, however potential change in definition for CAMHS services to be confirmed).

Baseline: Adult Mental Health – 65 >9-weeks
CAMHS –.0 >9-weeks
Dementia Services – 41 >9-weeks
Psychological Therapies – 54 >13-weeks

TDP Assessment: Adult Mental Health – Partially achievable/achievable with additional resources
CAMHS – Achievable and affordable
Dementia Services – Achievable and affordable
Psychological Therapies – Partially achievable / achievable with additional resources

Standard: Adult Mental Health 9-weeks
CAMHS 9-weeks
Dementia Services 9-weeks
Psychological Therapies 13-weeks

Note: Standard maintained as Goal/objective in 16/17 Commissioning Direction

Comments:

Adult Mental Health Care

The number of patients waiting in excess of 9-weeks has continued to decrease in April The service is currently working through a Performance Management process with the Independent Sector Provider in relation to their contract with on-going fortnightly review meetings.

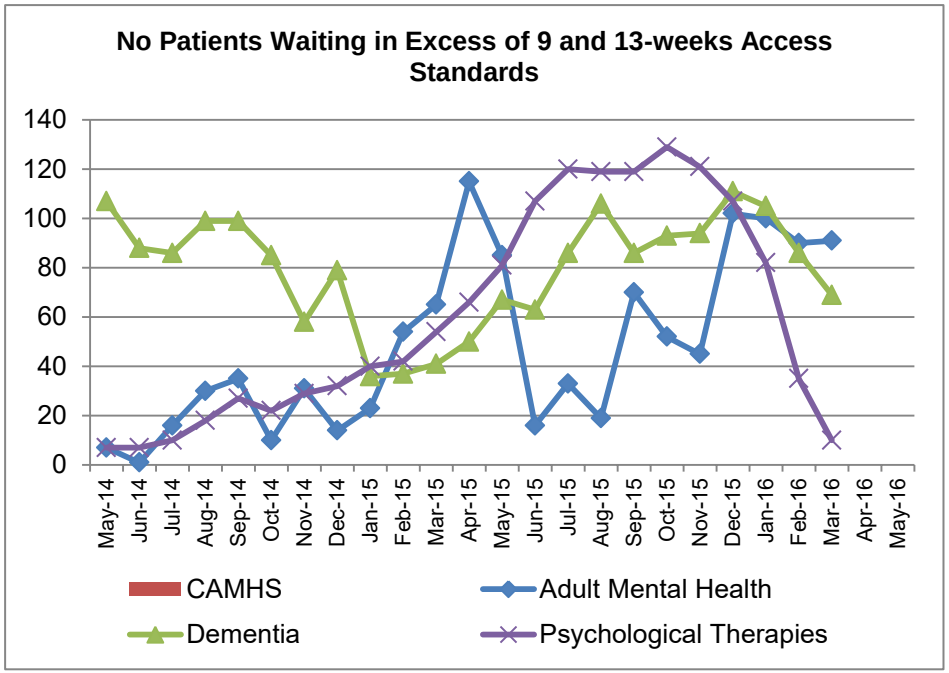
Regional performance at the end of March demonstrated a total of 338 patients waiting in excess of 9-weeks with SHSCT accounting for 24% (81); BHSCT 73% (246); and WHSCT 3% (8).

Actions to Address:

- Additional capacity in place via Independent Sector provider. On-going performance management process with the Independent Sector Provider.

Child and Adolescent Mental Health Service

Whilst there are currently no breaches of the 9-week standard within CAMHS the ability to maintain this position is potentially unsustainable. The current longest waiting patient is 9-weeks.



Within CAMHS the 9-week standard currently only applies to Step 3 referrals. Within the Step 2 service there is a significant pressure on the waiting lists.

Regional performance at the end of March demonstrated a total of 34 patients waiting in excess of 9-weeks with BHSCT accounting for 74% (25) and WHSCT accounting for 26% (9).

Actions to Address:

- Additionality has been provided in Q1/2 to provide an additional 60 weekend sessions which will be utilised to reduce waiting times for Step 2 services and help maintain access standards for Step 3 services during the summer period.

Memory/Dementia Services

A capacity gap has been identified for this service as part of Regional demand and capacity work. No indication on how this will be addressed until work related to a consistent Regional model of service provision is completed. The service had anticipated a much improved position at end April, due to the introduction of a new clinic dedicated to the screening Waiting List, but this has not yet been realised due to a small number of long waiters requiring validation.

The Trust is seeking to develop a short-term recovery plan to improved capacity in 2016/2017 and address increasing waits. Additional consultant capacity for mental health services, which is anticipated to be in place July/August 2016, will provide additional consultant capacity to this area.

Regional performance at the end of March demonstrated a total of 69 patients in excess of 9-week all of which were SHSCT.

Actions to Address:

- On-going work to finalise capacity and demand issues in association with HSCB; and
- Short term recovery plan in development, pending funding.

Psychological Therapies

Table 22 (a)

Specialty	Access Time (end April)	Volume >9 />13 weeks and +/- from March position	SBA performance
Adult Mental Health	22 weeks	61 (-20)	To be agreed
CAMHS	9-weeks	0	To be agreed
Dementia Services	29 weeks	44 (-25)	To be agreed
Psychological Therapies (waiters >13 weeks)	22 weeks	16 (+6)	To be agreed

New ways of working had been implemented with Psychological Therapies, however, there remains a shortfall in capacity associated with vacancies, for which recruitment is underway. In the interim additional temporary capacity has been established and this has resulted in a decrease in the number of patients waiting greater than 13-weeks in-month. April demonstrated an increase in the volume of patients waiting greater than 13-weeks, with the longest waiter at end April 22-weeks.

Regional performance at the end of March demonstrated a total of 1,176 patients in excess of 13-weeks with significant variation in the level of breaches SEHSCT 50% (588); BHSCT 29% (338); NHSCT 12% (142); WHSCT 8% (98); and SHSCT 1% (10).

Actions to Address:

- Internal review on-going to consider manpower issues; and
- Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards.

	Monthly Position:												Cum Assess	Trend
	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 2016		
Adult Mental Health	85	16	33	19	70	52	45	102	100	90	81	61	R	↑
CAMHS	0	0	0	0	0	0	0	0	0	0	0	0	G	⇔
Dementia	67	63	86	106	86	93	94	111	105	86	69	44	R	↑
Psychological Therapy	81	107	120	119	119	129	121	107	82	35	10	16	Y	↓

OUT PATIENT REVIEWS Patients waiting beyond their clinically indicated timescales: Lead Director Mr Bryce McMurray, Acting Director of Mental Health & Disability (Not a commissioning plan target)

Comments:

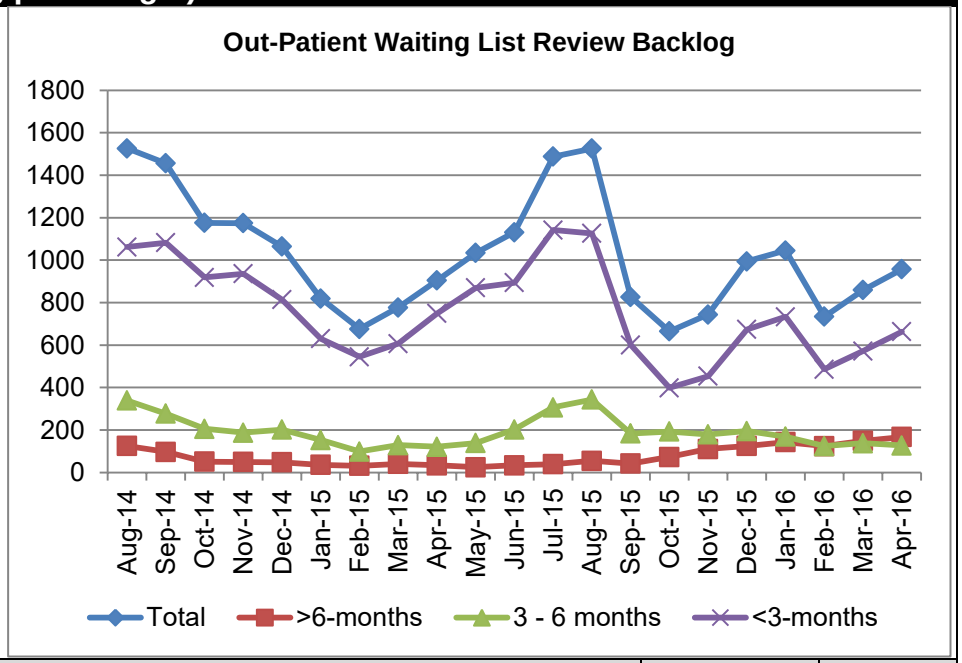
Of the 957 review patients waiting beyond their clinically indicated timescales:

- 17% (167) of these are waiting in excess of 6-months;
- 13% (127) of these are waiting between 3 – 6 months; and
- 70% (663) are waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal re-direction of resources when available, demonstrated an initial decrease in the cohort of patients waiting. However, due to a reduction in capacity, in April, the cohort of patients at the front end of the waiting list demonstrated an increase in additions to the review waiting list.

Actions to Address:

- Discussion paper submitted to HSCB and SLCG to highlight on-going issues (July 2015); and
- Trust to continue to re-direct resources into this area, as this becomes available and an assessment of the level of additional capacity that can be provided is currently on-going.



	Monthly Position:												Cum Assess	Trend
	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16		
Total	1034	1131	1488	1525	827	665	744	994	1045	734	859	957	R	↓
>6-months	25	34	39	55	42	73	111	125	143	124	149	167		
3 – 6 months	139	203	307	344	184	193	179	195	169	124	138	127		
<3-months	870	894	1142	1126	601	399	454	674	733	486	572	663		

CP 23: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

From April 2015, increase the number of children in care for 12 -months or longer with no placement change to 85%

Baseline: To be confirmed
TDP Assessment: Partially achievable/achievable with additional resources

Target: Increase to 85%

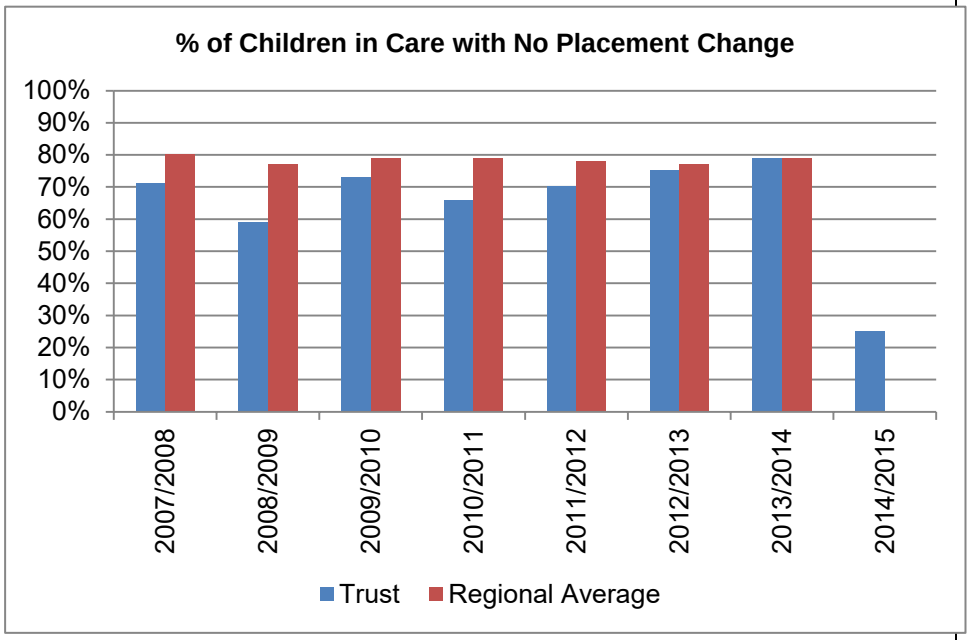
Note: Target not maintained as Goal/objective in 16/17 Commissioning Direction

Comment/Actions: 2014/2015 performance information is collated during August – September 2015 for the year and will not be available until July 2016 due to the annual reporting cycle associated with this target area

This area remains an on-going priority in relation to care planning for all children, however, this is influenced by a number of factors including availability of carers, Court process including the planned change of placement for some children i.e. return home, or change from fostering to an adoptive placement.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008 to 2013/2014. Trust performance in 2013/2014 was at its highest, for this 7-year period, at 79%. Trust performance was below the Regional average from 2007/2008 through to 2012/2013; however, in 2013/2014 Trust performance equalled the Regional average.

Cumulative performance in 2013/2014 across the Region varied from 84% (BHSCT) to 76% (NHSCT).



	Monthly Position:							Cum Assess	Trend
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014		
Trust	71%	59%	73%	66%	70%	75%	79%	**W**	↔
Regional Average	80%	77%	79%	79%	78%	77%	79%		↔

CP 24: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

By March 2016, ensure a 3-year time frame for 90% of children who are to be adopted from care.

Baseline: HSCB to source from AD1 return

TDP Assessment: Achievable and affordable

Standard: 3-Year timeframe for 90%

Note: Target not maintained as Goal/objective in 16/17 Commissioning Direction

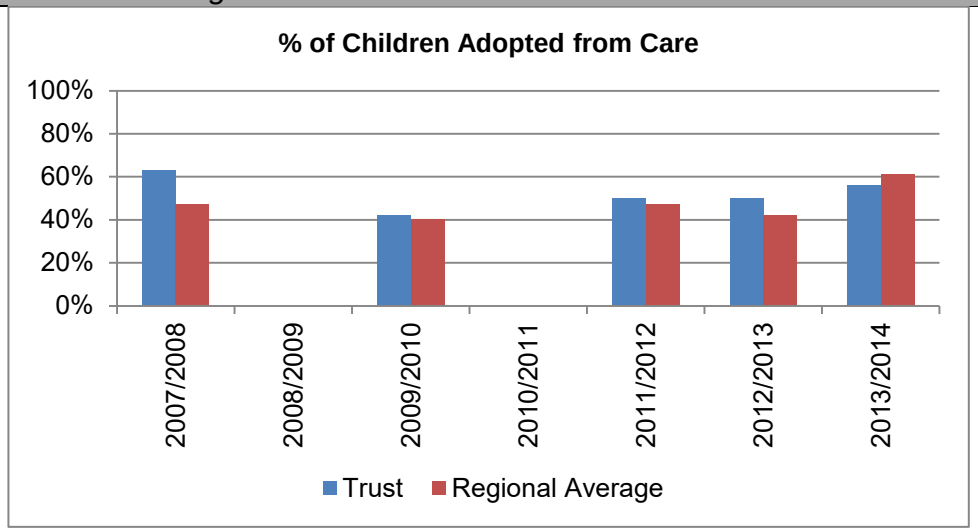
Comment/Actions: Regional data not yet available

In 2014/2015 25% of children were adopted within 3 years, 65% were adopted between 3 and 5 years and 10% over 5 years.

Performance against the 3-year target is impacted on by the higher than normal number of older children being adopted, with over half of those adopted in the 5 – 9 years age bracket. The majority of these older children were adopted by their foster carers, which is typically a longer process.

The Trust has the highest percentage (28%) of children adopted regionally (20 in total for the year 2014/15).

Cumulative performance in 2013/2014 across the Region varied from 64% (SEHSCT) to 19% (WHSCT).



	Monthly Position:								Cum Assess	Trend
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	2014/15		
Trust	63%	No data	42%	No data	50%	50%	56%	25%	**W**	↓
Regional Average	47%	No data	40%	No data	47%	42%	61%	N/A		

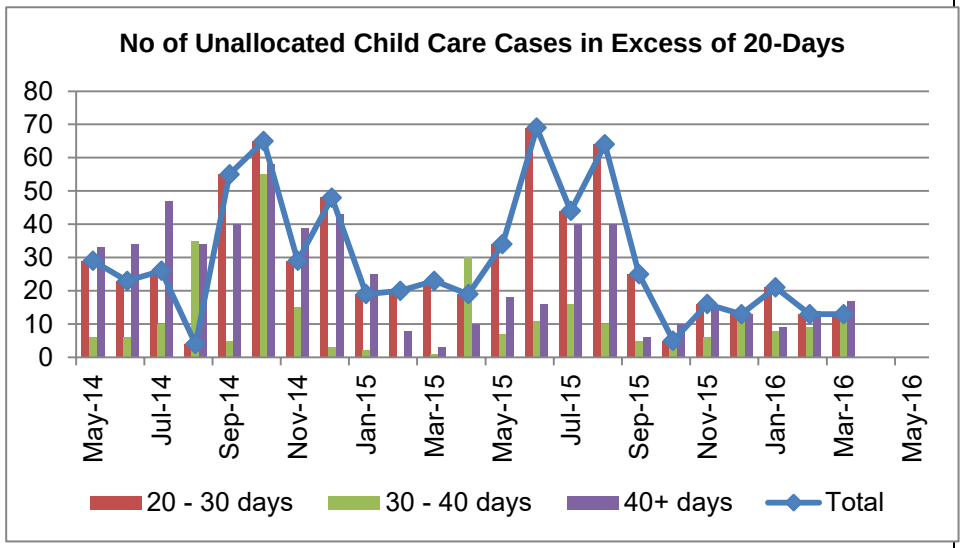
UNALLOCATED CHILD CARE CASES: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services (Not a formal CP target)

Comment/Actions: April data not yet available

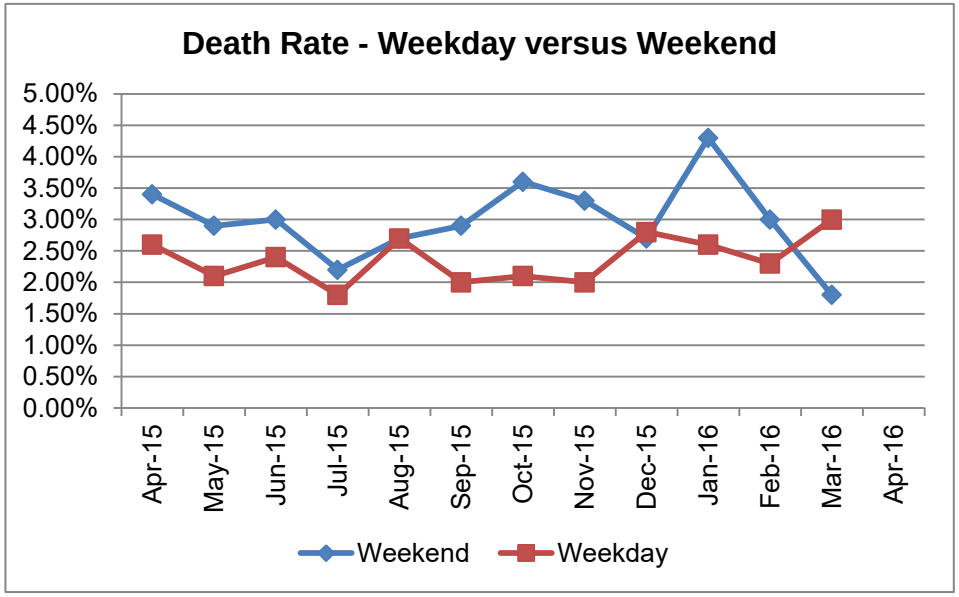
At the end of March there were a total of 44 unallocated child care cases in excess of 20 days.

30% (13) of these are waiting between 20 and 30 days; and the volume over 40-days is 17.

Further information on the Unallocated Child Care Cases is provided within the Director of CYPS Trust Board Report.



	Monthly Position:												Cum Assess	Trend
	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16		
Total	59	96	100	152	36	21	37	40	38	36	44	N/A	R	↓
>20 and <30-days	34	69	44	64	25	5	16	13	21	13	13	N/A		
>30 and <40-days	7	11	16	10	5	6	6	14	8	9	14	N/A		
>40-days	18	16	40	78	6	10	15	13	9	14	17	N/A		

CP 25: PATIENT SAFETY: Lead Director(s) Mrs Esther Gishkori, Director of Acute Services & Dr Richard Wright	
From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. (New target)	
Baseline: Clarification waited from HSCB on technical definitions **TDP Assessment:** Partially achievable/achievable with additional resources	
Comments: April data not yet available Across Northern Ireland in 2013/2014, the percentage of unplanned admissions resulting in patient death was 3% for those admitted on a weekday and 3.2% on a weekend. As such, the target for 2015/2016 is to ensure that there is no more than 0.1 percentage point difference between weekday and weekend rates. Technical guidance has been received from HSCB for reporting against this target. As per this technical guidance, Deaths and Discharges are used as an approximation of Admissions and figures are presented by Month on Discharge not Month on Admission. Cumulatively for 2015/2016 there is a 0.6% difference between the death rate of unplanned admissions on a weekday compared to the weekend (2.4% weekday and 3% weekend). Regional performance demonstrated minimal variation with year-end cumulative assessment of NHSCT 0.2%; WHSCT 0.4%; SEHSCT 0.5%; BHSCT and SHSCT 0.6%, giving a Regional average of 0.5%. Trust has a range of process in place to review mortality and morbidity and is working closely with HSCB and DHSS in the development of enhanced mortality information based on the Summary Hospital level mortality indicator (SHMI) rates.	

The drivers for this target include: • Implementation of recommendations from RQIA reviews of: a) Acute Hospitals at Nights and Weekends (July 2013); b) Care of Patients Following Stroke (11/12/2014); and c) Care of Older People in Acute Hospital Wards (when Published). • Implementation of safety initiatives around Early Warning Systems, Sepsis, Reducing Falls and VTE Risk Assessments.	

	Cumulative Position 2015/2016	Cum Assess	Trend
Weekend	2.4%		
Weekday	3.0 %		
Variance	N/A	**W**	

CP 26: NORMATIVE STAFFING: Lead Director Mrs Angela McVeigh, Executive Director for Nursing and Allied Health Professionals	
By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical in-patient units. (New target)	
Baseline: To be confirmed **TDP Assessment:** Partially achievable/achievable with additional resources	**Standard:** 95% *Note: Standard maintained as Goal/objective in 16/17 Commissioning Direction – adjusted to reflect implementation of four phases of Delivery Care*

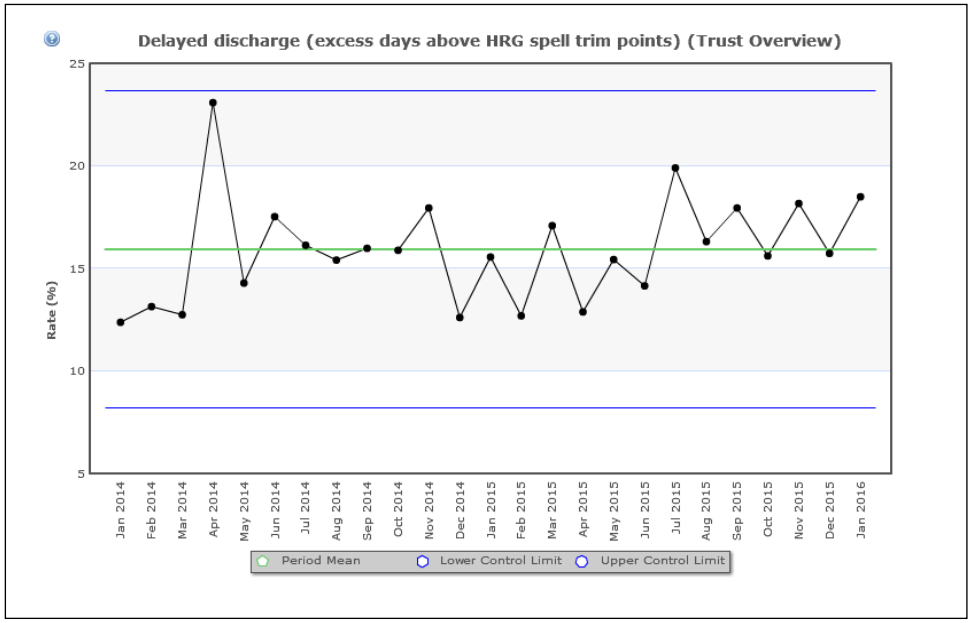
Comments:

The Trust received confirmation of £2 million recurrent funding towards the implementation of normative staffing across medical and surgical wards from HSCB in March 2015, plus an additional non-recurrent £250k towards covering maternity leave. This funding has been allocated across the FSLs of all specified wards in Phase 1.

A report detailing the end of year compliance for 2015/2016 is currently being collated for submission to the HSCB by 18 May 2016. This data will be submitted to Trust Board via the Executive Director of Nursing Report.

Monthly Position:												Cum Assess	Trend
Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16		
N/A												**W**	

MINISTERIAL PRIORITY: TO ENSURE THAT SERVICES ARE RESILIENT AND PROVIDE VALUE FOR MONEY IN TERMS OF OUTCOMES ACHIEVED AND COSTS INCURRED

CP 27: EXCESS BED DAYS: Lead Director Mrs Esther Gishkori, Director of Acute Services	
By March 2016, reduce the number of excess beddays for the Acute Programme of Care by 10%. (No change in target)	
Baseline: Clarification waited from HSCB on technical definitions – HSCB (April – November 2014) position indicates SHSCT 44% above the target profile for 2014/2015 **TDP Assessment:** Unlikely to be achieved/affordable	**Target:** Reduce by 10% *Note: Target not maintained as Goal/objective in 16/17 Commissioning Direction*
Comments: Internal reporting in development CHKS, the comparative benchmarking system, measures excess bed days (delayed discharges) against the Top Hospital peers. Whilst this definition and the comparators are different from that used by HSCB as it is based on expected length of stay at condition level calculated for the payment by results (PbR) methodology adopted in England, it is a useful guide to peer performance. CHKS utilises information on 'spells' which will include the aggregated length or stay (beddays) in a patients total journey in the hospital system, including acute and non-acute hospital episodes and transfers across hospital sites. Information available using CHKS data, January 2014 to January 2016 demonstrates the Trust with excess bed days of 16% against the HES Peer Average of 15.5%. The Trust has an average of 16% for excess bed days in the last 24 months which is in line with the peer. The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years which is largely within normal levels of variation.	

CP 28: CANCELLED APPOINTMENTS: Lead Director Mrs Esther Gishkori, Director of Acute Services	
By March 2016, reduce by 20% the number of hospital cancelled consultant-led out-patient appointments in the Acute Programme of Care which resulted in the patient waiting longer for their appointment. (Change in target from 17% to 20% and area of focus)	
additional resources	**Target:** Reduce by 20%; Target 4335 *Note: Target maintained as Goal/objective in 16/17 Commissioning Direction*

Comments: April 2016 not available

This target focuses on the hospital cancelled consultant-led appointment, in the Acute Programme of Care, which resulted in patients waiting longer for this appointment. This revised definition is in line with the work undertaken by a Short Life Working Group at the request of the Health Committee.

Cancellations primarily fall into 3 categories:

- Where the appointment is cancelled and 'put back' so the patient waits longer for their appointment;
- Where the appointment is cancelled and 'brought forward' so the patient actually is seen sooner than originally scheduled; and
- Where the appointment time or location is changed which while impacting on the patient does not lead to a longer wait.

Of those patients cancelled 2.7% had their appointments put back and waited longer. This equated to 1.8% of new patients and 3.2% of review patients. This relatively low rate of hospital cancelled consultant-led outpatient appointments, where the patient is 'put back' and effectively waits longer for their appointment, makes achievement of the target challenging in that the Trust had the lowest number of cancellations in the Region as a baseline.

Cumulative performance at the end of March of 5,439 demonstrates that the Trust has cancellation rate of +25% (+1,104) above its target of 4,335.
Regional performance at the end of March demonstrates a total of 53,604 cancelled appointment which resulted in patient waiting longer. All Trust were in excess of their target with WHSCT +30% (+1,875); BHSCT +26% (+5,367); SHSCT +25% (+1,104); NHSCT +22% (+1,402); and SHESCT +8% (+490).

Actions to Address:

- Analysis to be undertaken related to the reasons for cancellations to inform action planning; and
- Key actions to be agreed to enable reduction of cancellations and install best practice in clinic management.

	Monthly Position:														
	Apr 2015	**May 2015**	**Jun 2015**	**July 2015**	**Aug 2015**	**Sept 2015**	**Oct 2015**	**Nov 2015**	**Dec 2015**	**Jan 2016**	**Feb 2016**	**Mar 2016**	**Apr 2016**	**Cum Assess**	**Trend**
Attendances	16534	15128	18070	14530	14220	19366	18329	19678	17689	18455	18773	17254	N/A		
Cancellations 'Put back' *	418 (2.5%)	347 (2.29%) 765 Cum	466 (2.6%) 1231 Cum.	332 (2.3%) 1563 Cum	380 (2.7%) 1943 Cum	508 (2.6%) 2451 Cum	544 (3.0%) 2995 Cum	582 (3.0%) 3577 Cum	412 (2.3%) 3989 cum	486 (2.6%) 4475 Cum	540 (2.9%) 5015 Cum	424 (2.5%) 5439 Cum	N/A	**R**	↑
Cancellations 'Brought Froward'	128(0.77%)	99 (0.65%)	160 (0.89%)	132 (0.91%)	140 (0.98%)	184 (0.95%)	205 (1.11%)	151 (0.76%)	120 (0.68%)	103 (0.55%)	126 (0.8%)	155 (0.9%)	N/A		
Cancellation of Time/ Location	86 (0.52%)	124 (0.82%)	113 (0.63%)	89 (0.61%)	122 (0.86%)	111 (0.57%)	118 (0.64%)	295 (1.49%)	228 (1.28%)	97 (0.52%)	155 (0.8%)	80 (0.5%)	N/A		
Total Cancellations	632 (3.8%)	570 (3.77%)	739 (4.09%)	553 (3.8%)	642 (4.5%)	803 (4.1%)	867 (4.7%)	1028 (5.2%)	760 (4.3%)	686 (3.7%)	821 (4.4%)	659 (3.8%)	N/A		

*__Note__ apportioned target for March 2016 is 4335 cancellations

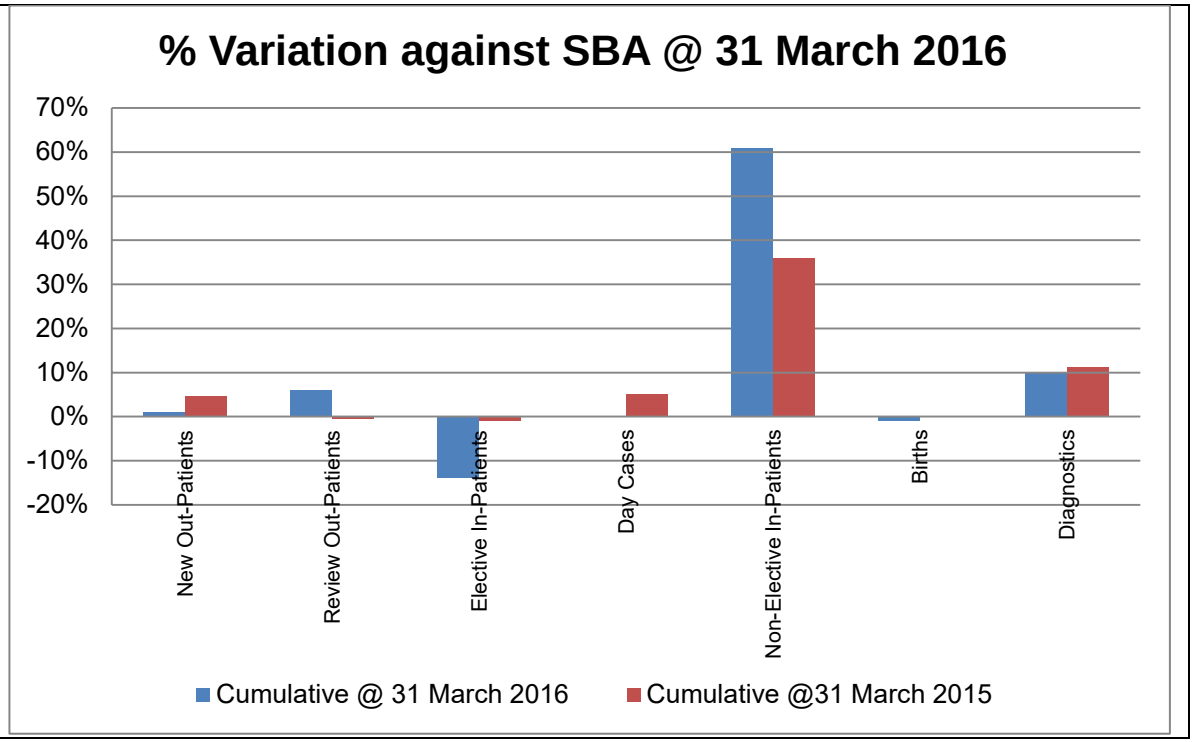
CP 29: DELIVERING TRANSFORMATION: Lead Director (All)	
By March 2016, complete the safe transfer of £83m from hospital/institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model. (New target)	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Trust Share:** To be confirmed *Note: Target not maintained as Goal/objective in 16/17 Commissioning Direction*
Comments: This target represents the 'shift-left' aims of the Transforming Your Care strategy in totality. A Regional methodology has been agreed to facilitate identification and measurement of the shift left funding transfer into primary, community and social care services. The Trust has reported, to HSCB, a cumulative total of 'shift-left' transformation investment of £7,351,700 as at March 2015. The 2015/2016 year-end position is currently not available.	

SBA PERFORMANCE SUMMARY FOR TRUST BOARD – MONTH END MARCH 2016 APPENDIX 1

Total SBA Performance per Activity Type (inclusive of newly agreed in-year uplifts): Table 1 below provides a summary of the total performance against elective and non-elective apportioned SBA baselines; this excludes visiting services where the Trust is not responsible for the SBA, a number of areas in Mental Health Directorate where SBAs require to be updated/agreed and activity related to daycentres and bedday contracts. Allied Health Professionals are currently excluded from SBA analysis pending input from HSCB/PHA on new baselines. SBA levels in a small number of areas may differ from regional reporting due to timeline for agreeing volumes. The table below reflects the variation against apportioned SBA volumes as at 31 March 2016. The graph reflects the variation in performance against the apportioned SBA compared to the same period last year.

Column A below details the cumulative percentage variation in performance against all activity recorded as SBA and includes additionality undertaken via internally redirected resources (IRR). Column B details the actual cumulative percentage variation in performance against SBA and excludes any additionality undertaken via internally redirected resources (IRR).

		Column B	
New Out-Patients		- -	
Review Out-Patients		- -	
Elective In-Patients	-14% (-964)	-15% -987	- -
Day Cases		- -	
Non-Elective In-Patients			
Births	- -	- -	
Diagnostics			
AHPs	SBA not yet agreed		



* **Note:** SBA performance includes ASD; CYPS; and OPPC specialties, where robust SBAs are in place. MHD is excluded as robust SBAs are not yet developed.

RAG Status:	On SBA or Over-performing on SBA	Underperformance of up to -4.9%	Underperformance of -5.0 to -9.9%	Underperformance of -10% and above

APPENDIX 2 - YEAR-END ASSESSMENT OF PERFORMANCE AGAINST COMMISSIONING PLAN STANDARDS/TARGETS 2015/2016

SUMMARY: Of the 39 Commissioning Plan Standards/Targets the Trust achieved the following breakdown by RAG status:			
Green (G)	Target Achieved	6 (15.3%)	17 (40.6%)
Yellow (Y)	Target substantially achieved, or narrowly missed	6 (15.3%)	
Amber (A)	Target partially achieved	4 (10%)	
Red (R)	Target not achieved	17 (44%)	
Unassessed (U)	Target cannot yet be assessed	6 (15.3%)	

2015/2016 Commissioning Plan Targets & Standards Year-End Assessment

No.	Target Area	TDP RAG Rating	Target	Internal Year-End Assessment	Year-End RAG
5.	**Unplanned Admissions -** reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.	R	-5%	9.5% cumulative April 2015 to December 2015 **Unvalidated** **Note: validated year-end assessment will not be available until July 2016**	**R**
6.	**Unplanned Admissions -** ensure that unplanned admission to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.	R	TBC	+11% cumulative April 2015 to December 2015 **Unvalidated** **Note: validated year-end assessment will not be available until July 2016**	**R**
7.	**Carers' Assessments -** secure a 10% increase in the number of carers' assessments offered.	A	838 March 2016	+10% (+88) achieved above target at 31 March 2016 (+21.5% above baseline) **Validated**	**G**
8.	**Direct Payments -** secure a 10% increase in the number of direct payments across all PoC.	A	816 March 2016	-8% (-68) achieved below target at 31 March 2016 **Validated**	**R**
9.	**AHPs -** no patient will wait longer than 13 weeks from referral to commencement of AHP treatment.	R	0	3459 patients in excess of 13-weeks at 31 March 2016: • Dietetics 90; • Occupational Therapy 377; • Physiotherapy 1062; • Podiatry 1441; and • Speech & Language Therapy 489 **Validated**	**R**
10.	**Hip Fractures -** 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	A	95%	90.9% cumulative April 2015 to March 2016 **Validated**	**A**
11.	**Cancer Services -** *all urgent breast cancer referrals should be seen within 14 days;	A	100%	93% cumulative April 2015 to March 2016 **Validated**	**Y**
	*at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31	A	98%	100% cumulative April 2015 to March 2016 **Validated**	**G**

No.	Target Area	TDP RAG Rating	Target	Internal Year-End Assessment	Year-End RAG
	days of a decision to treat; *at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	A	95%	88% cumulative April 2015 to March 2016 **Validated**	**A**
12.	**Unscheduled Care** - 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours.	A	95%	Trust 80.1% (126,044 out of 157,394) cumulative April 2015 to March 2016 • CAH = 72% (58,310 out of 80,996) • DHH = 82.7% (41,419 out of 50,076) **Validated**	**R**
		A	0	93 (0.1% of total attendances) cumulative April 2015 to March 2016 **Validated**	**Y**
14.	**Emergency Readmissions** - secure a 5% reduction in the number of emergency readmissions within 30 days.	A	+5.6% cumulative December 2014 – December 2015 (CHKS information) **Unvalidated** **Note: validated year-end assessment will not be available until July 2016** (Benchmarked CHKS performance shows Trust performing better than Peer)		**U**
15.	**Elective Care – Out-patients** *60% of patients wait no longer than nine weeks for their first outpatient appointment.	R	60%	40.2% <9-weeks at 31 March 2016 **Validated** Note: Visiting Specialties included	**R**
		R	0	13,363 patients waiting in excess of 18-weeks at 31 March 2016 **Validated** Note: Visiting Specialties included	**R**
16.	**Elective Care – Diagnostics** *number of patient waits longer than nine weeks for a diagnostic test imaging *all urgent diagnostic tests are reported on within two days of the test being undertaken.	R	0	Imaging – 2180 in excess of 9-weeks at 31 March 2016 Non-Imaging – 1541 in excess of 9-weeks at 31 March 2016 Endoscopy – 716 in excess of 9-weeks at 31 March 2016 **Validated**	**R**
		R	100%	DRTT – 78% at 31 March 2016 (Imaging and Non-Imaging) • Imaging – 76.3% (2,569 out of 3,366) • Non-Imaging – 97.1% (204 out of 210) **Validated**	**R**

No.	Target Area	TDP RAG Rating	Target	Internal Year-End Assessment	Year-End RAG
17.	**Elective Care – Inpatient/Day cases** *65% of in-patients and day cases are treated within 13 weeks and *no patient waits longer than 26 weeks.	A	65%	58.7% <13-weeks at 31 March 2016 **Validated**	**R**
		A	0	1,365 patients waiting in excess of 26-weeks at 31 March 2016 **Validated**	**R**
19.	**Stroke Patients -** ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.	G	13%	13% cumulative April 2015 to December 2015 **Unvalidated** **Note: validated year-end assessment will not be available until July 2016**	**G**
20.	**Healthcare Acquired Infections -** secure a reduction of 20% in MRSA and Clostridium Difficile infections compared to 2014/15.	W	MRSA 5	MRSA 2 cumulative April 2015 to March 2016 **Validated**	**G**
		W	C Diff 32	C Difficile 54 cumulative April 2015 to March 2016 **Validated**	**R**
21.	**Patient Discharge –** *ensure that 99% of all learning disability (LD) and mental health (MH) discharges take place within 7 days of the patient being assessed as medically fit for discharge, with *no discharge taking more than 28 days; *90% of complex discharges from an acute hospital take place within 48 hours, with *no complex discharge taking more than seven days; and *all non-complex discharges from an acute hospital take place within six hours.	A	99%	Learning Disability 81% (20 out of 25) cumulative April 2015 to March 2016 **Validated**	**A**
		G	99%	Mental Health 94% (1100 out of 1167) cumulative April 2015 to March 2016 **Validated**	**Y**
		A	0	Learning Disability 1 patient (discharged in excess of 28-days) cumulative April 2015 to March 2016 **Validated**	**Y**
		A	0	Mental Health 21 patients (discharged in excess of 28-days) cumulative April 2015 to March 2016 **Validated**	**R**
		A	90%	48-hours – 95.8% (1278 out of 1334) cumulative April 2015 to March 2016 **Validated**	**G**
		A	100%	7-days – 98.7% (1317 out of 1334) cumulative April 2015 to March 2016 **Validated**	**Y**
		A	100%	6-hours – 92.3% (27,088 out of 29,335) cumulative April 2015 to March 2016 **Validated**	**A**
22.	**Mental Health Services** – *no patient waits longer than nine weeks to access child and adolescent mental health services; *nine weeks to access adult mental health services; * nine weeks to access	G	0	CAMHS – 0 patients in excess of 9-weeks at 31 March 2016) **Validated**	**G**
		A	0	Adult Mental Health – 81 patients in excess of 9-weeks at 31 March 2016 **Validated**	**R**

No.	Target Area	TDP RAG Rating	Target	Internal Year-End Assessment	Year-End RAG
	dementia services; and *13 weeks to access psychological therapies	G	0	Dementia – 69 patients in excess of 9-weeks at 31 March 2016 **Validated**	**R**
		A	0	Psychological Therapies – 10 patients in excess of 13-weeks at 31 March 2016 **Validated**	**Y**
23.	**Children in Care – Placement Change –** ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.	A	85%	Note: 2014/2015 performance information is collated during August / September 2015 and will not be available until July 2016 due to the annual reporting cycle	**U**
24.	**Children in Care- Adoption within 3 years -** ensure that a three year time frame for 90% of children who are adopted from care.	G	90%	Note: 2014/2015 performance information is collated during August / September 2015 and will not be available until July 2016 due to the annual reporting cycle	**U**
25.	**Patient Safety -** ensure that the death rate of unplanned weekend admission does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.	A	Not >0.1%	0.6% variance in death rate at 31 March 2016 **Validated**	**R**
26.	**Normative Staffing-** implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.	A	Note: Year-end assessment of performance will not be available until the end of May 2016.		**U**
27.	**Excess Beddays -** reduce the number of excess bed days for the acute programme of care by 10%.	R	+16% cumulative January 2014 to January 2016 (CHKS information) **Unvalidated** (Benchmarked CHKS performance shows Trust 0.5% higher than the Peer)		**U**
28.	**Cancelled Appointments -** reduce by 20% the number of hospital cancelled Consultant-Led outpatient appoints in the acute programme of care which resulted in the patient waiting longer for their appointment. (Volumes & % rate in month)	A	< 4335	+25.5% (+1104) above profiled target at 31 March 2016 **Validated**	**R**
29.	**Delivering Transformation –** Safe transfer of £83m from hospital/institutional based care into primary, community and social care services	W	Note: Year-end assessment of performance currently not available.		**U**

APPENDIX 3 - ACCESS TIMES (Routine waits) – Month ended April 2016 and projected month end position for May 2016

OUT-PATIENTS - From April 2015, at least 60% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 18-weeks. 18 weeks is the defined backstop for outpatient waits

Specialty	SBA Performance: Over / Under (at 31/03/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016							Estimated position at End of May 2016
				End of April 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks) *April 2016 data not available if section is blank*					
						18 - 21	21 - 26	26-31	31-36	36 +	
Anti-Coagulant	Under -6%	Minor capacity gap	9 weeks	7 weeks	0	0	0	0	0	0	2 weeks
Breast Family History	On SBA 0%		9 weeks	10 weeks	0	0	0	0	0	0	13 weeks
Cardiology (including ICATS)	Over +14%	Capacity gap	9 weeks	44 weeks							42 weeks
Cardiology – Rapid Access Chest Pain	Over +19%		2 weeks	8 weeks							8 weeks
Chemical Pathology	Over +13%	Capacity Gap	9 weeks	18 weeks							20 weeks
Colposcopy	Under -18%		9 weeks	5 weeks							5 weeks
Community Paediatrics	No SBA	N/A	9 weeks	9 weeks[1]	0	0	0	0	0	0	9 weeks
Dermatology (includes ICATS)	Under -11%		18 weeks	22 weeks							22 weeks
Endocrinology	Under -28%	Capacity gap	9 weeks	75 weeks							74 weeks
Diabetology	Under -10%			63 weeks							62 weeks

[1] Community Paediatrics figure excluding Education referrals which do not follow the 9-week access standard.

Specialty	SBA Performance: Over / Under (at 31/03/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016							Estimated position at End of May 2016
				End of April 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks) *April 2016 data not available if section is blank*					
						18 - 21	21 - 26	26-31	31-36	36 +	
ENT (Cons Led includes ENT ICATS)	Over +14%	Residual Capacity gap	9 weeks	36 weeks							38 weeks
Gastroenterology	Over +16%	Capacity gap	9 weeks	54 weeks							58 weeks
General Medicine	Over +4%		9 weeks	15 weeks							17 weeks
Geriatric Medicine	Over +61%	Capacity gap	9 weeks	9 weeks (Acute)							9 weeks (Acute)
Ortho-Geriatric	Over +43%	Capacity gap	9 weeks	55 weeks							57 weeks
General Surgery (1)	Under -8%	Residual capacity gap	9 weeks	38 weeks							41 weeks
Gynaecology	Under -3%	Previous capacity gap/ accrued backlog	9 weeks	27 weeks							33 weeks
Haematology	Over +43%	Capacity gap	9 weeks	18 weeks							22 weeks
Nephrology	Over +11%	Minor capacity gap	9 weeks	9 weeks							9 weeks
Neurology	Over +6%	Capacity gap	9 weeks	55 weeks							57 weeks
Orthopaedics	Under -10%	Previous capacity gap/ accrued backlog	13 weeks	60 weeks							62 weeks
Orthopaedic ICATS	Under -13%	Previous	9 weeks	33 weeks							29 weeks

Specialty	SBA Performance: Over / Under (at 31/03/16)	Known Capacity Gap	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016							Estimated position at End of May 2016
				End of April 2016 position	Actual Volume of patients waiting in excess of 18-week 'backstop'	Time Bands (in weeks) *April 2016 data not available if section is blank*					
						18 - 21	21 - 26	26-31	31-36	36 +	
		Capacity gap/ accrued backlog									
Paediatrics	Over +11%	Capacity gap	9 weeks	26 weeks							30 weeks
Pain Management (3)	Under -3%	Capacity gap	9 weeks	48 weeks							53 weeks
Rheumatology	Over +4%	Capacity gap	18 weeks	69 weeks							71 weeks
Symptomatic Breast Clinic	Over +8%		9 weeks	2 weeks (Red Flags) & 24 weeks (Routine)							4 weeks (Red Flags) & 27 weeks (Routine)
Thoracic Medicine	Over +10%	Capacity gap	9 weeks	45 weeks							47 weeks
Urology (2) **(includes ICATS)**	Under -9%	Minor Capacity gap	9 weeks	73 weeks							73 weeks

(1) Urology – Proposal has been submitted to SLGT to revise SBA to reflect the new agree pilot one stop model which has been agreed regionally. Subject to agreement this will see a more accurate and improved position on performance against SBA for this area.

IN-PATIENTS / DAY CASES - From April 2015, at least 65% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks. 26 weeks is the defined 'backstop'

Specialty	SBA Performance: Over / Under (at 31/03/16)	Known Capacity Gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of April 2016					Estimated End of May 2016 position
				End of April 2016 position	Actual Volume of patients waiting in excess of 26-week 'backstop'	Timebands (in weeks) *April 2016 data not available if section is blank*			
						26-31	31-36	36+	
Breast Surgery	Over +2%	Emergent minor capacity gap	26 weeks	67 weeks					22 weeks
Cardiology	TBC	Capacity gap	13 weeks	46 weeks					47 weeks
Community Dentistry	Under -17%		13 weeks	11 weeks	0	0	0	0	12 weeks
Dermatology	Over +37%	Capacity Gap	13 weeks	22 weeks					23 weeks
ENT	Under -11%	Emergent minor capacity gap	13 weeks	27 weeks					24 weeks
Gastroenterology (Non Scopes)	TBC		13 weeks	5 weeks					8 weeks
General Surgery	Under -15%	Previous Capacity gap / accrued backlog	26 weeks	94 weeks					97 weeks

Specialty	SBA Performance: Over / Under (at 31/03/16)	Known Capacity Gap	Access Standard or Backstop	Actual Access Time and Volume of Waits (By Time Band) at end of April 2016					Estimated End of May 2016 position
				End of April 2016 position	Actual Volume of patients waiting in excess of 26-week 'backstop'	Timebands (in weeks) *April 2016 data not available if section is blank*			
						26-31	31-36	36+	
Gynaecology	Under -4%	Previous Capacity gap/ accrued backlog	13 weeks	36 weeks IP 25 weeks DC					36 weeks IP & 25 weeks DC
Haematology	Over +32%		13 weeks	13 weeks	0	0	0	0	13 weeks
Orthopaedics	On SBA 0%	Residual Capacity gap	26 weeks	88 weeks					92 weeks
Pain Management (1)	Over +14%	Capacity gap	26 weeks	80 weeks					84 weeks
Rheumatology	Over +8%		26 weeks	15 weeks					18 weeks
Urology	Under -5%	No Capacity gap	26 weeks	124 weeks					126 weeks

DIAGNOSTICS - From April 2015, no patient waits longer than 9-weeks for a diagnostic test (Routine)

Specialty	SBA Performance – over/under (at 31/03/16)	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016						Estimated End of May 2016 position
					End of April 2016 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks) *April 2016 data not available if section is blank*				
							9 - 13	13 - 21	22 - 26	26 +	
Endoscopy Symptomatic	Under -7%	Capacity gap	-	9 weeks	50 weeks						52 weeks
Cardiac Investigations (Non-Echo)	No SBA		Pacing, ECG, BP, CM, Tapes (28/48 /72 hr), Tilts, Treadmill, DSE,TOE	9 weeks	29 weeks						TBC
Cardiac Investigations (Echo)	Under -5%	Capacity gap	Echo	9 weeks	30 weeks						TBC
Neurophysiology (EEG only)	Under -28%			9 weeks	7 weeks	0	0	0	0	0	7 weeks
Audiology	Over +3%			9 weeks	9 weeks	0	0	0	0	0	9 weeks
Sleep Studies	No SBA			9 weeks	9 weeks						10 weeks
Urodynamics (Urology)	Included in OP SBA			9 weeks	71 weeks						73 weeks
Urodynamics (Gynae)	Under -27%			9 weeks	6 weeks						6 weeks
Imaging	Over +7%	Capacity gap	CT	9 weeks	19 weeks						22 weeks
			CTC	9 weeks	23 weeks						26 weeks
	Under -2%	Capacity gap	NOUS	9 weeks	17 weeks						22 weeks
	Over +3%	Capacity gap	DEXA	9 weeks	21 weeks						24 weeks
	Over +9%	Capacity gap	MRI	9 weeks	21 weeks						19 weeks

Specialty	SBA Performance – over/under (at 31/03/16)	Known capacity gap	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016						Estimated End of May 2016 position
					End of April 2016 position	Actual Volume of patients waiting in excess of target	Timebands (in weeks) *April 2016 data not available if section is blank*				
							9 - 13	13 - 21	22 - 26	26 +	
	-		Fluoroscopy	9 weeks	22 weeks						26 weeks
	-		Barium Enema	9 weeks	13 weeks						13 weeks
	-		Gut Transit Studies	9 weeks	13 weeks						13 weeks
	-		Radio Nuclide	9 weeks	13 weeks						13 weeks

MENTAL HEALTH AND DISABILITY - By April 2015, no patient waits longer than 9-weeks to access Child and Adolescent Mental Health Services; 9-weeks to access Adult Mental Health Services; 9-weeks to access Dementia Services; and 13-weeks to access Psychological Therapies

Specialty	Sub Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016							End of May 2016 position
			End of April 2016 position	Actual Volume of patients waiting in excess target	Timebands (in weeks) April 2016 data not available if section is blank					
					9 - 13	13 - 18	18 - 26	26 - 39	39 +	
Adult Mental Health Services	Primary Mental Health Care	9-weeks	22 weeks (IS)	61	52	6	3	0	0	19 weeks (IS)
	Memory / Dementia Services		29 weeks	44	28	12	2	2	0	22 weeks
CAMHS	-	9-weeks	9 weeks	-	-	-	-	-	-	9 weeks
Learning Disability	-	9-weeks	9 weeks	-	-	-	-	-	-	9 weeks
Psychiatry of Old Age	-	9-weeks	18 weeks							13 weeks
Autism	-	13-weeks	13 weeks	-	-	-	-	-	-	13 weeks
Psychological Therapies	-	13-weeks	22 weeks	16	11	5	0	0	0	26 weeks

ALLIED HEALTH PROFESSIONALS - From April 2015, no patient waits longer than 13-weeks for referral to commencement of AHP treatment.

Specialty	Access Standard	Actual Access Time and Volume of Waits (by Time Band) at end of April 2016				End of May 2016 position
		End of April 2016 position	Actual Volume of patients waiting in excess of 13 weeks.	Timebands (in weeks)		
				13 - 26	26 +	
Dietetics – Acute	13-weeks	13 weeks	-	-	-	13 weeks
Dietetics – Elderly and Primary Health Care	13-weeks	15 weeks	20	20	0	18 weeks
Dietetics – Paediatrics	13-weeks	26 weeks	73	73	0	26 weeks
Occupational Therapy – Acute	13-weeks	13 weeks	0	0	0	13 weeks
Occupational Therapy – Elderly and Primary Health Care	13-weeks	21 weeks	58	56	2	25 weeks
Occupational Therapy – Paediatric	13-weeks	49 weeks	190	89	101	46 weeks
Occupational Therapy – Physical Disability	13-weeks	32 weeks	89	66	23	28 weeks
Occupational Therapy – Learning Disability	13-weeks	21 weeks	14	14	0	13 weeks
Orthoptics	13-weeks	13 weeks	0	0	0	13 weeks
Physiotherapy – Adult	13-weeks	28 weeks	1068	1067	1	28 weeks
Physiotherapy – Paediatrics	13-weeks	22 weeks	21	21	0	23 weeks
Physiotherapy -Physical Disability	13-weeks	24 weeks	1	1	0	TBC
Physiotherapy - Learning Disability	13-weeks	17 weeks	1	1	0	TBC
Physiotherapy – Mental Health	13-weeks	14 weeks	1	1	0	TBC
Podiatry – Adult	13-weeks	37 weeks	1383	1003	380	33 weeks
Podiatry – Paediatrics						
Speech & Language Therapy Elderly & Primary Health	13-weeks	32 weeks	75	72	3	36 weeks
Speech & Language Therapy Paediatrics	13-weeks	28 weeks	417	409	8	28 weeks

Commissioning Plan Direction 2016/2017 (Objectives and Goals for Improvement)

Appendix 4

Desired outcome 1: Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.

Objectives/ goals for improvement		New Target for 16/17
1.1	In line with the Departmental strategy A Fitter Future For All, by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	Yes
1.2	In line with the Department's policy framework, Living with Long Term Conditions, continue to support people to self manage their condition through increasing access to structured patient education programmes. **In 2016/2017, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.**	No
1.3	In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	Yes
1.4	By March 2020, to reduce the differential in the suicide across Northern Ireland and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/2017 should include early intervention and prevention activities, for example through improvement of self harm care pathways and appropriate follow-up services in line with NICE guidance.	No
1.5	By March 2018 ensure full delivery of the universal child health promotion framework for Northern Ireland, *Healthy Child, Healthy Future*. Specific areas of focus for 2016/2017 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.	Yes
1.6	During 2016/2017, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/2017, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.	No
1.7	During 2016/2017, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/2017, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.	No

Desired outcome 2: People using health and social care services are safe from avoidable harm

Objectives/ goals for improvement		New Target for 16/17
2.1	By March 2017, secure a reduction of [10 to 20%] in MRSA and Clostridium difficile infections compared to 2015/2016 [*DN Final figure defined after examination of 2015/2016 statistics*]	No
2.2	From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration	No
2.3	By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services	No
2.4	The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice.	Yes
2.5	The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice and that subsequently attract a notice of decision	Yes

Desired outcome 3: People who use health and social care services have positive experiences of those services.

Objectives/ goals for improvement		New Target for 16/17
3.1	To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/2017 is to develop and implement appropriate systems to support this.	Yes
3.2	By March 2017, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need (or alternatively timely access to treatment).	Yes
3.3	Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.	Yes

3.4	HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	Yes
3.5	By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.	Yes

Desired outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Objectives/ goals for improvement		New Target for 16/17
4.1	By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/2017 is on developing a comprehensive baseline of such activity, to be used to inform future work.	Yes
4.2	From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.	No
4.3	From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	No
4.4	From April 2016, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	No
4.5	By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	Yes
4.6	From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	No
4.7	From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	No
4.8	By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	No

4.9	By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	No
4.10	By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.	No
4.11	From April 2016, all urgent diagnostic tests should be reported on within two days.	No
4.12	From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	No
4.13	From April 2016, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	No

Desired Outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.

Objectives/ goals for improvement		New Target for 16/17
5.1	From April 2016, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	No
5.2	By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions	No
5.3	By March 2017, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.	No
5.4	By March 2017, secure a 10% increase in the number of direct payments to all service users.	No
5.5	By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.	Yes

Desired outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

Objectives/ goals for improvement		New Target for 16/17
6.1	By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.	No
6.2	By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	Yes
6.3	By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and:	Yes
	I. the need for further advice, information or signposting has been identified;	Yes
	II the need for appropriate training has been identified;	Yes
	III.the need for a care package has been identified;	Yes
	IV.the need for a short break has been identified;	Yes
	V.the need for financial assistance has been identified.	Yes

Desired outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.

Objectives/ goals for improvement		New Target for 16/17
7.1	By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.	No
7.2	From April 2016, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.	No
7.3	By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.	No
7.4	By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered	Yes

Desired outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide

Objectives/ goals for improvement		New Target for 16/17
8.1	By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.	Yes
8.2	By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/2016 figure.	Yes
8.3	During 2016/2017, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging staff.	Yes
8.4	By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans'	Yes
8.5	By March 2017, 10% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework.	Yes
8.6	By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/2016. This will require a renewed focus on improving the Patient and Client Experience Standards.	Yes

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: Date:	Trust Board Thursday, 29 November 2018
Title:	**Performance Dashboard (Ministerial Targets) at October 2018**
Lead Director:	Aldrina Magwood, Director of Performance & Reform
Corporate Objective:	➢ Promoting safe high quality care ➢ Supporting people live long, healthy, active lives ➢ Make best use of our resources ➢ Improving our services ➢ Being a great place to work - supporting, developing and valuing our staff ➢ Working in partnership
Purpose:	For Approval

High Level Context

Commissioning Plan Direction & Performance Management Arrangements

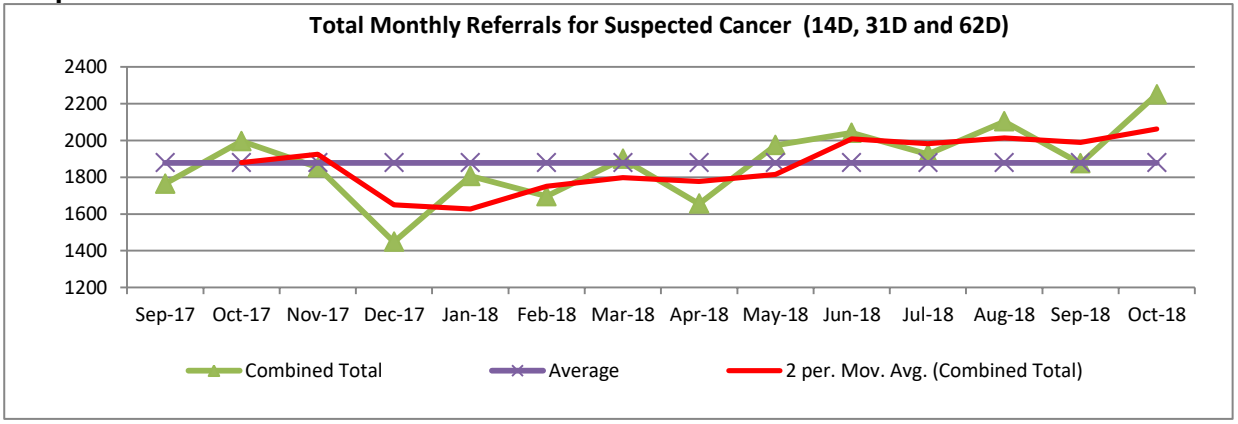
- In response to the Department of Health's draft **Commissioning Plan Direction (CPD) t**he Trust has considered each objective and goal for improvement (OGI) and made an assessment of the anticipated level of performance to be achieved by March 2019. This takes into account the key constraints and challenges and the availability of any additional investment.
- The Corporate Dashboard provides a summary of assessed performance against all OGIs and against Performance Improvement Trajectories (PIT) for key areas, submitted to the (HSCB), which form part of new HSC performance management arrangements.
- This summary report will assesses performance against the OGIs as at the October 2018 position on an 'exception basis' and focus on areas where the assessment of performance at this stages is not in accordance with that anticipated, presents greatest challenge or where there has been a change/improvement as well as actions being taken to manage risks.

Summary of Key Issues / Points of Escalation

1 Cancer Care

- In October 2018 the Trust received 2250 referrals for assessment of patients with suspected cancer across the 14-Day, 31–Day and 62-Day pathways. **This equates to a 13% increase from the same month last year**. There is a clear step change in the volume of referrals received monthly, for the last six months, compared to the average for the last 14 months.
- Whilst the volume of confirmed cancers, April and October 2018 (1,394) demonstrates an increase compared to the same period in 2017 (1,191), the percentage of confirmed cancers, against referrals, has remained relatively static at 16%.

Graph 1



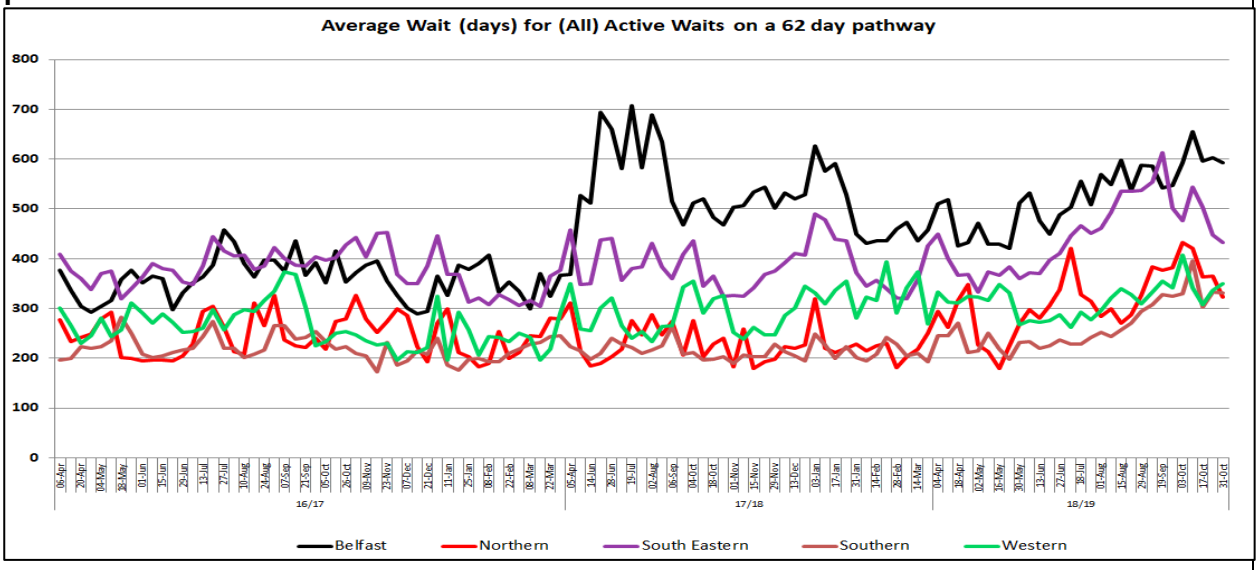
1.1 Breast Cancer Services (14-day target)

- October was Regional breast awareness month and **the Trust received 328 referrals for assessment, the highest recorded.**
- Capacity for out-patient assessment was increased during this period by the clinical team to meet demand. Whilst surgical capacity is prioritised for red flag patients the ability to further flex up surgical capacity to deal with peaks in demand is restricted due to unscheduled care pressures, which limits elective capacity. This will impact on performance against the 62-day pathway.
- **Cumulatively from April 2018, 99% of patients referred with suspected cancer have been assessed within 14 days**. In October one patient waited more than 14 days; cumulative performance against the planned trajectory remains on track.
- The longest wait for routine assessment at the end of October 2018 was 87-weeks. This increased wait time was associated with the late return of a cohort of Southern Trust patients who had refused offers of assessment in another Trust. These patients are all appointed for November 2018 and the access time at end of November 2018 will reduce to 39-weeks.
- Public consultation on proposed changes to the future configuration of breast assessment services will be undertaken, subject to Departmental approval.

1.2 Waits on the Cancer Pathway: (62-day(D) target)

- **The % performance in 2018/2019 continues to be impacted by an increased volume of patients on the cancer pathway pathways which challenges resources.** All patients are actively individually tracked through the pathway and revised escalation arrangements have been issued to support this process
- Current indicative information indicates 21 patients did not have their first treatment initiated before D-62; 10 of these patients were managed by the Trust and 11 were transferred to other Trusts for treatment in accordance with agreed protocols.
- **12 patients waited between D-62 and D-85, and 9 patients waited in excess of D-85 for their first treatment**. The majority of those waiting more than 62-days were urology (10).
- The longest waits were in urology and lower gastrointestinal surgery at D-213 and D-195 respectively.
- **Additional capacity, provided via the Confidence and Supply funding, for red flag and urgent out-patient capacity, endoscopy and key diagnostics will support the management of demand on the cancer pathway.** However, longer term sustainable improvement will not be demonstrated without the recurrently funded provision of capacity levels, including workforce, sufficient to meet the demand.
- Graph 2 shows the Trust's performance (brown line), which remains regionally comparable; with all Trusts reflecting an increase in the average wait for patients on the pathways.

Graph 2



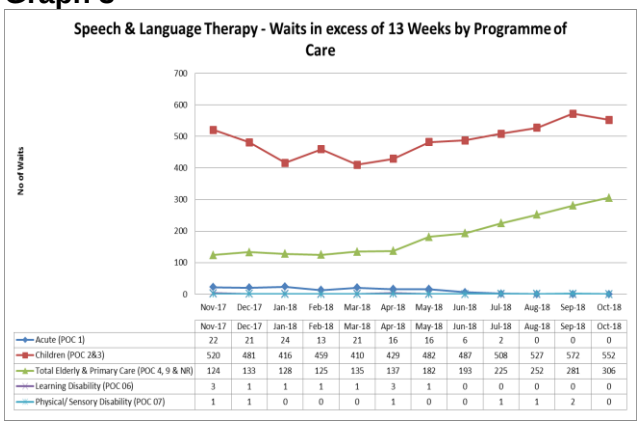
2 Elective Care

- As demand for elective care services continues to exceed health service capacity for both out-patients and in-patients/day cases waiting times will increase.
- **From the last report the Trust has been allocated further funding, in the region of £3.3m to provide additional in-house capacity and also for the provision of activity in the Independent Sector**. This supplements additional funding, in the region of £6.4m, previously allocated from the HSCB via the Department of Health Confidence and Supply funding.
- Additional non-recurrent funding to undertake additional activity will benefit patients and reduce waits in the short-term, however, it is recognised reform of services, as set out in the Departments of Health's Elective Care Plan, will be required to see longer-term gains.
- A number of initiatives have been progress as part of this Plan and **in October 2019, South Tyrone Hospital was announced as a prototype elective care centre for delivery of routine cataract surgery.** Elective care centres for varicose veins have also been established regionally which will support delivery of additional routine day case procedures.
- The Trust continues to seek to optimise capacity via delivery of its agreed performance trajectories. **At the end of October 2018, whilst core capacity is below the service and budget agreement levels, activity is reflective of the submitted trajectories** with New Outpatients, In-Patients and Day Cases collectively over the level projected (+2% and +3%) with diagnostic imaging on track for their projected level of activity.

2.1 Allied Health Professionals

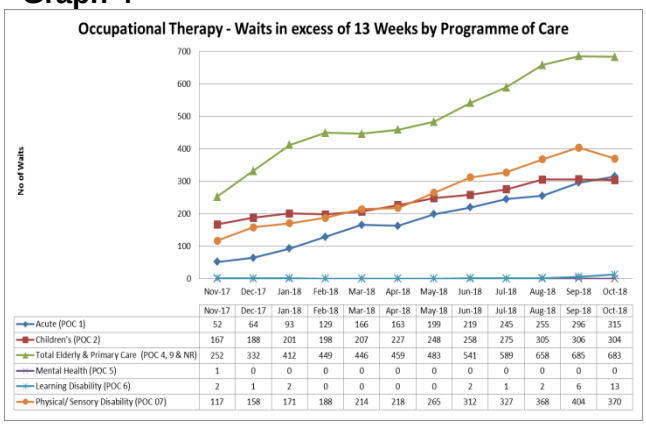
- **The number of patients waiting in excess of 13-weeks has decreased by 4% from March 2018/**
- Two professions account for the majority of waits; Occupational Therapy (OT) 44% (1,685) and Speech and Language Therapy (SLT) 22% (858) out of a total 3,792 patients waiting in excess of 13-weeks. Whilst OT is showing growth in total waits, SLT total waits are not showing growth and therefore, **it is anticipated additional capacity to address long waits should impact positively in SLT.**
- Core commissioned capacity is being delivered, and analysis is underway to examine trends in urgent referrals. **Detailed improvement plans will be put in place to ensure longest waits are targeted as planned**.

Graph 3



	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Acute (POC 1)	22	21	24	13	21	16	16	6	2	0	0	0
Children (POC 2&3)	520	481	416	459	410	429	482	487	508	527	572	552
Total Elderly & Primary Care (POC 4, 9 & NR)	124	133	128	125	135	137	182	193	225	252	281	306
Learning Disability (POC 06)	3	1	1	1	1	3	1	0	0	0	0	0
Physical/ Sensory Disability (POC 07)	1	1	0	0	0	1	0	0	1	1	2	0

Graph 4



	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Acute (POC 1)	52	64	93	129	166	163	199	219	245	255	296	315
Children's (POC 2)	167	188	201	198	207	227	248	258	275	305	306	304
Total Elderly & Primary Care (POC 4, 9 & NR)	252	332	412	449	446	459	483	541	589	658	685	683
Mental Health (POC 5)	1	0	0	0	0	0	0	0	0	0	0	0
Learning Disability (POC 6)	2	1	2	0	0	0	0	2	1	2	6	13
Physical/ Sensory Disability (POC 07)	117	158	171	188	214	218	265	312	327	368	404	370

- At end of October the longest wait is 62-weeks in both OT and SLT, which is an improvement. Physiotherapy longest waits is 38-weeks with the remaining Professions 26-weeks or less.
- **Additional capacity (c £960,000) from Confidence and Supply Funds will deliver additionality of circa 4,000 AHP assessments, with subsequent treatments/reviews.** At October approximately half of the additional resources required to deliver this are now in post and the Trust continues to seek additional staff via agency to complement this.
- This **additionality will not facilitate the maintenance of reduced access times** as there continues to be emergent capacity gaps.

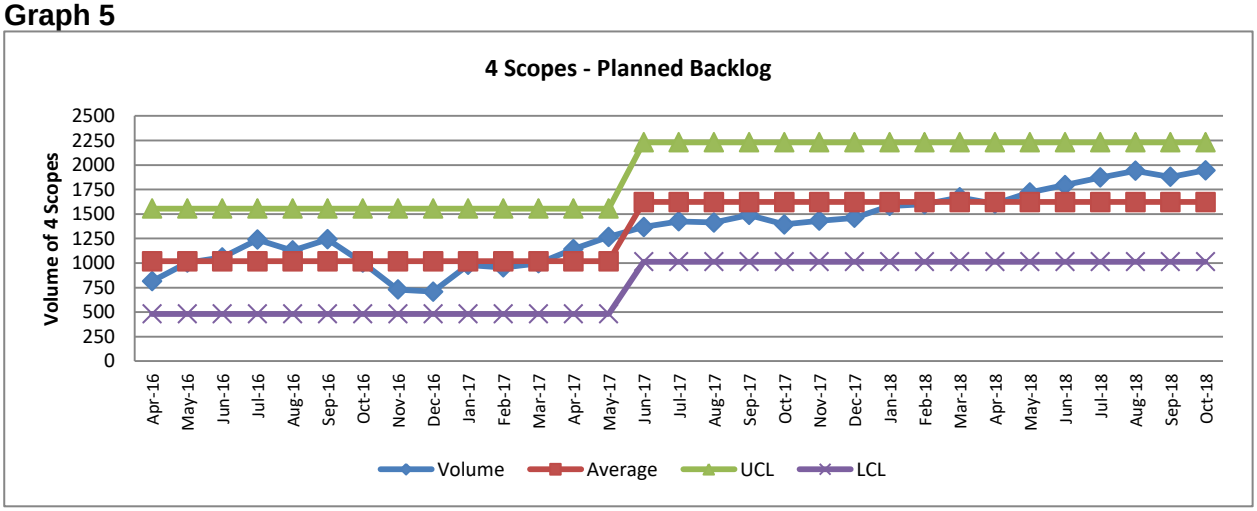
2.2 Diagnostics, including Endoscopy

- At September 2018 47% of patients waited less than 9-weeks which is slightly ahead of the Regional cumulative performance of 50%.
- At the end of September there were 13,377 patients waiting in excess of 9-weeks for diagnostics, of which 5,238 (39%) were waiting in excess of 26-weeks. Waits in excess of 26-weeks continue associated with defined capacity gaps in diagnostics:
  - Imaging, with largest volumes in CT (1,011); DEXA (741); and MRI (148); and
  - Non-imaging, with largest volumes in Cardiac investigations (2,924).

Endoscopy

- In relation to Endoscopy 230 patients are waiting in excess of 26-weeks for first procedures
- Additional allocated funding will deliver in-house additionality of circa 2150 scopes with a further circa 770 scopes in the Independent Sector by March 2019.
- A further **1,946 patients are waiting beyond their clinically indicated timescale for a planned repeat procedure**.
- The volume of patients waiting for repeat procedures has increased as a large cohort of additional patients who have received treatment over the last number of years now require on-going management.
- The management of this caseload is challenging within the existing capacity and in the context of new red flag and urgent demand which absorbs capacity. Graph 5 demonstrates a step change in the average volume of patients on the Scopes planned backlog from an average of 1,019 (Apr 16 –May 17) increasing to an average of 1,623 between June 2017 and October 2018 with an increasing trend.

Graph 5



- Funding allocated by HSCB has supported:
  - **The validation of planned patients, waiting longer than clinically indicated, assisting in the stratification and management of risk**;
  - **Treatment of approximately 370 additional patients** from the planned repeat procedure lists where patients have waited longer than clinically indicated (circa £200,000), and
  - Treatment of additional red flag/urgent endoscopy (both new and planned urgent patients) which will support those on the cancer and urgent clinical pathways (circa £1.2m).

Imaging/Non-Imaging

- **HSCB has allocated circa £1.2m in year for additional CT demand which will provide capacity for up to 6,500 general scans**. In lieu of a second substantive CT scanner on the CAH site a mobile facility is in place.
- A capacity gap however remains associated with further increasing demand for both general CTs and specialist work. HSCB have funded a further £406,500 associated in respect of this gap which will see an additional 1,960 CT examinations undertaken in the Independent Sector including specialist CT Colonography (100) and specialist CT Cardiac Angiography (260).
- **The total funding will deliver an additional 8,100 CT scans in the on-site mobile facility**

and 260 in the Independent Sector to reduce volumes waiting.

- Additional capacity provided for Cardiac Investigations; Urodynamics (Urology); and Dexa Scanning via the Confidence and Supply fund will deliver **approximately 1100 additional diagnostic examinations, for those patients waiting in excess of 26-weeks at 31 March 2018**.

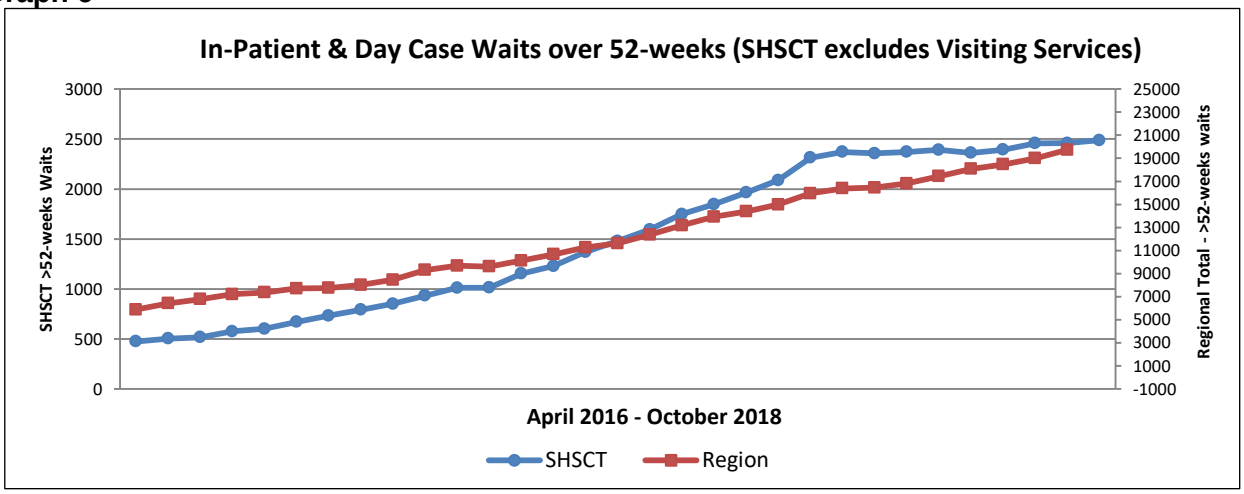
2.3 Diagnostic Reporting Turnaround Times (Plain Film)

- **There has been significant improvement in the volume of plain films which wait over 28-day waits for formal reporting**. The longest waiting unreported plain film chest x-ray is 40-days, with the longest waiting unreported plain film, non-chest, x-ray at 38-days.
- The service have worked with the Providers to resolve the volumes unreported, as demonstrated above, and in addition are putting in place in-house solution to report those most critical.
- **To manage the demand on an on-going basis the service will be sending out additional volumes of plain films routinely to the IS Providers and will be re-commencing additional locum sessions** in November to increase its in-house capacity (Locum not available until November).

2.4 In-Patients and Day Cases

- **In-Patient (IP) and Day Case (DC) waits over 52-week at end of October are relatively static with 2,487 people waiting across 8 specialty areas** – Breast Surgery; Cardiology; ENT; General Surgery; Orthopaedics; Paediatrics; Pain Management; and Urology. The increasing trend in waits over 52-weeks continues to be demonstrated Regionally (Graph 6)
- **Whilst the longest wait remains within Urology at 248-weeks it is of note that the average waiting time is 35-weeks with the 95th percentile wait at 111-weeks (Pain Management).**
- The Trust's percentage of patients waiting less than 13-weeks at October 2018 has demonstrated a slight improvement to 36% and is more favourable compared to the Regional cumulative for September of 33%.

Graph 6

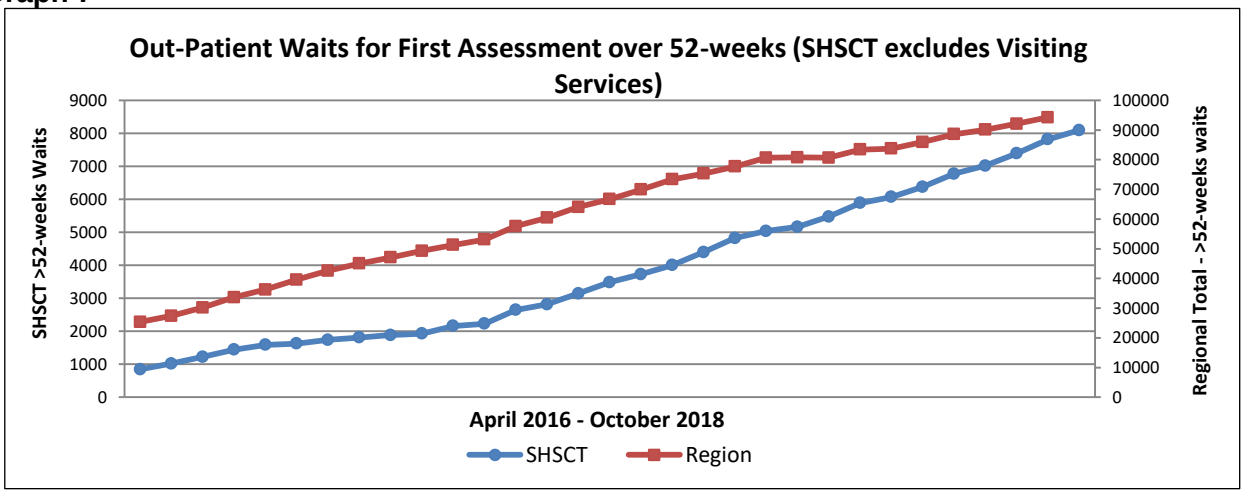


- **Additional capacity has been secured for surgical in-patient and day case treatments via non-recurrent monies, totalling circa £3.15m** for:
  - 520 IP/DC long waits via in-house additionality for a mixture of red flag/urgent and long waiting patients within Dermatology; ENT; Gynaecology; Orthopaedics; and Pain Management.
  - 710 day case cardiac diagnostic angiograms via the additional (leased) modular Catheterisation Laboratory.
  - 314 orthopaedic and 20 general surgery treatments in the Independent Sector.

2.5 Out-Patients

- **At the end of October new out-patient (OP) waits over 52-weeks continued to increase with 18.5% waiting in excess of 52-weeks (8,094 people) across 13 specialty areas –** Breast Family History; Breast Surgery; Cardiology; Endocrinology; ENT; Gastroenterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology. The increasing trend in waits over 52-weeks continues to be demonstrated Regionally.
- **Whilst the longest wait remains within Ortho-Geriatrics at 146-weeks it is of note that the average waiting time is 31-weeks with the 95th percentile wait at 91-weeks (General Surgery).**

Graph 7



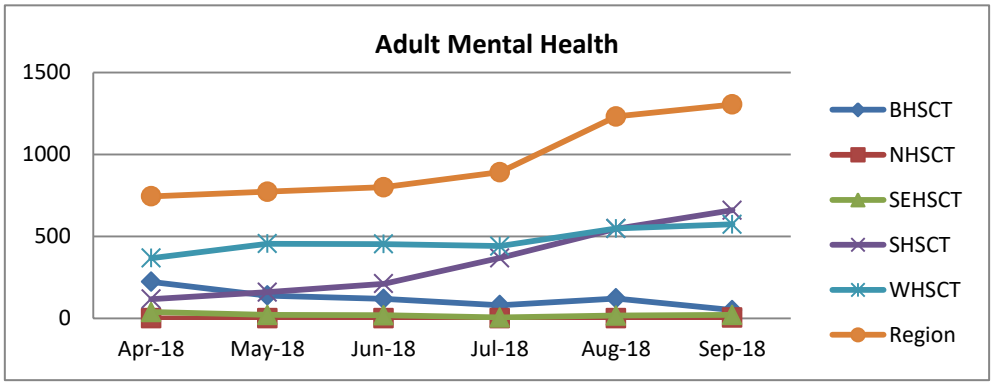
- The Trust's percentage of patients waiting less than 9-weeks has increased in October to 29.6% and remains more favourable than the Regional cumulative position, for September 2018, of 25%.
- **Additional investment committed by Department of Health in year, from Confidence and Supply funding, is projected to provide additional in-house capacity** for circa 19,000 additional red flag; urgent; and long-waiting out-patient assessments (both new and review patients). At 26 October 2018 the Trust has delivered 6,945 out-patient assessments against this projected activity.
- **This will support those most clinically urgent patients, including those on the cancer pathway, and will only address a small volume of the longest waits**.

3 Mental Health

3.1 Adult Elective Services

- Access time objectives in Mental Health continue to be challenged, which is reflected in the number of patients waiting in excess of 9-weeks. In the main **this is associated with demand in excess of capacity, however, it has been further compounded with funded workforce pressures**.
- As per Graph 8 below the Trust's performance, in comparison to the Region, is less favourable with an increasing trend in waits over 9-weeks. The Trust's position is set in the context of demand and capacity gaps and workforce challenges.
- **The specialties affected are: Addiction Services; Eating Disorder Services; and Primary Care Mental Health. The longest wait has demonstrated a slight reduction to 43-weeks and is within the Addictions Service**.

Graph 8

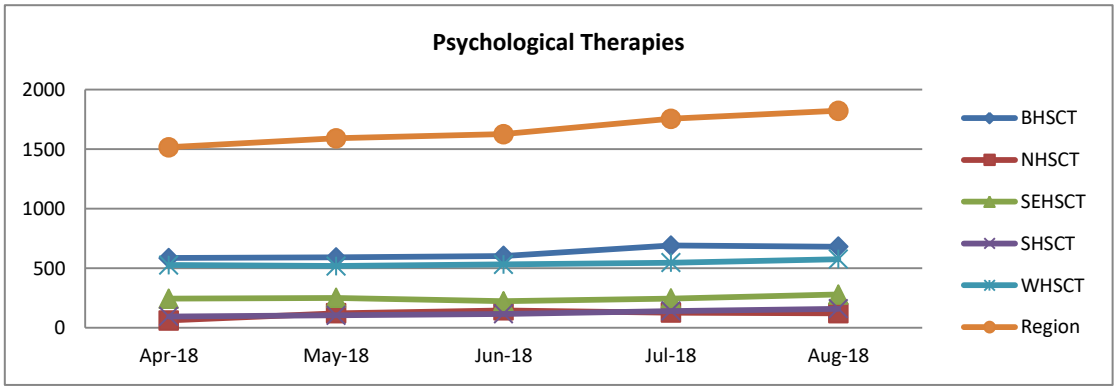


- **Performance against the 9-week objective and against submitted trajectories is anticipated to be further impacted over the next few months associated with the requirement to align staff to support the in-patient Acute wards within Bluestone**.
- The Trust has secured the provision of additional capacity for Tier 3 referrals to be provided in-year by the Independent sector, supported by non-recurrent funding from HSCB. **This will reduce the total waits and reduced wait times for Tier 3 patients, including adult mental health and psychological therapies**
- The Trust has reviewed the projections of performance for Addictions and Primary Care Mental Health reflecting the additional factors that have impacted on the original planning assumptions, which have had an impact on the performance. These revised trajectories will be re-submitted in November 2018.

3.2 Psychological Therapies

- **October 2018 demonstrated a further increase in patients waiting in excess of 13-weeks**, to 240, which is above the planned submitted projections of performance.
- **The specialties affected are: Adult Mental Health and Adult Health Psychology with the longest wait demonstrating an increase to 57-weeks within Adult Mental Health.**
- The Trust has reviewed the projections of performance for Adult Mental Health and Adult Health Psychology reflecting the additional factors that have impacted on the original planning assumptions, which have had an impact on the performance. These revised trajectories will be re-submitted to HSCB in November 2018.

Graph 9



- **Recruitment and retention of workforce continues to impact capacity, with 11 qualified Psychology vacancies at present**, which is reflective of the Regional shortage of skilled psychologists. Whilst the Trust has been successful in making appointments to vacancies these in the main are staff internal to the Trust which has not resulted in a net increase in staff. The recruitment process remains on-going for the remaining vacancies.
- **A local review of Psychological Therapies is planned** to be undertaken in 2018/2019, commencement anticipated in January 2019, with Regional work on-going to consider workforce issues and parity with other Regional models.
- **The Trust had submitted a proposal to HSCB, in July, for funding (circa £191,000) to**

increase capacity for lower level referrals within the Independent Sector. Whilst the HSCB has indicatively confirmed this allocation the Trust now required to re-confirm with the Provider the volumes that cannot be achieved further to the passage of time since the proposal was made. If capacity can be secured in year this will decrease the total volumes of waits but may not reduce the longest wait times as some patients are waiting for specialist psychology input which cannot be increased.

4 Optimisation of Resources

4.1 Hospital Out-Patient Cancellations

- The OGI for 2018/2019 has been revised to reflect cancellations, that are initiated by the hospital, in the Acute Programme only, that have an adverse impact on the patient; for example which may result in the patient waiting longer.
- Whilst the Trust's baseline is relatively low, with 5,546 patients cancelled in 2017/2018, actions are in place to examine reasons for cancellation and learning from this to seek further improvement. **Currently, this year, at September 2018, 3.1% of patients have been adversely affected by hospital cancellations** (against the cumulative 2.7% for 2017/2018).

5 Safe Systems of Care

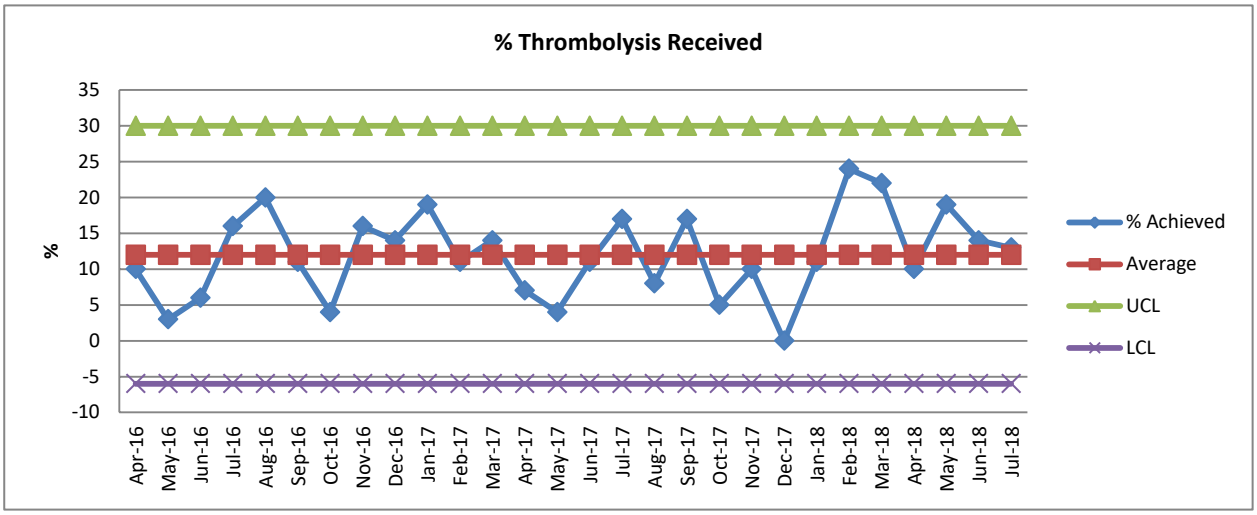
5.1 Health Care Acquired Infections: Summary Position

- As previously reported the range of objectives related to infection prevention and control (IPC) has been extended this year to include antibiotic prescribing and consumption, and gram negative blood stream infections in additional to HCAI, and C Difficile. Further work is required to establish formal reporting however infection control measures continue to be developed to seek improvement and more analysis will be available in future reports.
- **October 2018 saw the launch of the Trust's new 3-year strategy to reduce healthcare acquired infections and a new interactive guide for staff went 'live'** across the Trust in October. This guide is the first of its type in Northern Ireland and was developed in-house and will assist in the management of risk at the point of care.
- The IPC strategy covers key areas such as clean hands; clean place; and best antibiotic usages whilst ambitious plans also seek to increasing the number of isolation facilities across the Trust; recruiting additional specialist staff; and introducing further measures to support all staff to achieve the very best IPC standards every day.

5.2 Stroke

- Graph 10 demonstrates the variability in administration of thrombolysis associated with the variable presentation of strokes and the clinical decisions which require to be made based on the risk and benefits of administration of thrombolysis. Performance therefore needs to be viewed over a longer period and month on month assessment is not useful
- **Cumulative performance August 2017 to July 2018 is static at 13%.**
- This percentage performance, on administration of thrombolysis, focuses on only one of the indicators on the patient's pathway when presenting to ED with query ischaemic stroke.
- **Data on individual pathway indicators, reviewed at operational level in August 2018 indicated 100% of patients potentially eligible for thrombolysis were assessed by Acute Stroke Team within 30 minutes of arrival; received their CT scans within 45 mins and first bolus of thrombolysis within 60 minutes**. Only 3 patients out of an initial cohort of 69 where ultimately suitable to receive thrombolysis.

Graph 10

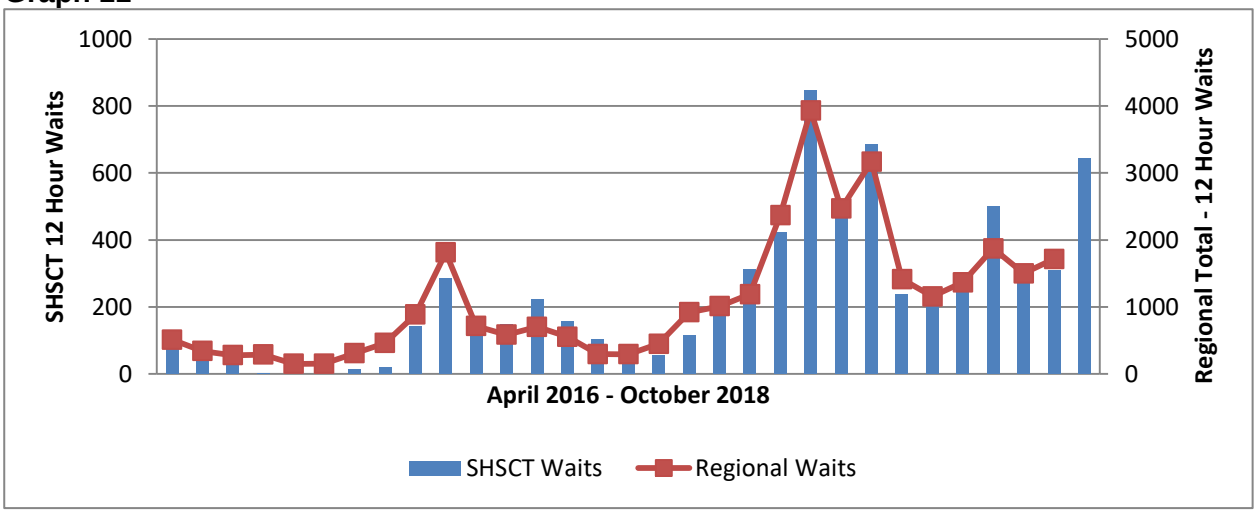


6 Unscheduled Care (USC)

6.1 Key Statistics

- USC Pressures reported in 2017/2018 continue into 2018/2019 Regionally and locally.
- **The % of patients presenting at the Emergency Department (ED) in October who were triaged as requiring immediate or very urgent assessment (25%), which is a proxy for acuity levels in this period, continued to reflect the increased position reported in August and September**.
- From April to October 2018, 71% of patients were treated, discharged or admitted within 4-hours. **Performance in October has remained challenging with only 55% of patients in Craigavon Area Hospital (CAH) and 70% in Daisy Hill Hospital (DHH)** within the 4-hour standard; and is below the anticipated performance trajectory.
- The volume of patients waiting in excess of 12-hours remains high, reflecting the regional pattern as demonstrated in graph 11 below. **The volume of patients waiting in excess of 12-hours in October (644) is close to the position felt in March 2018.**

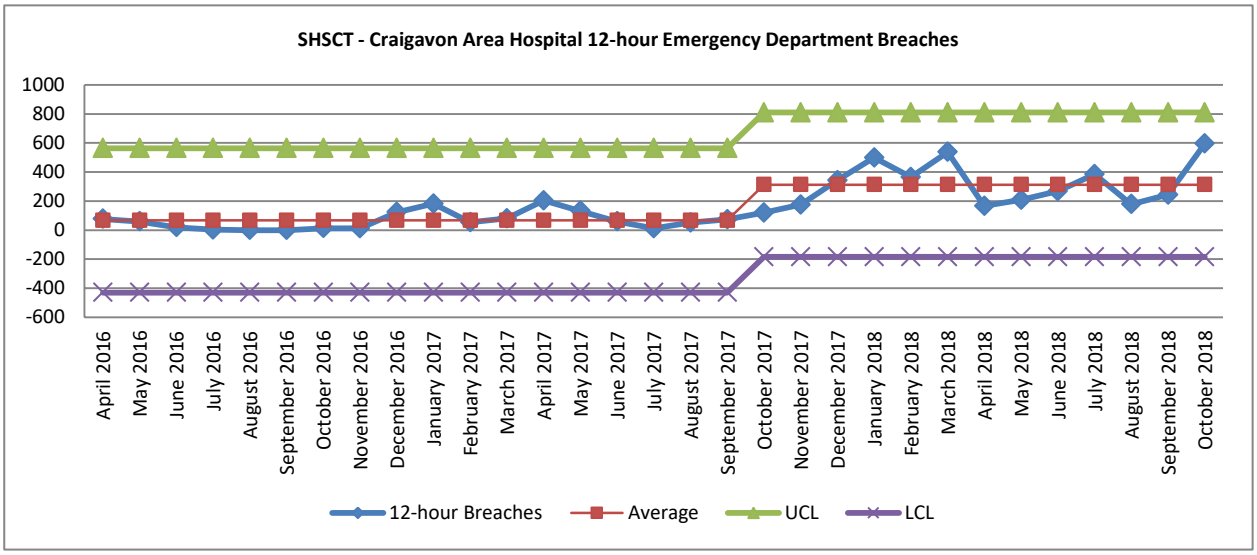
Graph 11

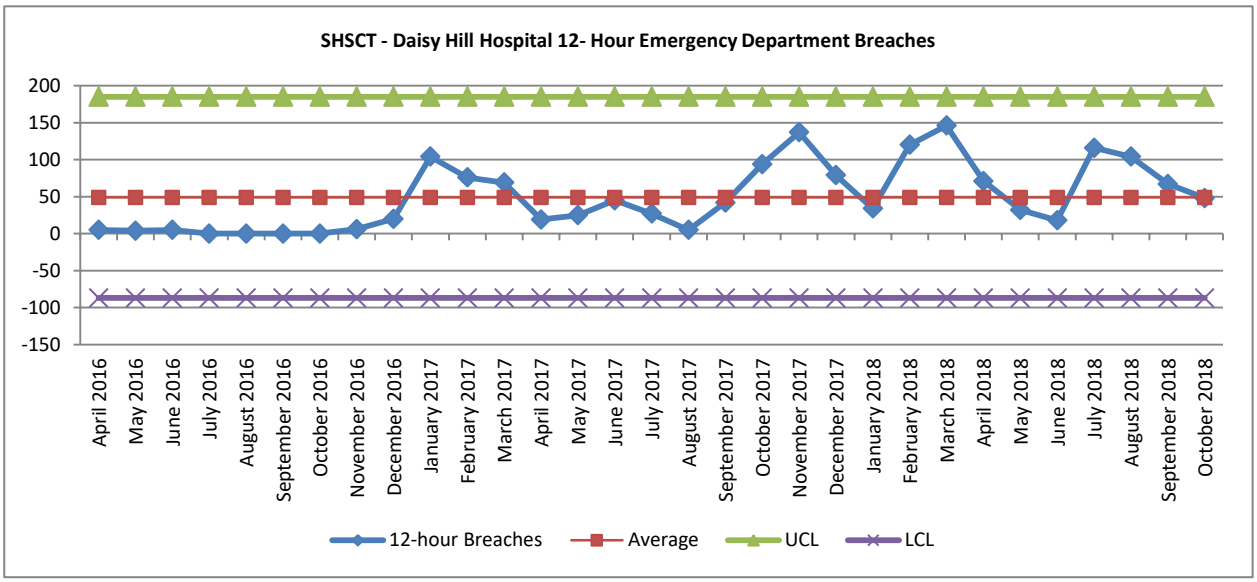


- The total number of non-elective admissions during April to October 2018 demonstrates a +3.6% (+715) increase in this period compared to last year with the Acute Care at Home service continuing to operate at capacity with a caseload averaging 20-30 per day in the community.
- The GP OOH has seen a decrease in the total volumes of calls/contact from April to October 2018, compared to last year and performance has improved.
- **The growth in 12-hour ED breaches has been more significant on the CAH site as demonstrated on graph 12 below with a clear step change in pattern of breaches in**

December 2017; in this period the Trust was constrained in its ability create additional bed capacity. The DHH pattern show a smaller change around December 2016 related to the onset of workforce challenges at this time as per graph 13.

Graph 12 & 13





- Whilst bed utilisation continues to be high throughout the Trusts Acute Programme, challenges still present in the discharge of complex patients. **The most complex are patients who reside outside the Trust area and those where options for suitable packages and placement is more challenging, including patient with a physical or mental disability**. Work is ongoing to optimise any opportunities to improve patient flow.
- **ED continues to be impacted by patient flow issues described above and related to the low level of bed availability**. This increases the volume of patients that require to wait in ED for transfer to an appropriate bed. The volume of patients waiting in ED for transfer to appropriate beds continues to be high. This 'blocking' of assessment and treatment space in ED is having a direct impact on ability to see new patients, increasing waiting times to be seen by a Doctor and presenting overcrowding in the Department. **High volumes of patients continue to wait between 6 – 10 hours.**

Actions to Address

- The Trust in partnership with the Southern USC Locality Network Group has developed and submitted its resilience plan for 2018/2019 to HSCB. **This plan has been influenced by staff**

via an engagement commencing with a staff survey in 2017/2018 and expanded with café conversations and workshops in year and further engagement with senior medical leaders.

- **Formal monitoring arrangements around the implementation of the plan are in place** at Senior Management Team level to provide assurance and a range of metrics are being developed to ensure a clear assessment of impact.
- A range of transformational programme work is embedded in USC resilience planning and additional resources have been allocated to support unscheduled care.
- The Trust acknowledges it will be challenging to see new initiatives in place before the peak of heightened unscheduled pressures impacted by **key risks including the ability to secure the appropriate levels of medical, nursing and other key workforce**, both in Acute and Community programmes, and to provide core additional capacity in parallel with the development of transformational initiatives.
- **New escalation arrangements have been established to enhance preparedness and communication with staff.**

6.2 Mental Health & Disability In-Patient Demands

Key challenges:

- **Bed capacity for mental health continues to be changing dynamic and is challenging locally and regionally with instances occurring where no admission beds are available to accommodate patients with Mental Health, Learning Disability (LD) or Dementia care needs.**
- **Significant workforce pressures are being experienced across our Dementia Admission Unit, Adult Mental Health and Learning Disability admission wards associated with shortage of registrant LD and MH nursing workforce; on-going nursing vacancies; a loss of experienced staff; and an increasing reliance on newly qualified workforce.**

Actions to Address:

- **Immediate actions have been taken and medium and long-term action plans are in place to address the workforce pressures, some of which will be subject to external support from DHSSPS/HSCB.**
- **SMT approval for agency staff to be secured from England, for the period 1 December 2018 to 31 March 2019, as redeployment of community staff into in-patient settings is not a suitable option due to community pressures. This will be actioned. The MH allocation will be used to secure an uplift of 17 x Band 5 posts to Band 6 posts, which will be advertised/recruited on an external basis.**
- **A meeting to agree a way forward for the achievement of full normative staffing levels, within in-patient units, has been scheduled with HSCB/PHA and the Trust for 7 December 2018.**
- A Directorate Oversight Group and sub-group structures have been established to address the breadth of workforce, bed-flow, governance, quality and E solutions themes.
- **Engagement meetings with the Trust; DHSSPS; HSCB; and RQIA are on-going.**
- Weekly Senior Management led patient flow meetings continue, supplementing the daily patient flow arrangements, and facilitate review of the complex cases. Additional resources have been committed, at risk, to co-ordinate complex discharges to improve flow.
- Additional demography investment aligned to this area to support placements outside hospital has been identified, however, with the lack of available appropriate community support/placements this remains challenging. Further gains will require a more strategic response on a Regional/Cross-Departmental basis.
- **Continuing initiatives are in place to promote mental health recruitment, with a recruitment event planned for 7 December 2018.**
- In-patient bed pressures/flow pressures and nursing workforce pressures within Dorsy and Bluestone is now a weekly reported standing items at and a corporate priority for SMT.
- **The Regional Review of Mental Health In-Patient Beds draft TOR has been developed, however, concerns have been raised by Trusts regarding the scope of this review that may not take account of the associated infrastructure to support patient flow. It is**

anticipated that the work will conclude by April 2019.

- A proposal for additional community rehabilitation is being developed, however, this is subject to funding.
- The Department of Health have established a new Regional Planning Group to establish the new 5-year plan for Mental Health Services and LD Services.

6.3 Paediatric Bed Management

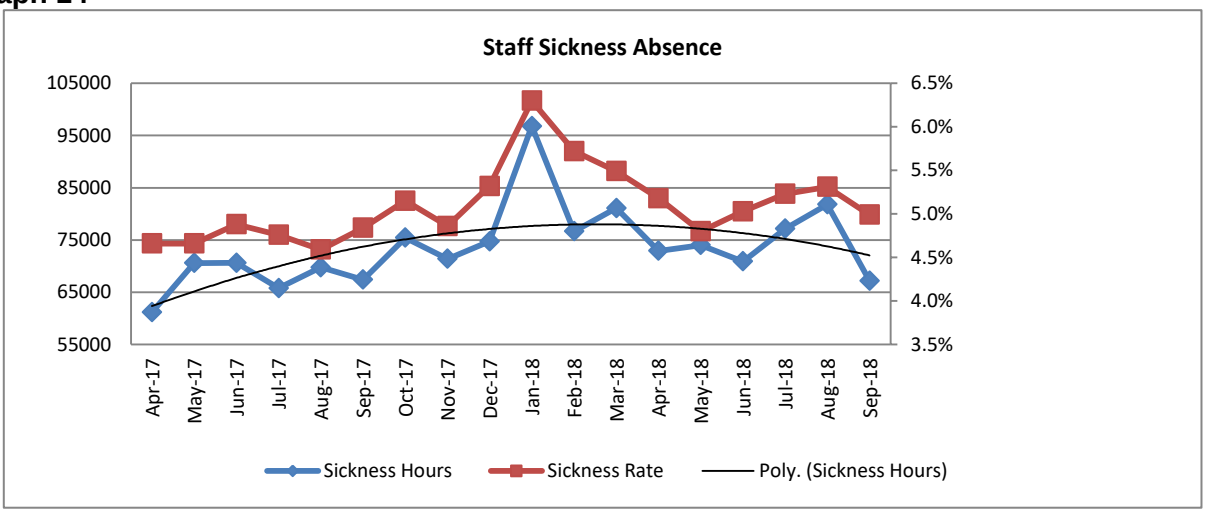
- Processes are in place to collate and report bed pressures across paediatric general and specialist beds at a regional level, supplementing current arrangements for management of specialist neo-natal cots.

7 Workforce

7.1 Staff sickness Absence: Summary Position

- Whilst staff sickness absence levels are currently in excess of the target level review of the trend does not indicate a month on month consistent increase in staff sickness absence levels.
- A range of actions remain on-going within the Trust in an attempt to address sickness absence levels.

Graph 14



- The Trust has commenced its annual flu vaccine campaign, on 1 October 2018, with a new element of the campaign being the Peer vaccination model, which seeks to increase the update of the vaccine amongst front line staff.
- At the end of October 2018 a total of 2,792 staff were in receipt of the flu vaccine, equating to 25% of the staff head count; albeit a greater percentage of non-front line staff (796 out of 2,707) have come being vaccinated compared to front line staff (1,996 out of 8,535).

Summary of SMT Challenge and Discussion:

- Unscheduled Care Operational Resilience Action Plan reviewed and escalation processes and assurance sought regarding management of acute and mental health bed capacity.
- Alignment of transformation programme priorities with key unscheduled pressures noted.
- SMT noted specific performance meetings in place with HSCB/operational teams relevant to cancer and elective performance targets.
- Issues related to MHD have been escalated to HSCB service issue/performance meeting
- Assurance sought regarding the delivery of levels of elective additional funded by HSCB and Department of Health via Confidence and Supply funding and high level of monitoring required.
- Concerns noted regarding the impact of diverting resource to support USC on Trust's SBA performance and assurance that these pressures are reflected in projections of performance (trajectories). Impact of unscheduled care on Elective capacity noted.
- Assurance sought on delivery of performance in line with submitted projections of

performance.
Internal / External Engagement • Formal communications regarding unscheduled care pressures are being managed centrally via HSCB communications. • Staff engagement in respect of unscheduled care planning ongoing via survey, focused conversations and senior medical leaders.
Human Rights / Equality: • The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate. • Equality screening and rural proofing to be undertaken on all transformational schemes in line with IPT processes.

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 24th September 2020
Title:	Clinical concerns within Urology
Lead Director:	Dr Maria O'Kane Medical Director
Purpose:	Confidential – For Information

Key strategic aims:

Delivery of safe, high quality effective care

Key issues/risks for discussion:

This report outlines a summary of the clinical concerns relating to Consultant A, the actions taken to review aspects of his practice and the development of appropriate management plans to minimise risk or harm to patients.

There is likely to be significant media interest in this case.

Plans need to be put in place to respond to primary care colleagues and to establish a targeted help line for patient concerns.

There is likely to be impact on other patients who are awaiting urological appointments/follow up.

Consultant A is no longer employed as of 17th July 2020, having given his notice of his intention to retire from his substantive post as at 30th June 2020. The Trust declined his request to return given outstanding employment matters relating to a previous MHPS case commenced on 30th December 2016. Although Consultant A initially challenged this matter, following correspondence exchange between his solicitor (Tughan's) and DLS, he is no longer employed as of 17th July 2020. There has been no legal challenge in respect of this matter, to date.

Introduction

On 7th June 2020, Consultant A sent an email to the Scheduling administrative staff for Urology, which was copied to the Associate Medical Director (AMD) – Surgery, in which Consultant A explained that he had added 10 patients to the Trust's list for urgent admission. On the AMD's initial review of the list of patients in his capacity as AMD, he noted that 2 of the patients were stated to have been listed on 11th September 2019 and 11th February 2020, both requiring *"Removal/Replacement of Stent and Right Flexible Ureteroscopic Laser Lithotripsy".*

It appeared to the AMD that these patients had been assessed on the dates given by Consultant A (11th Sept 2019 and 11th Feb 2020), but the outcomes of these assessments did not appear to have been actioned by him as required i.e. to add the patients to the inpatient waiting list on the Trust's Patient Administration System at that time. These patients therefore appeared on the face of it to fall outside the Trust's systems with all the potentially very serious clinical risks attendant on that.

As a result of these potential patient safety concerns a review of Consultant A's work was conducted to ascertain if there were wider service impacts. The internal reviews, which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), identified the following:

- The first internal review concentrated on whether the patients who had been admitted as an emergency had had a stent inserted during procedure and if this had been removed. There were 147 emergency patients under the care of Consultant A listed as being taken to theatre. Of these, information was not available on NIECR for 46 patients. Following further review of inpatient notes, it was identified that 3 patients had not had their stent management plans enacted. Management has been subsequently arranged for these 3 patients.

- The second internal review was for 334 elective-in patients admitted under Consultant A's name during the same period. Out of the 334 patients reviewed there were 120 of cases who were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system.

- To date five patient cases have been identified through screening for Serious Adverse Incident review - this screening has indicated potential deficiencies in the care provided by Consultant A. A further two cases, managed by Consultant A, have been identified and these are being screened as Serious Adverse Incidents. These seven patients' care is now being followed up by the Urology Team.

Immediate actions following discovery of concerns in June 2020

- Advice sought from NHS Resolutions (formerly NCAS) who recommended restrictions of clinical practice.
- Referral of these concerns in respect of Consultant A was made to the GMC.
- Up until the date of termination, restrictions were placed by the Trust that Consultant A was to no longer undertake clinical work and that he did not access or process patient information either in person or through others either in hard copy or electronically. A request was also made that he voluntarily undertake to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Consultant A's solicitor.
- Given that Consultant A is no longer employed, the handling of this case is now through the GMC, relevant solicitors and Trust.
- The Trust has set up a panel for the Serious Adverse Incident Reviews and this is being chaired by an independent Chair, with a Urology Consultant recommended by the Royal College of Surgeons as a Urology Subject Expert (from England).
- An Early Alert has been sent to the Department of Health advising them of the issues.
- Two separate weekly meetings have been established:
    - Internal oversight meeting - chaired jointly by Director of Acute Services and Medical Director;
    - External – Chaired jointly by Medical Director and Director of HSCB with representatives from Trust, PHA, HSCB and Department of Health.

The following are the areas that have been identified that immediately need to be concentrated on and actions being taken on these patients to mitigate against potentially preventable harm:

1. A concern identified in the SAIs is that a Cancer MDM treatment recommendation for a patient was not enacted. As a result, all notes for post MDM follow-up patients for Consultant A are being reviewed to ensure MDM treatment recommendations have been actioned. (This data is currently being collected as this is a manual exercise)
2. A further concern identified is patients have had diagnostic tests and the results have not been actioned or communicated to the patients, including results with significant findings. The diagnostic tests identified are Pathology and Radiology results. A total of 1711 results are currently being looked at by two of the Trust's Clinical Nurse Specialists. Where they identify that follow-up may not have been actioned, this is escalated for a Consultant Urologist to review and provide input.

Where the reviewing consultant feels that there is a possible issue with care provided, a Datix will be completed by the Consultant Urologist.

3. A further review of inpatients who had stent procedures performed by Consultant A from January 2018 to December 2018 is being carried out to ascertain if any further patients require stent management plans.

In addition, a significant number of patients who are overdue follow up on Consultant A's Oncology Outpatient Review Waiting List (patients who are past their review date) are having their outpatient assessment provided by a recently retired Urologist who has been engaged by the Trust - 235 patients.

A preliminary discussion has been undertaken with the Royal College of Surgeons Invited Review Service regarding Consultant A's practice and potential scope and scale of any independent external review, if required.

Timescales

The above reviews and scoping exercises are either completed or under way so timescales still need to be clarified. The Department of Health is keen to manage the oversight of the review process. The Minister will be required to share details of this with the Assembly and this is likely to be mid- October, subject to the outcomes of the review exercises. A resource plan is in development to identify clinical capacity for communication, patient information and clinical assessment and management plans. This will present significant challenge given the current workforce issues within the Urology speciality.

Previous concerns relating to Consultant A

Previous concerns relating to Consultant A were being addressed since March 2016, and under Maintaining High Professional Standards from December 2016. The timeline for these previous concerns is detailed below:

March 2016

On 23 March 2016, Mr EM, the then Associate Medical Director (Consultant A's clinical manager) and Mrs HT, Assistant Director (Consultant A's operational manager) met with Consultant A to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Consultant A was provided with a letter dated 23 March 2016 detailing their concerns and asking him to respond with an immediate plan to address the concerns. Four broad concerns were identified:

- **Un-triaged outpatient referral letter**
  It was identified at that time that there were 253 un-triaged referrals dating back to December 2014.

- **Current Review Backlog up to 29 February 2016**
  It was identified at that time that there were 679 patient's on Consultant A's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- **Patient Centre letters and recorded outcomes from clinics**
  The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Consultant A on Patient Centre or on patient notes.

- **Patient's hospital charts at Consultant A's home**
  The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016
During the period April to October 2016, discussions were on-going between Acute Directorate and Medical Director about how best to manage the concerns raised with Consultant A in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Consultant A advised the review team he did not reply to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016
Consultant A was off work on sick leave from 16 November 2016 Personal information redacted by USI and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient (Patient 10) who may have a poor clinical outcome because the GP referral was not triaged by Consultant A.

An SAI investigation was commenced in Autumn 2016. Through the SAI it was identified that the referral for patient Patient 10 had not been triaged by Consultant A. An initial look back exercise was undertaken and a number of other patients were identified as not having been triaged by Consultant A. Further assessment of the

issue identified a significant number of patients who had not been triaged by Consultant A.

The issues of concern relating to patient Patient 10 were wider than the referral delay. There were issues of concerns in respect of the radiology reporting on diagnostic images however from a urology perspective, it was felt that the symptoms recorded by the patient's GP on the initial referral should have resulted in the referral being upgraded to a 'red-flag' referral and prioritised as such.

December 2016

The concerns arising from the SAI were notified to the Trust's Medical Director, Dr RW in late December 2016. As a result of the concerns raised with Consultant A on 23 March 2016 and the serious concern arising from the SAI investigation by late December 2016, the Trust's Medical Director determined that it was necessary to take formal action to address the concerns.

Information initially collated from the on-going SAI of Consultant A's administrative practices identified the following:

- from June 2015, 318 GP referrals had not been triaged in line with the agreed / known process for such referrals. Further tracking and review was required to ascertain the status of all referrals.
- there was a backlog of 60+ undictated clinics dating back over 18 months amounting to approximately 600 patients, who may not have had their clinic outcomes dictated. It was unclear what the clinical management plan was for these patients, and if the plan had been actioned
- some of the patients seen by Consultant A may have had their clinical notes taken back to his home, and are therefore not available within the hospital. The clinical management plan for these patients was unclear, and may be delayed.

As a result of these concerns, work was undertaken to scope the full extent of the issues and to put a management plan in place to review the status of each patient. The management plan put in place was to provide the necessary assurances in respect of the safety of patients involved.

28 December 2016

Advice was sought from the National Clinical Assessment Service (NCAS) on 28 December 2016 and it was indicated that a formal process under the Maintaining High Professional Standards Framework was warranted.

30 December 2016
Consultant A was requested to attend a meeting on 30 December 2016 with Dr RW, Medical Director and Ms LH, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken.

A letter was issued to Consultant A in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Consultant A that Dr AK had been appointed as Case Manager for the case and Mr CW was identified as the Case Investigator.

03 January 2017
Consultant A met with Mrs MC, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr RW on 30 December 2017.

20 January 2017
During the period of the 4 week immediate exclusion period notified to Consultant A on 30 December 2016, Mr CW wrote to Consultant A to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Consultant A to state his case and propose alternatives to formal exclusion.

23 January 2017
On 23 January 2017, Mr CW wrote to Consultant A seeking information from him in respect of 13 sets of case-notes that were traced out on PAS to him but could not be located in his office and which had not been returned to the Trust with the other case-notes on 3 January 2017.

24 January 2017
The meeting between Mr CW and Consultant A took place on 24 January 2017 with Mrs SH, Head of Employee Relations present.

26 January 2017
In line with the MHPS Framework, prior to the end of the 4 week immediate exclusion period, a case conference meeting was held within the Trust to review Consultant A's immediate exclusion and to determine if, from the initial preliminary enquiries, Consultant A had a case to answer in respect of the concerns identified.

A preliminary report was provided for the purposes of this meeting.

At the case conference meeting, it was determined by the Case Manager, Dr AK that Consultant A had a case to answer in respect of the 4 concerns previously notified to him and that a formal investigation would be undertaken into the concerns.

The matter of his immediate exclusion was also considered and a decision taken to lift the immediate exclusion with effect from 27 January 2017 as formal exclusion was not deemed to be required. Instead, Consultant A's return to work would be managed in line with a clear management plan for supervision and monitoring of key aspects of his work.

These decisions were communicated to Consultant A verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017
A letter was sent to Consultant A on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work.

9 February 2017
Consultant A attended a meeting with the Case Manager, Dr AK on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs SH and Consultant A's son were in attendance at the meeting. The action plan was accepted and agreed with Consultant A at the meeting.

20 February 2017
Between 27 January 2017 when the immediate exclusion was lifted and 17 February 2017, Consultant A was unable to return to work due to ill health. He returned to work on 20 February 2017 in line with action plan agreed at the meeting on 9 February 2017.

As part of the action plan agreed, monitoring mechanisms were put in place to continuously assess his administrative processes to safeguard against a recurrence of the concerns raised with regards to his outpatient work. This monitoring arrangement was in place up until Consultant A's date of leaving. There were 3 occasions when there were deviations from the agreed actions, and on two occasions Consultant A offered acceptable explanations. On the third occasion, Consultant A had no acceptable explanation for the delay in dictation, however all dictation was completed at the point of retirement.

January and February 2017
During January and February 2017, Consultant A made a number of representations to Dr RW, Medical Director and Mr JW, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr CW should step down as Case Investigator prior to the commencement of the formal investigation. Dr NC, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017
The terms of reference for the formal investigation were shared with Consultant A along with an initial witness list.

April, May and June 2017
During April, May and June 2017 the Case investigator met with all witnesses relevant to the investigation. Witness statements were prepared and issued for agreement.

14 June 2017
Dr NC, Case Investigator wrote to Consultant A requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified.

19 June 2017
Consultant A requested to reschedule the meeting to secure his preferred accompaniment to the meeting. This was facilitated. A meeting on 29 June, 30 June and 1st July was offered. Consultant A requested to defer the meeting until later in July until after a period of planned annual leave, and a meeting was confirmed for 31 July 2017.

05 July 2017
Consultant A advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017
A first investigation meeting was held with Consultant A in order to seek his response to the issues of concern.

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Consultant A had been furnished to him. It was agreed that

a further meeting date would be arranged for this purpose once all information had been provided. Consultant A's responses to the remaining terms of reference were gathered.

16 October 2017
A meeting date for the second investigation meeting was agreed for 06 November 2017.

06 November 2017
A second investigation meeting was held with Consultant A in order to seek his response to the issues of concern in respect of term of reference 4. At the meeting of 6 November 2017, Consultant A advised Dr NC that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018
By 15 February 2018, Consultant A had not provided the comments he had previously advised he wished to make and therefore this was queried with Consultant A and an update sought.

22 February 2018
No response was received and a further email reminder was sent to Consultant A on 22 February 2018. On the same day, Consultant A responded to advise that he had not had time to attend to the process since the meeting in November 2017. He requested a copy of the statement from the November meeting and indicated he would provide commentary on all documents by 31 March 2018.

Consultant A was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018
Comments on the documents were not received on 9 March 2018 and a further reminder was sent to Consultant A requesting his comments no later than 26 March 2018. It was advised that the investigation report would be concluded thereafter if comments were not provided by 26 March 2018.

26 March 2018
No comments were received from Consultant A.

29 March 2018
A final opportunity was provided to Consultant A to provide comments by 12 noon on 30 March 2018. It was advised that the investigation report would be thereafter drafted.

30 March 2018
No comments were received from Consultant A.

2 April 2018
Comments on the statements from the meetings of 3 August and 6 November were received from Consultant A. Consultant A also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

21 June 2018
In the interests of concluding the investigation report without further delay, all comments from Consultant A were considered and a finalised report was provided to Consultant A on 21 June 2018 for comment.

14 August 2018
The Case Manager, Dr AK wrote to Consultant A acknowledging receipt of his comments and advising he would consider these along with the final report and reach his determination in terms of next steps.

1 October 2018
Dr AK, Case Manager met with Consultant A to outline outcome of his determination that the case should be forwarded to a Conduct Panel under MHPS.

The Findings from the investigation

There were 783 un-triaged referrals by Consultant A of which 24 were subsequently deemed to need upgraded and a further 4 with confirmed diagnoses of cancer (plus the original SAI patient.) There was therefore potential for harm of 783 patients.

Consultant A stored excessive numbers of case notes at his home for lengthy periods. 288 charts were brought by him from his home and returned in January 2017. This is outside normal acceptable practice. There were 13 case notes missing

but the review team is satisfied with Consultant A's account that he does not have these.

There were 66 clinics (668 patients) undictated and 68 with no outcome sheets, some going back a few years. Consultant A gave an explanation of doing a summary account of each episode at the end. He indicated patients were added to waiting lists at the point they should have been in any event.

Some of Consultant A's private patients were added to the HSC waiting list ahead of HSC patients without greater clinical need by these private patients.

27 November 2018

Consultant A submitted a lengthy and detailed grievance of 40 pages, with 49 Appendices. It was lodged along with a request for information. The grievance was held in abeyance pending completion of the information requests.

9 April 2019

Consultant A was advised by Dr AK, Case Manager that a GMC referral was to be submitted following a discussion regarding the case with the GMC Liaison Officer.

Timeline for grievance process – November 2018 to June 2020:

The requested information relating to the information request was provided to Consultant A in 2 returns – one on 21 December 2018 and one on 11 January 2019.

Consultant A wrote to the Trust again on 12 March 2019, and advised that he had sought the advice of the Medical Protection Society and also Legal Counsel, and that he was therefore submitting a request for further information. Consultant A advised that following its receipt, the Trust would be advised whether any further information was to be requested, and /or whether the Formal Grievance was to be amended.

HR Director wrote to Consultant A on 3 June 2019, seeking further clarity on information requested in his 12 March 2019 letter. The Trust advised him that the information request was extensive in nature and would require significant time and resources within the Trust to compile. The Trust advised him that all reasonable efforts were being made to gather the requested information, however within his request there were elements which were much too wide and not properly defined.

Consultant A was therefore asked to refine and clarify the specifics of his request in respect of a number of points.

Consultant A responded on 24th June 2019, clarifying the information plus seeking 2 additional items. The request for information was still significant in nature, and took significant time and resources for the Trust to compile. The requested information was delivered to Consultant A's Secretary for his attention on 30th October 2019.

Since Consultant A had indicated that, following receipt of the requested information, he would advise whether or not his formal grievance was to be amended, the Trust awaited hearing from him in this regard. However, no further correspondence was received from Consultant A in respect of his grievance, or any amendments to it.

At this stage, from November 2019 through to end of January 2020, the Trust suffered significant disruption to its services and its HR function by reason of widespread Industrial Action by health service trade unions.

Furthermore, work was ongoing to finalise the SAI (Serious Adverse Incident) processes in respect of the patients affected by the original concerns in respect of Consultant A's practise.

In recent months the Trust's services and normal HR processes has been very severely impacted by the Covid – 19 pandemic. This prevented any employee relations work, including the hearing of grievances, being taken forward for a 3 month period from March to start of June.

On 26th April 2020, Consultant A wrote to the Trust's HR Director again, highlighting that a number of pieces of information from original requests had not been provided, and he requested these by 15th May 2020. On 15th, 22nd May and also on 8th June the Director of HR wrote to Consultant A with responses to these requests. The Trust believes that all substantial and detailed information requests have now been responded to.

June 2020 – September 2020

Grievance process ongoing. The grievance panel is due to conclude by mid October 2020.

As Consultant A is no longer employed, the Conduct Hearing under MHPS cannot be concluded. The GMC processes will continue regarding Consultant A's fitness to practise in light of both the previous concerns and the most recent concerns.

Summary of previous Serious Adverse Incidents – from 2016 onwards

Following the SAI Index Case (Patient 10) which triggered the first MHPS case, the Trust identified a number of GP Urology referrals who were not triaged by Consultant A. 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient, discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed. These five cases were subject to a further SAI review process.

Lessons Learned from the 5 SAI's

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant A (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The

Review Team consider that Consultant A's refusal to triage to a level similar to other clinicians, led to patients not being triaged, and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Consultant A confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Consultant A's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Consultant A consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Consultant A is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 12th November 2020
Title:	Urology Update
Lead Director:	Dr Maria O'Kane, Medical Director Melanie McClements, Director of Acute Services
Purpose:	Information

Overview:

The purpose of this paper to provide an update to Trust Board (November 2020) on the ongoing review of urology services relating to Consultant A

Key areas for SMT / Committee consideration:

- Update on review progress to date (10th November 2020)
- Formation of Department of Health Oversight group and details of planned ministerial statement to the NI Assembly
- Update on the progress of identified Serious Adverse Incidents and Public Health Agency advice regarding a proposed 'Clinical Investigation' model for future identified urology incidents
- Update on engagement with the Independent Sector Provided engagement to provide review appointments for 236 oncology backlog patients
- Update on review of prescribing of the medication Bicalutamide, an Anti-androgen drug, to date there have been 26 patients out of 300 identified as needing an urgent appointment.

Human Rights/Equality:

None to declare

Background to Review

A review of clinical processes has been undertaken, the background and current status of the ongoing review is provided below. The necessity of a further review of clinical care is being discussed with the Royal College of Surgeons.

Elective Care	The review has identified that Consultant A had operated on 334 patients, and out of these 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust's electronic care record (NIECR). **Of the 36 patients, there have been 2 incidents identified that meet the threshold for SAI reviews.**
Management of Pathology and Cytology Results	The review has identified 50 out of 168 patients that require review as a result of un-actioned Pathology or Cytology results. **Of the 50 patients requiring review there have been 3 incidents identified that meet the threshold for SAI reviews with a further 5 requiring a review follow-up to determine if these patients have come to harm.**
Management of Radiology Results	The review has identified 1536 radiology results which require review to ascertain if appropriate action was taken. A review of the 1536 cases is ongoing.
Actions required as a result of Multidisciplinary Team Meetings	There were 271 patients under Consultant A's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patient records is being undertaken. To date there are currently **3 confirmed SAI's and a further 1 needing a review follow-up** to determine if these patients have come to harm. This exercise is ongoing.
Oncology Review Backlog	236 review oncology outpatients will be seen face to face by an Urologist in the independent sector for review. To date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance.
Patients on Drug "Bicalutamide"	There are concerns regarding Consultant A's prescribing of androgen deprivation therapy outside of established NICE guidance regarding the diagnosis and management of prostate cancer[1]. *Bicalutamide is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;* *'1.5.9 For people with metastatic prostate cancer who are willing to*

[1] Prostate cancer: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 131. May 2019.

	accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide[6] (150 mg). ***[2008]*** *1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function.* ***[2008]'*** All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to facilitate a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

Department of Health Oversight Group

The Permanent Secretary has established a Department of Health level of external oversight and assurance group to review progress and guide the way forward in terms of the Trust's management plan. Currently the Urology Assurance Group has begun to meet weekly. Michael O'Neill, Acting Director of General Healthcare Policy, is leading on this in the Department and providing secretariat for the group.

Ministerial Statement

The Minister for Health issued a written statement to the NI Assembly on the 26th October. The Trust has been advised a further statement from the Minister to the NI Assembly will be made on 17th November 2020 which will provide additional details. The Trust is preparing proactive communication arrangements in anticipation of this announcement.

Serious Adverse Incidents (SAI) Update

The SAI panel membership has been agreed Terms of Reference have been internally agreed and have been forwarded to the HSCB. All 9 patients/families identified through the SAI process have been spoken to this week with some of them being offered a further appointment with a Consultant Urologist, taking place this week. During the initial consultations with one family there appears to be some discrepancies in what the families understanding of what had been said by the consultant and what the expert reviewer has indicated.

Four out of the five patients/ families, along with the index patient of the previous SAI's, have also been spoken to. The family of the fifth patient's family (RIP) is still outstanding as this is being

clinically considered due to the recent death of the patient. The Chair of the SAI panel is also going to meet with these patients and this is currently being organised.

Given the number of patient cases from this review period (January 2019 to June 2020), this review exercise continues to be ongoing, and the above information is the current position at this point in the review.

The Health and Social Care Board / PHA have advised that any additional incidents that are identified as meeting the threshold for an SAI review should be paused will be managed via a separate 'clinical investigation' process. The Public Health Agency has indicated that this process will be independent of the Trust and will be guided by and have parameters set by the HSCB/PHA/Department of Health.

Consultants Private Practice

It was requested at the Department of Health Oversight Group meeting on 6th November 2020 that the Trust write to the Consultant to gain assurances surrounding their private practice for the last 5 years. Either of the options below are to be offered:

- A written assurance from the Consultant to the Trust that they will make arrangements for their private patients to be reviewed by an independent urologist; or
- The Consultant provides details of their private practice and the Trust will make arrangements for the review of these patients and recharge the cost to them / their medical insurer

Summary of Activity for Patient Facing Information Line

The Trust established since 26th October 2020 a patient information line available for patients who may have questions or concerns regarding their care. The details of contacts made to date:

- **Total calls – 153 (up to and including Tuesday 10 November)**
- **2** patients are being seen as part of the oncology review backlog in Independent Sector
- **1** patient was on Bicalutamide and was seen at clinic on Monday 2 November
- **1** patient was picked up as not having been added to any system for a Red Flag Flexible Cystoscopy and has an appointment for Monday 9 November 2020

The Trust has also set up an accompanying GP information line for GP's who may wish to find out more information regarding patients who have been referred to Trust urology services. The details of contacts made to date:

- **1** GP has called the **GP Information line** - communication has been sent by HSCB

Independent Sector Clinics

A total of **236** oncology patients were deemed to be part of a backlog relating to Oncology Reviews. These patients will be seen for review by an Urologist in the Independent Sector. There have been **191** oncology review patients transferred to the Independent Sector and clinics are fully booked for the month of November for these patients. To date one case has been identified as meeting the threshold for an SAI review from this backlog.

- **131** patients have been offered and accepted an appointment over the next four weeks.
- **39** patients still to be contacted (not answering phone) so a letter has been sent asking them to ring to arrange an appointment
- **21** patients have been returned to Trust
    - 8 patients have advised that they no longer require an appointment and happy to be discharged
    - 1 patient has moved to Scotland
    - 12 patients not willing to travel so will be offered an appointment in the Southern Trust by end of November 2020.

Bicalutamide Audit

There are concerns regarding Consultant A's prescribing of a particular drug, which appears to be outside of established NICE guidance, regarding the diagnosis and management of prostate cancer. The drug is Bicalutamide, an Anti-androgen drug, which has a number of recognised short term uses in the management of prostate cancer. All patients currently receiving this treatment are currently being identified by the Trust, in order to facilitate a review to ascertain if their ongoing treatment with this drug is indicated or if an alternative treatment management plan should be offered. To date there have been 26 patients out of 300 identified as needing an urgent appointment.

- **26** patients identified from the first review of the patients:
- Two all-day clinics (Monday 2nd & Tuesday 3rd November) were held in Craigavon Hospital clinical team (1 x Consultant, 2 x Specialist Nurses and 1 x Pharmacist in attendance)
- **26** patients were contacted and offered an appointment:
- **9** patients attended the hospital
- **2** patients cancelled on the day
- **1** patient did not attend

- **14** patients (or their main carer) declined face to face appointment and these patients will be followed up by a telephone consultation

General Medical Council

The Trust is continuing to liaise with the General Medical Council regarding professional issues.

Royal College of Surgeons Invited Review Service

The Trust has approached the Royal College of Surgeons (RCS) Invited Review service to request a review of Trust urology services in relation to consultant A's practice. This engagement is at an initial stage and a meeting with a clinical lead from the RCS is being scheduled for this week / beginning of next week.

Grievance Hearing

The outcome of the formal grievance hearing was communicated to Consultant A on 26th October 2020 by report.

The panel was constituted by an external HR professional and a senior medic not previously involved in the case from within the Trust.

Overall, the panel did not find Consultant A's grievance upheld. Consultant A has subsequently lodged an appeal.

Additional Subject Matter Expertise / Consultant Reviews

The Trust via the Royal College of Surgeons has engaged with the British Association of Urological Surgeons (BAUS) who have provided two subject matter expert Consultant Urologists to assist with the ongoing work. One subject matter expert is providing independent expertise for the SAI process with the second expert engaged to assist with the review of electronic patient records.

Investment Proposal Template (IPT) HSCB

The HSCB have advised that the Trust develop and submit an IPT to cover additional costs associated with current and projected future work relating to the Urology review. This work will include clinical, managerial and governance oversight costs.

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 10th December 2020
Title:	Urology Update
Lead Director:	Dr Maria O'Kane, Medical Director Melanie McClements, Director of Acute Services
Purpose:	Information

Overview:

The purpose of this paper to provide an update to Trust Board (December 2020) on the ongoing review of urology services relating to Consultant A

Key areas for SMT / Committee consideration:

- Update on review progress to date (4th December 2020)
- Update on the progress of identified Serious Adverse Incidents and Public Health Agency advice regarding a proposed 'Clinical Investigation' model for future identified urology incidents
- Update on engagement with the Independent Sector Provided engagement to provide review appointments for 236 oncology backlog patients
- Update on review of prescribing of the medication Bicalutamide, an Anti-androgen drug, to date there have been 26 patients out of 300 identified as needing an urgent appointment.
- Update on GMC process

Human Rights/Equality:

None to declare

Summary of reviews of clients under Consultant A since July 2020 by SHSCT

- Review of stent removals Jan 2019 - June 2020 - 160 pts
- Review of elective activity Jan 2019 - June 2020 - 352 pts – **2 SAI's**
- Review of pathology results Jan 2019 August 2020 - 168 pts – **3 SAI's**, (further 2 now requiring review)
- Review of Radiology requests Jan 2019 - August 2020 - 1536 results/1028 pts episodes. 511 completed and no delays/concerns raised. 1025 still to be reviewed by Subject Matter Experts.
- Review of MDM episodes Jan 2019 - July 2020 - 271 pts - **3 SAI's**.
- Oncology Review Backlog – 236 patients to be reviewed by Independent Urologist. – **1 SAI** identified in backlog review

Serious Adverse Incidents (SAI) Update (9)

The SAI panel membership has been agreed Terms of Reference have been internally agreed and have been forwarded to the HSCB. Chair of SAI review is working to a 4 month completion date by end January 2021 with 9 individual reports and 1 overarching report to be produced. All 9 patients/families identified through the SAI process have been spoken to with some of them being offered a further appointment with a Consultant Urologist.

Meetings with the Chair of the SAI panel and 8 families has taken place. (One of the families declined to meet or be involved in the process).

Four out of the five patients/ families, along with the index patient of the previous SAI's, have also been spoken to. The family of the fifth patient's family (RIP) is still outstanding as this is being clinically considered due to the recent death of the patient. One of these patients on his request had a meeting with a consultant this week.

Mid report of early identification of learning expected mid-December and full reports x 10 (9 + 1 overarching) due end January 2021.

Clarity requested by Trust with regard to approach in advance on Statutory Independent Inquiry for those cases identified that meet threshold of SAI. Trust to scope potential interim approaches for discussion with HSCB (3/12/20) and DOH Urology Assurance group on 4/12/20. Meeting planned with DLS for Monday 7 December to discuss.

Summary of Activity for Patient Facing Information Line (26/11/20)

The Trust has established a patient information line since 26th October 2020 for patients who may have questions or concerns regarding their care. The details of contacts made to date:

- **Total calls – 158 (up to and including Friday 20 November):**

5 patients with key issues raised to date, 3 were already picked up in review exercises and 1 was brought in for assessment, no clinical concern noted; 1 was a previous Private Patient no concerns.

- The Trust has also set up an accompanying **GP information line** - 2 GP's contacted to date.

Calls from 23 November 2020 until 3 December 2020

- Since Minister's statement there have been 124 calls to information line.
- 1 email to the inquiry email address
- No GP calls
- Overall, a range of individual issues need followed up and many calls taking lengthy periods with some very upset patients.
- **9 patients who had contacted the information line have been seen at clinic in the past week (1 & 2 December) where the patients were afforded the opportunity to discuss their concerns, 8 have no concerns in respect to the inquiry however one patient needs their case investigated further**.
- **2 further patients who had come via Chief Executive's office – MP & MLA inquiry have also been seen at the above clinics.**

Independent Sector Clinics

A total of **236** oncology patients were deemed to be part of a backlog relating to Oncology Reviews. These patients will be reviewed by an Urologist in the Independent Sector. There have been **191** oncology review patients transferred and clinics are fully booked for the month of November.

- **134 management plans** have been received back from Independent Sector
  - **80** of these have been referred back to the care of their GP
  - **24** have been sent back to Trust for further care/follow-up.
  - **27** to be reviewed at Trust's Urology MDT
  - **3** referral to Oncologist for Urgent reassessment of treatment

Bicalutamide Audit

There are concerns regarding Consultant A's prescribing which appears to be outside of established NICE guidance, regarding the diagnosis and management of prostate cancer. The

drug is an Anti-androgen drug, which has a number of recognised short term uses in the management of prostate cancer. All patients currently receiving this treatment have been identified by the Trust in order to ascertain if their ongoing treatment with this drug is indicated or if an alternative treatment management plan should be offered.

To date 479 patients over 6 months have been identified across NI who have been prescribed a dosage of 50mg. 447 patients have been prescribed this appropriately but 32 patients, all of whom were under the care of Mr O'Brien, have been identified as receiving a low dosage medication (outside of licensed indications) and who require an urgent review. All have been contacted and to date 10 have been reviewed, all 10 have had their treatment revised. Plans are in place to review the remainder of these patients.

The second stage of this Audit has identified there are 486 patients across NI who are prescribed a higher dosage of 150mg Bicalutamide. These patients records are being viewed and information is being collated as to how many of these patients will require review to amend medication. To date, of the 300 cases reviewed, 60 require further assessment to ascertain if they require a full case review in the context of their overall management, including radiotherapy.

One of the Subject Matter Expert Consultant Urologists has also agreed to review these patients.

Admin & Clerical Review

A review of processes including triage, communications, patient information and private patient management has been completed. This has considered issues, gaps, policies/processes and risks. An external opinion is currently being progressed to cross reference with other Trust processes to ascertain any learning – meeting planned.

General Medical Council

The Trust is continuing to liaise with the General Medical Council regarding professional issues. **New information regarding potential private patient practice still occurring, escalated to GMC 27/11/20. (3 cases to date)**

Grievance Hearing

The outcome of the formal grievance hearing was communicated to Consultant A. on 26th October 2020 by report. Overall the panel did not find Consultant A's grievance upheld. Consultant A has subsequently lodged an appeal and panel currently in development.

Consultant's Private Practice

A Meeting has taken place with DLS regarding private practice considerations as advised by DOH. Personal information redacted by USI for Consultant A has resulted in deferral of legal communication x 2 weeks as mark of respect. As above re liaison with GMC.

Internal Audit has commenced a review of Mr O'Brien's patients transferring into SHSCT as HSC patients. The review will also consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Royal College of Surgeons Invited Review Service

The Trust has approached the Royal College of Surgeons (RCS) Invited Review Service to request a review of Trust urology services in relation to Consultant A's practice. This engagement is at an initial stage and a meeting with a Clinical Lead from the RCS took place on Monday 30 November 2020.

Additional Subject Matter Expertise / Consultant Reviews

The Trust via the Royal college of Surgeons has engaged with the British Association of Urological Surgeons (BAUS) who has provided two Subject Matter Expert Consultant Urologists to assist with the ongoing work. One Subject Matter Expert is providing independent expertise for the SAI process with the second engaged to assist with the review of electronic patient records.

Staff engagement since Ministerial statement to Assembly

Two sessions held with clinical multi-disciplinary staff with CEO, Medical Director and Acute Director in attendance. These will be scheduled fortnightly. Some natural concerns expressed within team including impact on team members, individually and collectively, capacity within the urology service to meet patient need and the potential to cause harm as a result of unacceptable waiting lists and delays. Assurances offered and Commissioner discussions to take place to consider same, including potential conflicts of interest. Wrap around supports for team to be developed in line with expressed need.

Investment Proposal Template (IPT)

IPT prepared associated with current and projected future work relating to the Urology review. This work will include clinical, managerial and governance oversight costs and patient related support services including SAI Review costs, information/help lines, counselling, psychological support and family liaison.

Conversations underway with Trust Psychology, HR and Inspire, regarding model of 6 sessions per person who require support. Role of GP referral to be further explored.

2 locum Urologists have also been recently appointed by the Trust. (= 6 WTE of 7 funded urology posts) which will increase capacity to progress clinical assessments and reviews.

Discussion with HSCB - Urologist (7) underspend can be repurposed towards IPT costings.

Communication Plan

Liaison across HSCB, DOH, Trust Communications Teams and operational /clinical staff. Trust website information updated regarding information line and FAQ's has been revised.

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Minutes of a Virtual Confidential Meeting of Trust Board held on, Thursday, 25th February 2021 at 9.00 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director
Mrs H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs M McClements, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Ms J McGall, Assistant Director, Mental Health (*for Mr McNeany*)
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr B McNeany, Director of Mental Health and Disability Services

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. Mrs Trouton declared an interest in item no. 6 in relation to clinical concerns within Urology. Mrs Trouton declared that she was Assistant Director for Surgery and Elective Care between 2009 – March 2016 and managed the Urology Service during that time. Mrs Trouton remained in the meeting for discussion on this item.

3. MINUTES OF PREVIOUS MEETINGS

The Minutes of the meetings held on 22nd October 2020, 12th November 2020 and 10th December 2020 were agreed as accurate records.

4. MATTERS ARISING

There were no matters arising.

5. Irrelevant information UPDATE

A short update was included in members' papers. Ms McGall informed members that whilst the purchase of Irrelevant information redacted by the USI has not been completed within the timescale originally reported, the purchaser has assured the Trust that the exchange of ownership will take place shortly. Mr McDonald asked if there was a risk that the current owners would have recourse on the Trust's decision to cease admissions to Irrelevant information redacted by the USI. Ms McGall advised that once the transfer of sale takes place, it is the understanding of the Trust that the current owners will have no say in the future or retrospective running of Irrelevant information redacted by the USI. She further advised that it is the view of the Trust the existing concerns will cease once the new Owners take over.

Mr Wilkinson sought assurance that the current owners would have no future employment opportunities in either Irrelevant information redacted by the USI under the new ownership. The Chief Executive undertook to seek a legal opinion in this regard.

Action: Chief Executive

6. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY**

The Chief Executive spoke of the ongoing engagement with the Department and the Health and Social Care Board on this matter. Mrs McClements updated on the SAI process to date and informed members that the 9 individual reports and the one overarching report were nearing completion. A mid report of early identification of learning was issued and shared with the families, the team and the Department. Dr O'Kane stated that early learning was in relation to appropriate use of systems and processes, use of NICE guidance, timely updating of clinical information and multi-disciplinary team working.

Mr Wilkinson welcomed the early learning and the themes that were emerging, and asked how the Trust was addressing the weaknesses identified. Dr O'Kane advised that a review of the multi-disciplinary team process was underway to include an audit against good practice to help understand what action needs to take place. She also advised that work was underway to redesign the Revalidation and Appraisal process. She noted that it has already been agreed that Appraisers would not be picked by the Appraisee, but would be appointed independently to undertake the appraisal. Mrs McClements spoke of the work underway on admin processes, triage, communications, patient information etc. and stated that the Trust was working with the Belfast Trust on the learning from the Neurology Review in terms of approaches in governance and systems and processes, particular in relation to the patient journey and multi-disciplinary team working.

Ms Donaghy raised the issue raised in the Neurology Review in relation to the private patient's journey into the Trusts as a HSC patient. She asked if action on this issue could be fast tracked as it has major consequences for the Trust given the already unacceptable waiting lists and delays. Dr O'Kane responded by advising that the whole private patient management process was being looked at.

Mr McDonald asked about the likelihood of criticism in the SAI report of systemic failure as opposed to individual failure. The Chief Executive stated that he believed there would be criticism of systems

and processes not working effectively as well as the failings of the individual clinician. Dr O'Kane advised that clinicians in other Trusts had raised concerns about this clinician's practice with the clinician, but these had not been escalated.

7. Irrelevant information redacted by the USI **MEDICAL PRACTICE**

The Chief Executive stated that the Trust was working in partnership with the HSCB to try to get a short term solution. Simultaneously, the HSCB is working with the Trust and the Department of Health to put in place a longer term solution to ensure that the patients of Irrelevant information redacted by the USI Practice continue to have access to the full range of services. Mr Beattie advised that the Trust has placed a number of Trust staff from mental health, nursing and AHPs into the practice, as well as a temporary Clinical GP Lead.

Mr Beattie advised that the Trust would be formally advising the HSCB in the coming days of its intention to withdraw from the contract. Mrs McCartan asked about the longer term solution, to which Mr Beattie advised that this will involve discussions between the HSCB and other GP practices to ascertain their interest in taking over the Irrelevant information redacted by the USI practice. Mr Beattie stated that if this does not come to fruition, the HSCB would have to move to dispersing 5,000 patients across to other GP practices.

8. **ANY OTHER BUSINESS**

None

The meeting concluded at 9.30 a.m.

SIGNED: _____ **DATED:** _____

Southern Health and Social Care Trust
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Minutes of a Virtual Confidential Meeting of Trust Board held on, Thursday, 25th March 2021 at 9.00 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director
Mrs H O'Neill, Director of Finance, Procurement and Estates

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs G Hamilton, Assistant Director, Nursing, Patient Safety, Quality and Experience (*for Mrs Trouton)*
Mrs M McClements, Director of Acute Services
Mr B McNeany, Director of Mental Health and Disability Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were none declared.

3. MINUTES OF PREVIOUS MEETINGS

The Minutes of the meeting held on 25th February 2021 were agreed as an accurate record.

4. MATTERS ARISING

i) Irrelevant information update

Mr McNeany provided a verbal update. He reported that it was his understanding that the exchange of ownership of Irrelevant information redacted by the USI would take place in the next few weeks. He also reported that the Trust has sought a legal opinion in relation to future employment opportunities of the current owners in either Irrelevant information redacted by the USI and a response is awaited.

5. UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY

Mrs McClements spoke to a paper which provided an update on the following areas:-

- Review progress to date (16th March 2021)
- Progress of Identified Serious Adverse Incidents and creation of a Structured Clinical Record Review model for future identified urology incidents
- Engagement with the Independent Sector to provide review appointments for 236 oncology backlog patients
- GMC and Private Practices process

In relation to the SAI process, Mrs McClements reported that each patient/family has received a copy of their SAI report and a copy of the overarching SAI report. Copies of all of the reports have been shared with the Urology and Cancer services teams for factual accuracy checking. Mr AOB's solicitor has received copies of all the draft SAI reports and the overarching report. Correspondence was received from Mr AOB and this was also included with the reports to the families and the clinical team.

Mrs McClements advised that a review of processes including triage, communications, patient information and private patient management has been completed. This has considered issues, gaps, policies/processes and risks. An external opinion was sought and they have cross referenced with other Trust processes to ascertain any learning. The report is due completion at end of March 2021. Mrs McClements provided assurance that the Trust was prioritising the learning and recommendations for service improvement and this work would be led by the Trust Urology Oversight Group chaired by Dr O'Kane and herself.

Dr O'Kane referred to the Structured Clinical Record Reviews (SCRR) and advised that the RCP are conducting two train the trainer sessions for using Structured Judgement Review (SJR) methodology for Trust medical staff in March 2021. The Trust has shared the SCRR draft form with the RCP and has received positive feedback in its design and structure. To support the SCRR process, the Trust has identified an additional Consultant Urology subject matter expert via the Royal College of Surgeons to support reviews as required.

Mrs McClements informed members that the Internal Audit review of Mr AOB's patients transferring into SHSCT as HSC patients was at the final stage of reporting. At this point, there has been one private patient anomaly identified. As regards private practice external to the Trust, the Trust held a meeting with the GMC and DoH on 16th March 2021 to discuss the Trust and DoH roles in consideration of Mr AOB's private practice.

The Chair of the SAI Panel intends to speak to the GMC on the Panel's concern at the lack of engagement by Mr AOB in getting clinical information.

Members were advised that regular meetings were continuing with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services. Conversations are taking place with the Clinical Teams to offer a range of support options on an individual basis or as a team going forward. Professional Nursing support has been planned as requested and being organized for the Cancer Nurse Specialists.

Mrs Toal updated on the Grievance Appeal process. She advised that the Trust had written to Mr AOB to outline how the process would be taken forward. The Trust has asked an Independent Appeal Panel to undertake a review of the Panel's outcome and Mr AOB's subsequent and recent correspondence.

In the interests of time, the Chair brought the discussion to a conclusion and asked members if they had any further questions to forward these via email to her office for response.

6. **ANY OTHER BUSINESS**

None

The meeting concluded at 9.28 a.m.

SIGNED: _____ **DATED:** _____

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: Date:	Trust Board 25th March 2021
Title:	Urology Update
Lead Director:	Dr Maria O'Kane, Medical Director Melanie McClements, Director of Acute Services
Purpose:	Information

Overview:

The purpose of this paper to provide an update to Trust Board (March 2021) on the ongoing review of urology services relating to Consultant A

Key areas for SMT / Committee consideration:

- Update on review progress to date (16th March 2021)
- Update on the progress of identified Serious Adverse Incidents and creation of a Structured Clinical Record Review model for future identified urology incidents
- Update on engagement with the Independent Sector Provided engagement to provide review appointments for 236 oncology backlog patients
- Update on GMC and Private Practices process

Human Rights/Equality:

None to declare

Summary of reviews of clients under Consultant A since July 2020 by SHSCT

- Review of stent removals Jan 2019 - June 2020 - 160 pts
- Review of elective activity Jan 2019 - June 2020 - 352 pts – **2 SAI's identified** –
- Review of pathology results Jan 2019 August 2020 - 168 pts – **3 SAI's**
- Review of Radiology requests Jan 2019 - August 2020 - 1536 results/1028 pts episodes. 511 completed and no delays/concerns raised. 1025 still to be reviewed by Subject Matter Experts.
- Review of MDM episodes Jan 2019 - July 2020 – 271 episodes/186 pts - **3 SAI's**. (Urology Subject Matter Expert is currently undertaking this review)
- Oncology Review Backlog – 236 patients to be reviewed by Independent Urologist. – **1 SAI** identified in backlog review – This exercise is now complete with 200 patients having been seen by 22 December 2020

  200 management plans have been received back from Independent Sector
  - **124** of these have been referred back to the care of their GP
  - **34** have been sent back to Trust for further care/follow-up.
  - **39** to be reviewed at Trust's Urology MDT (Professor Sethia has agreed to be the independent Consultant on these MDT's and these are commencing on 14 January and will be every fortnight.
  - **3** referral to Oncologist for Urgent reassessment of treatment

Public Inquiry

The Minister for Health has announced the chairperson of the Public Inquiry will be Ms Christina Smyth QC. The Minister has also indicated the aim of the inquiry being fully underway by summer 2021. The next steps for the Chairperson will be to finalise the terms of reference for the inquiry, following engagement with the Assembly's Health Committee and the patients affected by the lookback, and to finalise the members of the Inquiry Panel.

Ms Smith is an experienced Queen's Counsel with a background in public inquiry work. She is Senior Counsel to the Independent Neurology Patients Recall Inquiry and was Senior Counsel for the Historical Institutional Abuse Inquiry. She also appeared for the Department of Finance in the RHI Inquiry.

Engagement with the HSCB / DoH

The Trust continues to attend separate fortnightly meetings with both the Department of Health and Health and Social Care Board. The Department of Health meeting, chaired by Richard

Pengelly, Permanent Secretary is responsible for ensuring a coordinated approach to with regard to all strands of the Urology review work across all domains of practice. The next meeting is due to take place 19th March 2021.

Serious Adverse Incidents Update

The SAI process chaired by Dr Dermot Hughes has concluded. A total of 10 reports (9 patient specific and 1 overarching report) have been completed in draft form. Each patient / family received a copy of the report relating to their / their family members care and copies of all of the reports have been shared with the Urology and Cancer services teams for factual accuracy checking, this process will conclude on the 2nd April 2021. Prior to finalising the draft reports Dr Hughes met individually with each family to discuss the format and progress of each SAI review.

- Families received a copy of their SAI report and also a copy of the overarching SAI report on 18th March 2021.
- The Urology Consultants and Clinical Nurse Specialists received a copy of the SAI reports and also a copy of the overarching SAI report on 16th March 2021.
- Mr O'Brien's solicitor received copies of all the draft SAI reports and the overarching report on Friday 5th March 2021.

Dr Hughes will meet with the families following sharing of the reports and the Trust will continue to offer support to those patients / families who feel they require this. There is also been a meeting organised for Tuesday 23rd March with Chief Executive, Medical Director, Acute Director and the urology team to afford them the opportunity to share their thoughts on this.

The Trust is prioritising the learning and recommendations for service improvement, this work will be led by the Trust Urology Oversight Group chaired by Melanie McClements and Dr Maria O'Kane.

The Family Liaison Officer has continued to support 8 out of the 9 families (9th family declined this support on their own wishes) and has advised all families that she will continue to be available for them once they have received and read through the reports.

Structured Clinical Record Reviews

RCP are conducting two train the trainer sessions for using Structured Judgement Review (SJR) methodology for Trust medical staff on 18th and 25th March. SJR principles are what underpin the SCRR process. The Trust has shared the SCRR draft form with the RCP and has received positive feedback in its design and structure. To support the SCRR process the Trust has identified an additional Consultant Urology subject matter expert via the Royal College of Surgeons to support reviews as required.

Summary of Activity for Patient Facing Information Line (16/03/21)

The Trust has established a patient information line since 26th October 2020 for patients who may have questions or concerns regarding their care.

- 154 calls/emails up to 16 March 2021

From Saturday 6th March one of the core consultant urologists has commenced weekly telephone clinics and will chronologically review patients from Mr O'Brien's review backlog list. The consultant is completely the Patient Review form for each of these patients. As of this report he has reviewed 20 patients.

The Subject Matter Expert has commenced reviewing the case notes of previous MDM patients that were under the care of Consultant A from January 2019- June 2020, and will complete a Patient Review form for each of these patients and will also escalate any patients he has concerns in respect of their care.

Admin & Clerical Review

A review of processes including triage, communications, patient information and private patient management has been completed. This has considered issues, gaps, policies/processes and risks. An external opinion was sought and they have cross referenced with other Trust processes to ascertain any learning, the report is due completion at end of March 2021.

General Medical Council

Further to Mr O'Brien's interim suspension from the Medical Register on 15th December 2020 the Trust is continuing to liaise with the General Medical Council regarding professional issues.

Grievance Hearing

Following receipt of the grievance outcome Mr O'Brien subsequently lodged an appeal. As a result an appeal panel had been organised with dates offered to Mr O'Brien. Mr O'Brien has indicated on 4th March 2021, through his representative, that he will not be attending any further meetings with the Trust with regards this process and intends to address the matters via Public Inquiry. His representative has stated that with regards to the appeal itself, they raise no objection to the Trust proceeding with the Appeal Panel. His representative's response has been forwarded to DLS for advice.

Consultant's Private Practice

Private Practice - Internal Audit

An Internal Audit review of Mr O'Brien's patients transferring into SHSCT as HSC patients is ongoing. Currently internal audit are scoping all diagnostics that were carried out under Mr O'Brien's name, along with auditing laboratory and pharmacy systems. At time of writing there has been one private patient anomaly identified.

Private Practice – External to the Trust

The Trust continues to liaise with the Department of Health regarding Mr O'Brien's private practice work outside of the HSC. The Trust held a meeting with the GMC and DoH on 16th March to discuss the Trust and DoH roles in consideration of Mr O'Brien's private practice. This issue is to be discussed further with at the fortnightly DoH UAG meeting 19th March 2021.

Royal College of Surgeons Invited Review Service

The Trust has approached the Royal College of Surgeons (RCS) Invited Review Service to request a review of Trust urology services in relation to Consultant A's practice. The following actions have been taken to advance this:

- Terms of reference for the review have been agreed with HSCB / DoH and shared with the Royal College of Surgeons
- The Royal College of Surgeons has identified a review team to undertake this project.
- A stratified approach to sampling of cases from calendar year 2015 has been agreed with the HSCB / DoH. Where required, an electronically driven random sampling method was used to select cases.

The Trust held a meeting on 11 March 2021 with the Royal College of Surgeons on how best to transfer the data for the review, so it was agreed that this would be done using the Egress secure platform. It is anticipated the review will commence in May 2022.

Additional Subject Matter Expertise / Consultant Reviews

The Trust has identified via the Royal College of Surgeons a Consultant Urology Subject Matter Expert to support the review of Mr O'Brien's clinical activity between 1st January 2019 and 30th June 2020. The Subject Matter Expert will review the patients in the following order:

- Cancer MDM (187)
- Triage of patients contacting the information line (154)
- Radiology results (1028)

Staff Engagement

Regular Team meetings are continuing with the Clinical Teams and the Chief Executive, Medical Director and Director of Acute Services, next one scheduled for 23 March 2021. Conversations are taking place with the Clinical Teams to offer a range of support options on an individual basis or as a team going forward. Professional Nursing support has been planned as requested and being organised for the Cancer Nurse Specialists.

Investment Proposal Template (IPT)

IPT prepared associated with current and projected future work relating to the Urology review. This work will include clinical, managerial and governance oversight costs and patient related support services including SAI Review costs, information/help lines, counselling, psychological support and family liaison.

- Conversations underway with Trust Psychology, HR and Inspire, regarding model of 6 sessions per person who require support. Role of GP referral to be further explored.
- 2 locum Urologists have also been recently appointed by the Trust. (= 6 WTE of 7 funded urology posts) which will increase capacity to progress clinical assessments and reviews.
- Discussion with HSCB - Urologist (7) underspend can be repurposed towards IPT costings.

Communication Plan

Liaison across HSCB, DOH, Trust Communications Teams and operational /clinical staff. Trust website information updated regarding information line and FAQ's has been revised.

Southern Health and Social Care Trust
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Minutes of a Virtual Confidential Meeting of Trust Board held on Thursday, 27th May 2021 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr P Morgan, Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director/Interim Director of Mental Health and Disability Services
Mrs H O'Neill, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs M McClements, Director of Acute Services
Mrs A Magwood, Director of Performance and Reform
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mr E McAnuff, Boardroom Apprentice
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mrs P Leeson, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the virtual meeting.

2. DECLARATION OF INTERESTS

The Chair requested members to declare any potential conflicts of interest in relation to any matters on the agenda. There were none declared.

3. MINUTES OF PREVIOUS MEETINGS

The Minutes of the meeting held on 25th March 2021 were agreed as an accurate record.

4. MATTERS ARISING

i) Irrelevant information update

Dr O'Kane referred members to the written update. She stated that invoices continue to be scrutinised by case managers and no further issues have been identified. The proposed sale of Irrelevant information redacted by the was discussed in which Mr McDonald stated that the Trust should be prepared for the likelihood of the current Owners taking a legal challenge and seeking financial compensation once they have sold the business. The Chief Executive agreed that the Trust would seek legal guidance in this regard.

Action: Dr O'Kane

5. UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY

Mrs McClements spoke to a paper which provided an update on the following areas:-

- Review progress to date (10th May 2021)
- Progress of identified Serious Adverse Incidents and creation of a Structured Clinical Record Review model for future identified urology incidents
- GMC and Private Practices process

- Urology and Cancer Services Quality Improvement work

In relation to the SAI process, Mrs McClements reported that 8 out of 9 SAI's have been finalised. One family, recently bereaved, have requested more time to consider the report and the Trust has agreed to extend their time for feedback. The Trust has agreed it will now formally move to apologise to these 9 families and a letter of apology is currently being drawn up to send to the families.

Mrs McClements advised that with regard to patient involvement, a meeting with the DoH, HSCB, the Trust and Patient Client Council (PCC) took place on 20 May 2021 to determine how the PCC can meaningfully contribute going forward with the other patients and families identified/affected through and by the Inquiry.

Mrs McClements noted a change to the summary of activity table in the document advising that this should read 3,852 patients with 2,744 episodes reviewed to date. She advised of a meeting with the Commissioner later that day to discuss additional support for the review of patients.

Members were advised that two extra Oncology Multi-Disciplinary Team meetings (MDTs) have been held with 28 cases discussed. From these 28 cases, there were 25 patients who were identified as having concerns regarding their treatment. It was recommended that these cases are screened and follow the structured clinical record review process (SCRR). All 25 patients are being or have been seen face to face at clinics by Mr Haynes. There has also been a further 14 patients identified through the review clinics as receiving sub-optimal care and these are being put forward for a Structured Clinical Record Review (SCRR). The total being considered under SCRR is 39 patients.

Mrs McClements referred to the focus on improvement and spoke of the establishment of a Trust Quality Improvement Group to oversee and take forward improvement work. This work includes developing 4 workstreams to manage the 134 learning points and recommendations. Members welcomed the establishment of the 4 workstreams.

The Internal Audit review of Mr AOB's patients transferring into SHSCT as HSC patients was raised. Dr O'Kane advised that a summary position has been received from Internal Audit. Mr Wilkinson asked if there will be an additional workstream to take forward the learning from the Internal Audit review report to which Dr O'Kane advised that the clinical and governance workstream would take forward any learning. Ms O'Neill advised that the final Internal Audit report would be discussed by the Audit Committee and progress on implementation of the recommendations monitored by the Trust's Internal Audit Forum. In response to a question from Ms Donaghy, Mrs McClements advised that the initial indications from the Internal Audit review is that that there was non-compliance with private practice guidance. Dr O'Kane advised that the Trust continues to work with the HSCB and the DoH to identify Mr AOB's private patients.

The Chief Executive informed members that he had met with the DoH the previous week in relation to the Terms of Reference of the Public Inquiry. He has suggested these should be organizational and system focused as opposed to individual focus.

Members raised the potential for the establishment of an additional corporate governance workstream. The Chair advised that time would be spent at the Board Workshop on 26th August 2021 to discuss preparedness for the Public Inquiry.

6. NEWRY CTCC

Mrs Magwood spoke to the summary of the briefing pack provided for the meeting with the Permanent Secretary and HSCB on 18th May 2021. She advised that this was a positive meeting on the proposed Newry CTCC and that Ministerial approval for the project to move to Full Business Case was awaited. The fact that none of the Newry GPs will relocate to the proposed new CTCC was discussed. Mr McDonald stated that this was disappointing given the efforts of the Trust and asked about contingency planning should GPs change their minds. Mrs Magwood advised that this is a primary care facing model and GPs will have access to bookable facilities within the Newry CTCC hub. She stated that it was regrettable that despite a

range of incentives, Newry District GP partners had taken the decision not to relocate.

Mrs McCartan asked for sight of the briefing pack provided to the Minister. Mrs Magwood agreed to provide a summary pack.

Action: Mrs Magwood

7. [redacted] Irrelevant information redacted by the USI

Mr Morgan provided a verbal update. He stated that the situation was now more settled since the update he had provided to Governance Committee on 13th May 2021. Both the [redacted] Irrelevant information redacted by the USI Mr Morgan paid tribute to the PSNI for their close collaborative working with the Trust on this issue.

8. [redacted] Irrelevant information redacted by the USI

Dr O'Kane reported that following a number of Adult Safeguarding investigations, anonymous concerns raised by staff and a Serious Concerns meeting by RQIA, a Quality Improvement project has commenced at [redacted] Irrelevant information redacted by the USI. A Project Initiation Document has been developed and a Project Manager appointed. A weekly Project Board meeting has been established, a fortnightly Governance Oversight Group has commenced and a monthly Directors Oversight Group is also in place.

A briefing paper was included in members' papers and the areas of improvement were discussed. The Chair referred to the fact that one of the areas of focus was changing the culture within the service and she asked Dr O'Kane if she was content with the overall safety of the tenants. Dr O'Kane advised that she was content with the safety of the tenants, but acknowledged there were improvements to be made. She advised that a staff safety climate survey has been sent to all Learning Disability supported living staff to obtain feedback on the safety culture within supported living as well as a survey with a focus on care and support of tenants. Staff have been written to by the Assistant Director outlining the QI project and advising them they are critical to delivering improvements.

Mrs McCartan raised the potential for reputational damage to the Trust and asked Dr O'Kane if there were sufficient resources to address the issues. Dr O'Kane advised that they were able to take forward the work in Irrelevant information redacted by the USI within current resources, but as this is rolled out across the Directorate to other Learning Disability facilities, additional support will be required. She spoke of the opportunity to involve Psychology services in moving this work forward.

Mrs Toal spoke of the importance of the unannounced visits by management being progressed and the focus of line management presence outside core working hours.

Members welcomed the appointment of the Project Manager and highlighted the importance of the learning from the QI project on how to address cultural issues across other Learning Disability facilities.

It was agreed that updates on progress would be provided to the Governance Committee.

9. **MENTAL CAPACITY ACT UPDATE**

Members discussed the fact that the Trust will not meet the 31st May 2021 deadline and will therefore risk criminal liability. Mr Morgan raised the significant pressure across many staff groups both in hospital and community settings to meet the ongoing demands of MCA work and stated that practitioners including medical practitioners do not have the capacity to undertake this additional work. Members noted that GP practices have not engaged in the process with only 1 GP in the Trust area supporting MCA and this will be raised with GP Federation colleagues again to try to generate interest. Mr Morgan advised that the Trust completed a summary of activity to the HSCB and their response is awaited as to what support may be available.

10. ANY OTHER BUSINESS

Mrs Toal informed members that a SAI review involving the tragic death by suspected suicide of a Trust employee Personal Information redacted by the USI had concluded. In addition, a parallel independent review of the management of HR processes had also concluded. A confidential briefing paper will be shared with members.

Action: Mrs Toal

The Chief Executive and Senior Management Team left the meeting for discussion on the next item.

11. FEEDBACK FROM REMUNERATION COMMITTEE MEETING

The Chair advised that at its meeting held on 20th April 2021, Remuneration Committee noted formal issue of Departmental Circulars HSC (SE) 1/2021 and HSC (SE) 2/2021 which provide details of the 2016/17 and 2017/18 Senior Executive pay awards respectively. The Committee also noted that at its meeting on 24th January 2019, members had recommended a fully acceptable performance rating for relevant Senior Executives in the periods 1st April 2015 – 31st March 2016 and 1st April 2016 – 31st March 2017 pending issue of these circulars. The Chair therefore sought retrospective approval on the implementation of these circulars.

Trust Board retrospectively approved implementation of the above-named circulars.

The meeting concluded at 9.50 a.m.

SIGNED: _____ DATED: _____

Southern Health and Social Care Trust

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TRUST BOARD COVER SHEET

Meeting Date	Thursday 27th May 2021	
Agenda item	Confidential Section - Update on Urology Incident	
Accountable Director	Dr Maria O'Kane, Medical Director Melanie McClements Director of Acute Services	
Report Author	Name	Dr Maria O'Kane, Medical Director Melanie McClements Director of Acute Services
	Contact details	Personal Information redacted by the USI Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

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

WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY	*This report cover sheet has been prepared by the Accountable Director.* *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:
The purpose of this paper to provide an update to Trust Board (May 2021) on the ongoing review of urology services relating to Mr Aidan O'Brien. • Update on review progress to date (10th May 2021) • Update on the progress of identified Serious Adverse Incidents and creation of a Structured Clinical Record Review model for future identified urology incidents • Update on GMC and Private Practices process • Update on Urology and Cancer Services Quality Improvement work
2. Areas of improvement/achievement:
Not applicable
3. **Areas of concern/risk/challenge:**
Not applicable
4. Impact: Indicate if this impacts with any of the following and how:

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Update on work on Patient Reviews

Serious Adverse Incidents (SAI)

All of the SAI reports have been shared with DoH and HSCB. 8 out of 9 SAI's have been finalised. One family, recently bereaved have requested more time to consider the report and the Trust have agreed to extend their time for feedback.

The Trust has agreed they will now formally move to apologise to these 9 families and a letter of apology is currently being drawn up to send to the families.

Patient Involvement

The HSCB had a meeting on Thursday 13 May with the Trust and PCC. This is to prepare for the meeting with the DoH, Board, Trust and PCC on 20 May 2021 and is to determine how the PCC can meaningful contribute going forward with the other patients and families identified/affected through and by the Inquiry.

General Medical Council

The Trust continues to liaise with the GMC regarding their investigation into Mr O'Brien. The Trust has supplied the available final copy SAI reports for their consideration.

Summary of Activity (10/05/2021)

Weekly telephone/face to face/virtual clinics continue for assessing patients from Mr O'Brien's review patients. The consultants doing this work are completing a patient review form for each of these patients.

	Patient Group	Number of Episodes/Patients in Group	Reviewed to date	Remaining to be reviewed
Administrative Review Only	***Elective Cohort***	*352 Patients*	*352 (Administrative Review)*	*0*
	Emergency Patients (Stents)	*160 Patients*	*160 (Administrative Review)*	*0*
	Radiology Results	1025 Patients (1536 Episodes)	750 (Result Review)	786
	Pathology Results	150 Patients (168 Episodes)	168 (Result Review)	0
	Oncology Reviews (IS)	236 Patients	200 (Face to Face ISP)	36
	Post MDM Patients	187 Patients (271 Episodes)	271 (SME Record Review)	52 (need second opinion)
	Review Backlog	511 Patients	86 (Virtual Clinics)	425
	Information Line	155 Patients	10(reviewed at clinic)	144
	Patients prescribed Bicalutamide	933 Patients	747 (Record Review, 26 Face to Face Reviews)	186
	Patients on Inpatient Waiting List for TURP	143 patients	0	143
	Total	**4321**	**2455**	**1918**

Patient line - 155 calls/emails up to 13 May 2021 no new inquiries received since last report on 16 April 2021).

Private Practice

The Trust has issued correspondence to Mr O'Brien that requested he forwards a Trust letter addressed to all of his private patients across all time periods. This is to inform them of the Trust's support for patients who may have concerns regarding their care provided by Mr O'Brien, in a private practice capacity. This letter includes contact details for the patient information line. Mr O'Brien's Solicitor has confirmed that the letter has been issued to all of his private patients for the period between January 2019 and June 2020. The Trust has sought clarification on issuing of this letter to Mr O'Brien's private patients prior to January 2020.

Looking Forward

Additional Support for Reviewing Patients

British Association of Urological Surgeons (BAUS) has identified another Subject Matter Expert Consultant Urologist who is willing to help with the review of patients and a meeting is planned next week with the Consultant to take this forward.

The Trust has approached the other three Trusts (Belfast, SET and Western Trust) to support reviewing the backlog of urology patients. All Trusts have responded, unable to offer any capacity.

A Service Specification is being prepared by the Trust, for the provision of Urology outpatient reviews from Independent Sector providers to support the Urology Team in seeing the patients identified as needing a review.

Additional Oncology MDT and Structured Clinical Record Review (SCRR) (previously referenced as SJR)

There have been two extra Oncology MDTs held, Chaired by Professor Sethia, External Subject Matter Expert Consultant Urologist, and attended by an additional Consultant Urologist, Clinical Oncologist, 2 Clinical Nurse Specialists and a Cancer Tracker. There were 28 cases discussed. From the 28 cases discussed there were 25 patients who were identified as having concerns regarding their treatment. It was recommended that these cases are screened and follow the structured clinical record review process (SCRR). All 25 patients are being or have been seen face to face at clinics by Mr Haynes.

There has also been a further 14 patients identified through the review clinics as receiving sub-optimal care and are being put forward for a SCRR. (Total being considered under SCRR is 39 patients).

Focus on Improvement

Service Quality Improvement

The Trust has developed a Project Initiation Document (PID) to support the operationalisation and fulfilment of the SAI recommendations. The PID outlines the Trust approach to ensuring both process and quality measures are associated with the planned improvement work. The work includes developing 4 workstreams to manage the 134 learning points and recommendations.

- Workstream 1 – Safe & Effective Care and Treatment (To include patient experience)
- Workstream 2 – Service Safety Culture
- Workstream 3 – Cancer Care Overarching Governance
- Workstream 4 – Clinical and Professional Governance

A Quality Improvement Group to oversee and coordinate this work is being established over the next week, to take this work forward.

Review of Urology Multi-disciplinary Meetings

The Trust is meeting with the PHE Peer Review team on the 14th May 2021. NICAN have suggested in the first instance to carry out an internal peer review audit while the external peer review is agreed. The Trust is progressing this. A qualitative audit has commenced to conduct an enhanced assessment of MDM effectiveness using the National Cancer Action Team document titled *Characteristics of an Effective Multidisciplinary Team (MDT)* in order to further develop improvement plans. This audit will include all Trust MDM's and will be internally peer reviewed. The resulting gap analysis and findings for urology MDT be available in June 2021.

Regional Lookback Policy & Guidance

The Trust has been made aware of the impending introduction of regional policy and guidance regarding Conducting of Lookbacks in HSC services. The Trust and HSCB will be discussing the implications of the introduction of this guidance with regard to Urology and consider the impact and consider what assurances / augmentations that will be required around existing processes. Once a position is agreed a proposal will be presented to an upcoming UAG meeting

IPT for Inquiry

The Trust has identified a number of areas that now require additional staff to start moving forward areas in the preparation for the Inquiry and are now in the process of preparing to recruit new posts. This includes support for securing and scanning patient records, supporting the MDT processes,

supporting and preparing for the identified SCRR's and supporting the litigation enquiries that are starting to be received.

Mrs Heather Trouton, Executive Director of Nursing, Midwifery and AHP's is taking on the Lead Director for the Public Inquiry and the Trust are appointing an Assistant Director for Public Inquiry and Trust Liaison Service to support her in this role.

Internal Audit

Internal Audit have shared a draft report of their findings into a review of Mr O'Brien's compliance with relevant authorities/guidance in terms of his private work 2020/21. The Trust needs to consider the recommendations in the report and agree an implementation plan for these.

Grievance Appeal

The Trust has established a panel to review the decision of the stage one grievance appeal. This has commenced with the Panel anticipating to have this concluded within 8 weeks.

Staff Engagement

No further team meetings have been requested by the teams and they are aware that these are available when there is anything that needs to be discussed /escalated.

Communications

The Trust have not received any media enquires since the last report.

Southern Health and Social Care Trust
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Minutes of a Confidential Meeting of Trust Board held on Thursday, 30th September 2021 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director and Interim Director of Mental Health & Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs J McConville, Assistant Director of Corporate Planning
(deputising for Mrs Magwood)
Mrs M McClements, Director of Acute Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms Susan McKinney, Boardroom Apprentice

APOLOGIES

Mrs H McCartan, Non-Executive Director
Mrs A Magwood, Director of Performance and Reform

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

2. **DECLARATION OF INTERESTS**

Ms Teggart declared an interest in agenda item no. 8 update from Remuneration Committee.

3. **MINUTES OF PREVIOUS MEETINGS**

The Minutes of meetings held on 27th May, 17th June and 26th August 2021 were approved as accurate records.

4. **MATTERS ARISING FROM 27TH MAY 2021**

i) Irrelevant information

As requested at the meeting on 27th May 2021, legal advice had been sought and was included in members' papers. The Chief Executive advised that new owners have been in place from 1.7.2021.

Members were content to agree that this concluded discussion on this item at Trust Board.

ii) Newry CTCC

Members noted the content of a paper which provides an update on progress and next steps relating to the Newry Health and Care Centre Third Party development. The Department of Health issued formal correspondence (1st July 2021) to confirm approval to proceed to finalise design of and prepare the Full Business Case for the Newry CTCC ahead of contract award. Mrs McConville raised the challenging programme to complete the Final Business Case and submit to the Department of Health by March 2022.

The Chair requested that time would be spent discussing this matter at the next confidential Trust Board meeting on 26th October 2021.

iii) SAI Personal Information

Mrs Toal spoke to the summary of the findings of the SAI Review and Independent Review of the HR / Line Management in relation to Personal Information redacted by the USI Mrs A Magwood and Mrs V Toal had met with Non-Executive Directors on 22nd June 2021 to brief them on the findings of both reviews in advance of the draft SAI being shared with Personal Information redacted by the USI family, as per normal SAI process. Mrs Leeson asked for assurance in relation to engagement with Personal Information redacted by the USI family to which Mrs Toal confirmed that the draft report was received by the family on 21.7.2021 and the Trust was working through the responses to their queries. She added that interaction with the family was being guided by the family.

The Chair advised that the action plan had now been uploaded to Decision Time and asked members to contact her if there were any points they wished to raise. Members highlighted the importance of the lessons learned from the SAI and the Independent Review of the HR/Line Management being taken forward. It was agreed that the learning would be brought to the Lessons Learned Forum and Mrs Toal advised that this report would be brought to her HROD Governance Forum meeting in October 2021 and she agreed to incorporate into her next HROD report to Trust Board how the recommendations were being implemented.

Action: Mrs Toal

MATTERS ARISING FROM 17TH JUNE & 26TH AUGUST 2021

i) Dorsy Unit

Dr O'Kane spoke to a paper which explores the Intellectual Disability service model currently being provided at Dorsy Unit detailing issues identified within the service, causative and contributory factors that have enabled the issues to manifest and actions that have been taken to safeguard service users and staff who reside and work in the unit.

Dr O'Kane drew members' attention to a range of actions that have been undertaken, as outlined in the paper, to improve the

service and ensure the safety of patients and staff. She stated that improvements are being made at pace on the culture and environment in unit and enhanced efforts to increase staff recruitment enacted.

Mr Wilkinson raised the challenge of Dorsy unintentionally becoming a 'long stay' Unit and asked if practices changed as that purpose evolved and sought assurance that there was a now a good understanding of the overall situation. Dr O'Kane spoke of the establishment of an overarching inpatient governance group to oversee existing sub groups for Bluestone and Dorsy and the weekly oversight group for Dorsy Unit with Directors input to support ongoing safety and service improvement activities. She referred to the regional ID service model and the challenges in meeting the needs of patients and acknowledged the pressures on the unit due to the need to provide care for patients from other Trust areas. Dr O'Kane advised that the Trust is pursuing a regional and local review of the ID service model.

In relation to safeguarding issues and investigation, Dr O'Kane advised that police interviews with some staff under the Joint Protocol were progressing.

The Chair stated that she was assured by the actions taken and the processes put in place by Dr O'Kane and the team to address the issues and improve the service.

It was agreed that a progress update would be provided at the next confidential Trust Board meeting on 28th October 2021.

5. UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY

Mrs Trouton provided an update on the work on outpatient reviews. There are currently 74 patients identified where there are concerns about their care.

Mrs Trouton stated that the Trust has now received the Terms of Reference for the Public Inquiry and she outlined the Trust's proposed internal Public Inquiry Structure. Members noted that the

Department of Health has issued Lookback Guidance that the Trust is required to implement for this Public Inquiry and Mrs Trouton referred members to the Trust's proposed structure to implement this guidance.

Ms Donaghy raised the draft Internal Audit report of their findings into a review of Mr AOBs compliance with relevant authorities/guidance in terms of his private work 2019/20 and asked if there was further action the Trust needed to take as regards obtaining private practice records. Mrs Trouton explained that whilst Mr AOB had contacted over 200 of his patients, the Trust was considering mechanisms for obtaining his private practice records.

6. FINANCIAL PERFORMANCE REPORT

Ms Teggart presented the Financial Performance Report for the 5 months ended 31st August 2021. She reported a current deficit of £12.8m which is in line with the forecast for the year. c£5.8m of the deficit relates to COVID-19 costs and, in addition, c£1.6m relates to Transformation schemes. Additional funding for Covid-19 response is awaited. In relation to payroll, the main areas of overspend are Medical and Nursing. Ms Teggart advised that the Trust awaits indication of any additional allocations to be secured under bids made under October Monitoring Round and hopes to receive confirmation of its revenue budget at the end of October 2021. She advised that the Trust is forecasting to spend all of the capital budget within this financial year. Mr McDonald raised the funding for Covid-19 response and Transformation schemes and sought assurance that this funding will be secured. Ms Teggart advised of ongoing discussions with the HSCB/DoH to secure this in-year funding.

The Chief Executive spoke of the financial challenge for 2022-23.

7. UPDATE ON STRUCTURES REVIEW

The Chief Executive provided a verbal update. Facilitated structured conversations are taking place to help define a proposed model. It is hoped that the final proposal will be brought to SMT by mid October 2021 and new roles recruited to thereafter. The first post to be advertised will be the Deputy Chief Executive.

8. **ANY OTHER BUSINESS**

i) Continuing Healthcare update

Mr Beattie provided a verbal update. He explained that continuing healthcare relates to the current practice of assessing whether a person's needs are primarily health care related or primarily social care related. This assessment can impact on whether the person is required to make a contribution to the cost of their care. Mr McDonald raised the lack of clarity on this matter and the need for clear guidance. Mr Beattie added that the Trust is continuing to work with the DOH, HSCB, DLS and other Trust colleagues, to agree a way forward in respect of CHC. He agreed to provide a briefing note for members on this matter.

Action: Mr B Beattie

Ms Teggart left the meeting for discussion on the next item

9. **UPDATE FROM REMUNERATION COMMITTEE**

The Chair advised that on 2nd July 2021, Remuneration Committee considered a proposal in respect of the commencement salary of Ms Catherine Teggart, Director of Finance, Procurement and Estates who commenced with the Trust on 6th September 2021. The Chair sought Trust Board approval of the recommendation of the Remuneration Committee that Ms Teggart would commence on minimum point of Level 4 scale in line with normal HSC practice.

Trust Board members approved the recommendation of the Remuneration Committee.

The meeting concluded at 9.50 a.m.

SIGNED: _____ **DATED:** _____

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	30 September 2021	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Dr O'Kane/ Mrs M. McClements/ Mrs H. Trouton	
Report Author	Name	Martina Corrigan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

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

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:

Update on work on Patient Reviews

Serious Adverse Incidents (SAI)

All 9 SAI's have now been commented on and finalised and letters of apology for each of the patients / families have been issued and these include timelines of when the Trust will contact the families regarding updates on implementation of recommendations.

Timelines agreed:

- First Update by 30th September 2021
- Second Update by 14th January 2022
- Third Update by 22nd July 2022

Patient Involvement

The first meeting with two of the service users took place 1 September 2021, one service user is a patient and the second is a family member. This was a positive meeting where the Trust were able to update on progress them on the work to date of the Task and Finish Group and we have agreed that this group who will focus on Urology only will meet monthly but information will be shared between meetings so as to inform the service users and allow any of their comments/observations to be fed back to the Task and Finish group.

General Medical Council

The GMC have reviewed 8 of the 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of the ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients and families and has shared patient casenotes with the GMC.

Summary of Activity (31/08/2021)

Patient line - 157 calls/emails up to 31 August 2021

Weekly telephone/face to face/virtual clinics continue to assess patients from Mr O'Brien's review list. The Consultants complete a patient review form for each.

Private Practice

The Trust has prepared correspondence to Mr O'Brien referencing a GDPR legislation clause that may allow access to private patient records on a lawful basis.

Looking Forward

Additional Support for Reviewing Patients

A Service Specification is being prepared by the Trust for the provision of Urology outpatient reviews from Independent Sector providers (1000 cases, initially all from Mr O'Brien's lists) to support the Urology Team in seeing the patients identified as needing reviewed. It should be noted that this is proving problematic in that the ISP are still having difficulty in securing consultants to carry out this piece of work. So the ISP have been are in ongoing discussions with a Limited Liability Partnership Group (LLP) from Manchester to see if they will come over at weekends to see these patients in the ISP premises and a meeting is planned with the Trust and DLS for week beginning 13 September to discuss the indemnity issues.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

Total patients being considered under SCRR is currently 61 patients. The Trust has contacted the British Association of Urology Surgeons to seek additional Subject Matter Expertise (SME) to help conduct these reviews. BAUS has identified six subject matter experts and the Trust is in the process of engaging the team to commence work. A quality assurance process will be required to support this.

Focus on Improvement

SAI Recommendations

In response to the 11 recommendations, the Trust is continuing work on developing cancer pathway assurance audit, to ensure NICAN pathways are adhered to.

The Trust held their second meeting of the Task and Finish group on 5 August 2021 and included the wider Clinical/Managerial and Nursing Teams from all Cancer Tumour sites. Terms of References and actions were agreed from this and there are smaller groups working through each of these actions and these will be updated regularly.

The Trust also has commenced strengthening the MDT team with additional multi-disciplinary members in line with SAI recommendations, including audit support, tracker capacity, Pathology and Radiology input.

Internal Audit

The Trust met with Internal Audit on 13 July and discussed the draft report of their findings into a review of Mr O'Brien's compliance with relevant authorities/guidance in terms of his private work 2019/20. The report has been amended and finalised from these discussions and this is to be presented to Audit Committee in September 2021.

Grievance Appeal

The panel have reviewed the decision of the stage one grievance appeal. The Trust does not have the final report but we understand it to be imminent.

Staff Engagement

No further team meetings have been requested by the teams however on the back of the Minister's written statement and the publishing of the Inquiry's Terms of Reference the team are being offered a meeting should they wish to avail of this.

Communications

The Trust have not received any media enquires since the last report

Public Inquiry Structure

The Trust have now received the Terms of Reference for the Public Inquiry and based on these the Trust attached is the proposed internal Public Inquiry Structure:

Public Inquiry Structure sept 2021.(

Lookback Structure

The Department of Health have issued Lookback Guidance that the Trust are required to implement for this Public Inquiry, in order to implement this guidance the Trust propose the attached structure:

Lookback Structure sept 21.docx

2. Areas of improvement/achievement:

- The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDT's.

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

Corporate Risk Register	The volume of potential patients that may be impacted from this Inquiry and the Trust being in a position to reassure them will be added to the Corporate Risk Register.
Board Assurance Framework	
Equality and Human Rights	

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

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 28th October 2021 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Mr S Devlin, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Dr M O'Kane, Medical Director and Interim Director of Mental Health & Disability Services
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs A Magwood, Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs J McKimm, Head of Communications
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms Susan McKinney, Boardroom Apprentice

APOLOGIES

None

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting.

2. DECLARATION OF INTERESTS

Mr McCafferty declared an interest in agenda item no.9 update from Remuneration Committee.

3. MINUTES OF PREVIOUS MEETING

Ms Donaghy requested an amendment to item no 4iii) SAI Personal Information redacted by the USI She asked that the wording 'as per normal SAI process' be removed from the following sentence:-

Mrs A Magwood and Mrs V Toal had met with Non-Executive Directors on 22nd June 2021 to brief them on the findings of both reviews in advance of the draft SAI being shared with Personal Information redacted by the USI family, as per normal SAI process.

Subject to this amendment, the Minutes of the meeting held on 30th September 2021 were approved as an accurate record.

4. MATTERS ARISING FROM PREVIOUS MEETING

i) Continuing Healthcare

As requested at the previous meeting, Mr Beattie provided a briefing note on Continuing Healthcare as included in members' papers.

5. NEWRY CTCC

The Chair welcomed Mrs A Turbitt, Head of Planning, to the meeting. Mrs Turbitt outlined the challenging timeframe and highlighted the next steps to enable construction to start June/July 2022. The Chief Executive welcomed this facility as an opportunity to develop a new service model for the Newry area. In response to a question from Mrs Leeson, Mrs Turbitt advised that maintenance and upkeep of the facility would be the responsibility of the sub contractor, but acknowledged that there would be elements of day to day maintenance that the Trust would have responsibility for. Allocation of space was discussed in which Mrs Magwood advised that the Trust and the HSCB continue to work with Construction and Procurement Delivery (CPD) Health Projects and the preferred bidder to adjust the current design of the GMS space so it can be used as

flexibly as possible going forward. Members raised the importance of any communications message highlighting that space will be used as flexibly as possible going forward.

Mr McCafferty referred to the Job Start scheme within the Trust and asked that any employment opportunities for care leavers on the project could be factored in. Mrs Magwood stated that this would be explored and brought into the considerations at implementation.

6. **UPDATE ON DORSY UNIT**

Dr O'Kane drew members' attention to a range of actions that continue to be undertaken to improve the service and ensure the safety of patients and staff. She particularly highlighted the Psychological Environment improvements and advised that a Divisional Nurse and Lead Nurse for Mental Health will relocate to Dorsy immediately to address nursing leadership, nursing morale, nursing management of patients and environment as a matter of urgency. She stated that there will be an emphasis on working with ID colleagues to develop a culture of enablement, rehabilitation and positive behavioral support and risk taking (Therapeutic Community ethos).

In respect of the physical environment, Dr O'Kane advised that short term improvements continue to be made with work focused on maximising what space is already there.

Mrs Leeson welcomed the positive changes and asked about the progress of a review of the ID service model. Dr O'Kane acknowledged the challenges of the current model in meeting the needs of patients as well as the pressures on the unit due to the need to provide care for patients from other Trust areas. She advised that this issue was again raised at the regional Directors Oversight Group the previous week.

In relation to safeguarding issues and investigation, Dr O'Kane reported that voluntary police interviews with 7 staff have been completed.

7. i) **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY**

Mrs Trouton provided an update on the following areas:

- **Urology Service Inquiry**

  The Trust has received Section 21 notice requesting 15 pages (77 requests for evidence) to be provided to the Urology Service Inquiry Team (USI) by 4 November 2021. The Trust has started to gather this evidence.

- **Look back**

  There are 75 patients on which the Trust is planning to undertake a structured clinical record review on each due to concerns regarding the quality of care given on first review. Capacity to undertake this work is a concern and the Trust has written to the Department to help to secure regional support for this work.

- **Improvement**

  In response to the SAI 11 recommendations, the Trust is continuing work on developing cancer pathway assurance audit to ensure NICAN pathways are adhered to. The Trust held its third meeting of the Task and Finish group on 11 October 2021 and included the wider Clinical/Managerial and Nursing Teams from all Cancer Tumour sites. The Trust also has commenced strengthening the MDT team with additional multi-disciplinary members in line with SAI recommendations, including audit support, tracker capacity, Pathology and Radiology input.

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The Chief Executive advised of the decision to appoint a Programme Director for the Inquiry, the details of which are to be worked through.

Mrs McCartan stated that the Internal Audit report of their findings into a review of Mr A's compliance with relevant authorities/guidance in terms of his private work 2019/20 was discussed by the Audit Committee at a confidential meeting on 14th October 2021. Due to the clinical governance concerns raised,

Audit Committee members agreed to remit the report to the Governance Committee for further consideration. Mr McDonald suggested that there was value in including some of the actions from the Internal Audit recommendations into the overall improvement strand. Mrs McClements welcomed this suggestion and advised that Dr O'Kane, Mrs Trouton and herself had recently met to consider mapping of the various strands to ensure there is one overall learning and improvement piece.

In response to a question from Mrs McCartan about resourcing of the Urology Service Inquiry, Mrs Teggart advised that this has been communicated to the HSCB and their view is for the Trust to submit a bid in the October Monitoring round.

7 ii) **REPORT OF THE REVIEW OF THE STAGE ONE GRIEVANCE PANEL DECISION IN THE CASE OF MR AOB**

Members considered the above-named report. Mrs Toal reminded members of the Trust's decision to appoint an independent panel to *"review Mr AOB's original grievance panel's decision along with the submissions made and the relevant documentation and to produce a written review outcome determining if the stage one grievance Panel's decision is fair, reasonable and sound."* Members noted that the review panel disagrees with the findings in several elements of the grievance.

Ms Donaghy noted the failings identified and stated that she would reserve comment until the management comments were received. Mrs Toal provided assurance that some changes have already been made based on the learning in respect of Trust's handling of cases relating to Doctors in difficulty. She stated that the Oversight Group will consider the Stage One Grievance Panel report and the Independent Panel's report to identify learning. She agreed to keep members updated on progress.

The MHPS process was discussed in which members sought assurance that the overall framework and procedure would be reviewed and improved. Mrs Toal advised that engagement has commenced to improve the process regionally. She also advised that she has been in contact with Ms June Turkington, DLS who is willing

to organise a training session for Non Executive Directors on the MHPS process.

8. FINANCIAL PERFORMANCE REPORT

Ms Teggart presented the Financial Performance Report for the six months ended 30th September 2021. She stated that the current deficit is £13.8m which is in line with the forecast for the year. c£5m of the deficit relates to COVID-19 costs, however, there is a positive movement in this variance in month due to confirmation of additional funding for Covid response. In addition, c£1.4m of the deficit relates to Transformation schemes. Ms Teggart advised that the Trust awaits indication of any additional allocations to be secured under bids made under October Monitoring Round and hopes to receive confirmation of its revenue budget at the end of October 2021.

The Board approved the Financial Performance Report

9. ANY OTHER BUSINESS

i) General Surgery provision

The Chief Executive advised that a paper on the future provision of general surgery within the Trust will be presented at a confidential Trust Board meeting in November 2021.

Mr McCafferty left the meeting for discussion on the next item

10. UPDATE FROM REMUNERATION COMMITTEE

The Chair advised that on 18th October 2021, Remuneration Committee considered a proposal in respect of the commencement salary of Mr Colm McCafferty, Acting Director of Children and Young People's Services/Executive Director of Social Work. Mr McCafferty's commencement date as Acting Director was 23.9.2021.

The Chair sought Trust Board approval of the Remuneration Committee's recommendation that Mr McCafferty would receive a 10% uplift on promotion in line with normal HSC practice.

The Board approved the recommendation of the Remuneration Committee.

The meeting concluded at 10.00 a.m.

SIGNED: _____ DATED: _____

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	28 October 2021	
Agenda item	Update on Clinical concerns within Urology	
Accountable Directors	Mrs Heather Trouton Executive Director of Nursing, Midwifery & AHPs	
Report Author	Name	Martina Corrigan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

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

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:

Update on work on Patient Reviews

Serious Adverse Incidents (SAI)

All 9 SAI's have been finalised and have now been shared with the Public Inquiry Team. As per the Chief Executive's apology letter to all the families in July 2021 the families have received their first progress report into the recommendations from the SAI's (letter and report attached to this paper).

20210929_Ltrfirst update_template.doc

First update for Families on Serious Ac

Patient Involvement

The second meeting with two of the service users took place on 7 October 2021 this was a positive meeting and as previously advised the purpose of these monthly meetings is for the Trust to update on progress on the work to date of the Task and Finish Group and as advised previously this smaller group will focus on Urology only and information will be shared between meetings so as to inform the service users and allow any of their comments/observations to be fed back to the Task and Finish group.

General Medical Council

The GMC have received all 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of their ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients and families and has shared patient casenotes with the GMC.

Summary of Activity (01/10/2021) Table attached to this report

Patient line - 159 calls/emails up to 30 September 2021 with two new inquiries received since last report 30 August 2021. (it should be noted that both these inquiries were from patients who wanted to tell their experience to the Public Inquiry Team – one positive and one negative), we have taken their details to pass on to the appropriate team.

Private Practice

The Trust discussed mechanisms for obtaining private practice records with RQIA and the DoH on the 28th September, a revised correspondence is being developed involving DoH, RQIA and the Trust.

Looking Forward

Public Inquiry now being referred to as Urology Service Inquiry

The Trust have received the following requests from the Urology Service Inquiry Team (USI);

- Copies of all 9 SAI's
- Contact details for Royal College of Surgeons
- Section 21 notice requesting 15 pages (77 requests for evidence) to be provided to the USI by 4 November 2021.

The Trust have started to gather this evidence and this is being uploaded to a dedicated section in SharePoint and this will be shared with Department of Legal Services who will then pass this information to USI.

The Trust have agreed to appointment of two senior Counsel (Donal Lunny QC and Michael McGarvey Barrister) and the Trust have met with them on 13 October 2021 along with the solicitors who have been assigned to the Inquiry from DLS.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

Total patients being considered under SCRR is currently 75 patients. The Trust has contacted the British Association of Urology Surgeons to seek additional Subject Matter Expertise (SME) to help conduct these reviews. BAUS has identified eight subject matter experts and the Trust is in the process of engaging the team to commence work. A quality assurance process will be required to support this

Focus on Improvement

SAI Recommendations

In response to the 11 recommendations, the Trust is continuing work on developing cancer pathway assurance audit, to ensure NICAN pathways are adhered to.

The Trust held their third meeting of the Task and Finish group on 11 October 2021 and included the wider Clinical/Managerial and Nursing Teams from all Cancer Tumour sites. (as per above section on the SAI's the progress report for this group is included with this paper).

The Trust also has commenced strengthening the MDT team with additional multi-disciplinary members in line with SAI recommendations, including audit support, tracker capacity, Pathology and Radiology input.

Internal Audit

The Trust met with Internal Audit on 13 July and discussed the draft report of their findings into a review of Mr O'Brien's compliance with relevant authorities/guidance in terms of his private work 2019/20. The report has been amended and finalised from these discussions and this is to be presented to Audit Committee in October 2021.

Grievance Appeal

The panel have reviewed the decision of the stage one grievance appeal.

Correction to September report: The panel passed the report to the Trust in August 2021.

October update: Oversight Committee members are reviewing the content of the report and will finalise actions to be taken forward on Monday 25th October 2021 including communication of the review findings to Mr O'Brien.

Staff Engagement

No further team meetings have been requested by the teams however on the back of the Minister's written statement and the publishing of the Inquiry's Terms of Reference the team have been offered a meeting should they wish to avail of this.

Communications

The Trust have not received any media enquires since the last report

2. Areas of improvement/achievement:	
• The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDT's.	
3. Impact: Indicate if this impacts with any of the following and how:	
Corporate Risk Register	The volume of potential patients that may be impacted from this Inquiry and the Trust being in a position to reassure them will be added to the Corporate Risk Register.
Board Assurance Framework	
Equality and Human Rights	

Patients under the care of Mr O'Brien and currently in process of being reviewed
30 September 2021

	Patient Group	Number of Patients in Group	Reviewed to date	Reviewed by	Remaining to be reviewed	Reviewed by	Provisional date	Quality Assured	Comment
Administrative Review Only	***Elective Cohort***	*352 Patients*	*352 (Administrative Review)*	*M Corrigan*	*352*	*Needs Clinical Review*	*N/A*	*No*	***All** are part of the 2309 patients required reviewed between Jan 2019 – Jun 2020. **Review to date only considered administrative processes***
	Emergency Patients (Stents)	*160 Patients*	*160 (Administrative Review)*	*M Corrigan*	*160*	*Needs Clinical Review*	*N/A*	*No*	***All** are part of the 2309 patients requiring reviewed between Jan 2019 – Jun 2020 **Review to date only considered administrative processes***
	Radiology Results	1025 Patients	1025	Professor Sethia	276 (second opinion)	Professor Sethia	July 2021	No	Update from last report: **No change**
	Pathology Results	150 Patients	150 (Result Review)	M Haynes/D Mitchell	0	N/A	N/A	Yes	Update from last report: **No change**
	Oncology Reviews (IS)	236 Patients	200 (Face to Face ISP)	P Keane	36	M Haynes	October 2021	No	Update from last report: **53 (M Haynes & M Corrigan currently reviewing all patients returned to Trust from this exercise)**
	Post MDM Patients	187 Patients	187 (SME Record Review)	Prof Sethia	52 (need second opinion)	M Haynes	July 2021	No	Update from last report: **No Change**

	Patient Group	Number of Patients in Group	Reviewed to date	Reviewed by	Remaining to be reviewed	Reviewed by	Provisional date	Quality Assured	Comment
	Review Backlog	511 Patients	209 (Virtual Clinics)	M Haynes	302	M Haynes	March 2022	No	Update from last report: **No Change**
	Information Line	159 Patients	13(reviewed at clinic)	M Haynes	146	M Haynes/ Prof Sethia	Dec 2021	No	Update from last report: **1 patient**
	Patients prescribed Bicalutamide	933 Patients	747 (Record Review, 26 Face to Face Reviews)	M Haynes	186	M Haynes	March 2022	No	Update from last report: **No change**
	Patients on Inpatient Waiting List for TURP	143 patients	0	TBA	143	Clinical Team	Dec 2021	No	Update from last report: **No change**
	Total	**3856**	**3043**		**1653**				

- **Please note that one patient can be included in a number of the groups listed above**

Southern Health and Social Care Trust

Quality Care - for you, with you

29 September 2021 Ref:

Private & Confidential

Dear

RE: Update on the Serious Adverse Recommendations

Further to my previous correspondence on 21 July 2021, I am writing to you today as agreed with the first update on progress towards implementing the recommendations in the Serious Adverse Incident Report. You will see from the membership of the Task and Finish Group that the Trust has applied these recommendations to all our Cancer Tumour Multi-Disciplinary Teams, such is our commitment to provide assurance to all patients referred into our Cancer Services that the care and treatment is in keeping with best clinical practices.

As you will be aware Fiona (Sloan) has returned to work and I know that Fiona has been speaking with you recently with regard to this update. Once you have had time to review this update should you have any questions please contact Fiona who will have your questions addressed.

Finally I do understand that this remains a challenging time for you and your family and I hope that this update provides you with a degree of assurance that progress is being made with the implementation of the recommendations.

.

Yours sincerely

_____

Mr Shane Devlin
Chief Executive, Southern HSC Trust

Southern Health and Social Care Trust

Update number one - 30 September 2021

The Trust has established a Task and Finish to work through each of the 11 recommendations coming from the 9 Serious Adverse Incidents (SAI's). The group have met on two occasions:

- 5 August 2021
- 13 September 2021
- Next meeting planned 11 October 2021.

The Group is co-chaired by Dr Shahid Tariq, Associate Medical Director for Cancer Services and Mr Ronan Carroll, Assistant Director for Anaesthetics and Surgery and Elective Care.

At the first meeting the Chairs shared the proposed membership of this group and it was agreed that as all of the recommendations applied equally to all cancer tumour sites that the membership should be as illustrated in table one:

Table one

Consultant	Nurse	Manager/Admin
Philip Murphy, Divisional Med Director Shahid Tariq, Divisional Med Director Mark Haynes – Divisional Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, MDT Chair Kevin McElvanna MDT Chair Art OHagan MDT Chair Geoff McCracken, MDT Chair Helen Mathers MDT Chair Rory Convery MDT Chair Christina Bradford MDT Chair Anthony Glackin MDT Chair Marian Korda MDT Chair	Tracey McGuigan, Lead Nurse Sarah Ward Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Cancer Manager Sharon Glenny, OSL Jane Scott OSL Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Clair, Quin, Head of Service Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer

Terms of Reference

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-Disciplinary Teams (MDT's) to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Southern Health and Social Care Trust

Life span of Task and Finish Group

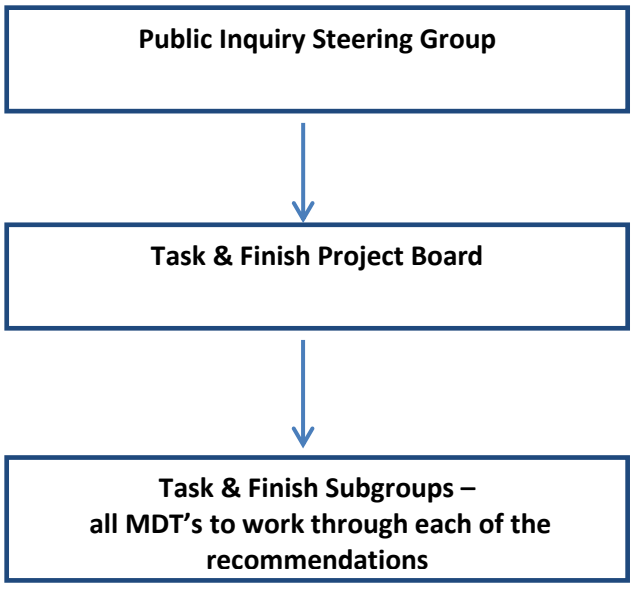
The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.

2. Task and Finish Group will report to the Public Inquiry Steering Group and regular updates will be provided to the HSCB, DoH and families involved in the SAI's.

Governance and Accountability



Frequency of Meetings

Monthly

Southern Health and Social Care Trust

Progress to date:

The Trust has completed an audit based on National Cancer Action Team (NCAT) Guidance (February 2010) for of all our cancer MDT meetings reviewing a number of elements, 1-5 in table two. Each of the elements detailed below have been scored as to whether they have been met in full, partial or are currently not in place.

Table Two

1. The Multi-disciplinary Team
   - Membership
   - Attendance
   - Leadership
   - Team working and culture
   - Personal development & training

2. Infrastructure for Meetings
   - Physical environment for meeting
   - Technology and equipment

3. Meeting organisation and logistics
   - Scheduling of MDT Meetings
   - Preparation prior to meetings
   - Organisation/administration during meetings
   - Post MDT meetings/coordination of services

4. Patient Centred Clinical Decision-Making
   - Who to discuss
   - Patient centred care
   - Clinical decision making process

5. Team Governance
   - Organisational support
   - Data collection, analysis and audit of outcomes
   - Clinical Governance

The Auditors that have carried out this audit on numbers 1-5 are collating the results and also mapping these results back to each of the recommendations which will be shared at the next Task and Finish group in October 2021.

At the next update in January 2022 it is hoped that I will be in a position to provide you with progress on the 11 recommendations.

Report of the Review of the Stage One Grievance panel decision in the case of Mr Aidan O Brien Consultant Urologist Southern Health and Social Services Trust.

Prepared in June 2021 by Professor Ronan O' Hare Assistant Medical Director Western HSC Trust and Therese Mc Kernan Associate HSC Leadership Centre.

June 2021.

Content	Page Numbers

1.0 Background and Context

1.1 Mr Aidan O' Brien Consultant Urologist Southern HSC Trust submitted a grievance in November 2018 and added additional issues in July 2020 at which time the grievance had not been heard. At the time of hearing in July and August 2020 Mr O' Brien had retired from his role.

1.2 The panel appointed to hear the grievance comprised Mrs Shirley Young Associate HSC Leadership Centre and Dr Aisling Diamond, Deputy Medical Director Southern HSC Trust. The grievance investigation was completed in October 2020, and the outcome was provided to Mr O' Brien at that time.

1.3 Mr O' Brien was advised of his right of appeal and an appeal was registered on his behalf by Mr Michael O' Brien by letter of 2nd November 2020.

1.4 The Trust was advised that despite registering his appeal against the findings of the grievance investigation, Mr O' Brien had decided not to participate in the appeal process. The Trust determined that as the appeal process requires the participation of the appellant, it could not proceed. Instead, the decision was made to appoint an independent panel to "review the original grievance panel's decision along with the submissions made and the relevant documentation".

1.5 The Trust appointed Professor Ronan O' Hare Consultant Anaesthetist and Assistant Medical Director Western Health and Social Services Trust and Miss Therese Mc Kernan, Associate HSC Leadership Centre to carry out the review.

2.0 The Terms of Reference for the Review are as Follows:

1. To undertake a full review of the issues of grievance raised in the correspondence to the Trust dated 27th November 2018 and 23 July 2020 from Mr A O' Brien.
2. To review all relevant grievance documentation provided by Mr O' Brien, the documentation gathered by the stage one grievance panel and the stage one grievance panel's decision, as part of the review.
3. To review any relevant notes, data or any other relevant information as part of the review of concerns.
4. To produce a written review outcome determining if the stage one grievance Panel's decision is fair, reasonable and sound.

2.1 The Trust provided a file containing the following information to the panel:

- Response to Stage One Grievance – report of the panel appointed to consider the grievance Mrs Shirley Young and Dr Aisling Diamond.
- Formal grievance from Mr O Brien dated 27th November 2018
- Schedule of documents Appendices 1-49
- Additional Issues raised in July 2020.
- Letter of appeal from Michael O Brien to Mrs Vivienne Toal dated 2nd November 2020.
- Terms of reference for the Review of the Stage one Grievance Panel Decision.

The panel requested additional information from the Trust as follows:

- The terms of reference for the Trust's Oversight Committee and confirmation of the membership. The response from the Trust advised that the oversight group has the role of considering concerns raised about consultants and that at the time concerned (2016) it did not have formal terms of reference. The membership of this group was the Medical Director (Dr Richard Wright) the Director of Human Resources (Mrs Vivienne Toal) and the Director of Service for the area to which the Consultant belonged (Dr Eleanor Gishkori)
- The action plan which was referenced as being developed by Drs Weir and Mc Callister. The Trust advised that there was no action plan available, and that Mr Colin Weir could be asked about this. As the stage one grievance panel referenced in its findings that the action plan was included in an email from Dr Weir the review team has drawn the conclusion that this had not been written up formally and included in the oversight groups papers.
- Mr O' Brien's appraisal documents for the years 2014 onwards. Mr O' Brien's appraisal documents for 2017 and 2018 were provided. The Trust failed to provide the 2014 and 2015 documents.

3.0 Methodology

3.1 The panel independently read and reviewed all the documentation provided by the Trust and met formally on the following dates to discuss the case and to formulate its response:

- 27th May 2021
- 17th June 2021.

4.0 Terms of Reference 1

To undertake a full review of the issues of grievance raised in the correspondence to the Trust dated 27th November 2018 and 23 July 2020 from Mr A O'Brien.

4.1 It is important at the outset to state that the review panel has undertaken to review all the information which has been provided to it with due care and attention. It is conscious that there is a crossover in the terms of reference, and it is not therefore possible to deal discreetly with one element without referencing another. We have therefore in considering Mr O' Brien's grievance issues, considered the responses which have been made by the Stage one Panel to these.

4.2 In his issues of grievance Mr O Brien has raised the acts and omissions of senior managers within the SHSCT in respect of the handling of concerns around his administrative practices, and that their actions and failures constitute a breach of Trust policies and procedures and a breach of his contract of employment.

4.3 The review team notes that the stage one grievance panel has not upheld this aspect of the grievance. While we do not accept that there is a breach of contract established and the approach taken by Mr O'Brien to attempt to argue that the approach was in breach of his contract of employment, we are concerned that no account has been taken of the failures of senior managers within the Trust in respect of discharging their responsibilities.

4.4 The grievance panel acknowledges that there was action taken by Mr Mackle and Martine Corrigan to meet with Mr O Brien in March 2016 to discuss concerns and that this was followed by a letter confirming the discussion and the need for action on the part of Mr O' Brien. The letter was sufficiently explicit in respect of an action plan being required. No response or action plan was received.

4.5 Mr O' Brien in his evidence suggests that he was responding by 1) arranging for the return of the patient notes from his home and 2) writing up letters when he was on sick leave months later; however, we do not accept that there was any real plan submitted in a prompt manner following receipt of the letter. He also references throughout his grievance that the Trust failed to approach this in the correct manner. While the grievance panel did not agree with this, from our perspective we are concerned that Mr O' Brien appears to focus on the perceived procedural weaknesses of the case and less on the seriousness of the issues raised.

4.6 In these matters we disagree with the conclusion of the grievance panel and do not find that there was appropriate action taken to affirm the seriousness of this situation. We do not base this purely on the lack of any follow up communication to Mr O' Brien but have noted other evidence contained within the documents. In witness statements it is indicated that the approach which Mr O Brien had to his work was known for years. It is reasonable then to conclude that if this were known for years and was his practice, that it would have taken more than the informal March meeting and the single letter to stress the seriousness with which this matter was viewed. We have noted the reference to Mr Mackle stepping down from his role in April 2016, but do not accept that this in any way explains the lack of follow up.

4.7 The matter was not referenced again until it came before the oversight committee in September 2016. At this time, the question of Mr O' Brien's practice was raised again and while there was an agreement that this needed to be addressed, an alternative approach was proposed by Dr Gishkori and was agreed by Dr Wright. The matters discussed and the action plan which was mentioned by other consultants with whom this had been discussed once again was not raised with Dr O' Brien. At the following month's oversight committee (October 2016) it was confirmed that given that he was due to go [redacted] in November and would be absent for a period thereafter no action had been taken to bring matters to his attention. The action plan which was available from the 16th September was not shared, and there is no explanation as to why this was not immediately actioned or why a further two months was lost (September to November) in making progress with the issues of concern.

4.8 While the grievance panel found that Dr Wright and the Oversight Committee had a reasonable basis for assurance in September 2016 that Dr Gishkori and her team would have actions in place on which progress could be reported at the meeting in October 2016, it also noted that this did not happen. Mr O' Brien had not been told of discussions at the Oversight Committee, some 5 months since they were first held which we find incredible particularly in the absence of any explanation. To advise that Mr O' Brien was [redacted] in an October meeting and to propose delaying even further raises a question as to the seriousness with which these "concerns" were viewed. The senior managers who did not act to bring these matters to Mr O Brien's attention had a responsibility to do so and are accountable for their failures to act in accordance with their own professional codes.

4.9 The grievance panel indicates that 9 months had passed by the time the December 2016 meeting of the Oversight Committee was discussing the SAI and that Dr Wright and the Oversight Committee were entitled to escalate to a formal MHPS investigation in the context of:

- The absence of assurances about progress made to manage and attend to the concerns.
- The Serious Adverse Incident.
- The information provided on the quantum of the alleged performance matters.

4.10 While we accept that the Medical Director can at any time initiate an MHPS investigation on foot of concerns being identified, what is clear is that the issues were known of from January 2016 and the SAI itself was the likely prompt for the initiation of the investigation and not the other issues which are stated above. We conclude that the failures to follow up from the March meeting, the reporting and development of the action plan in September and lack of action on this and agreed deferral at the October meeting suggest that if the SAI had not arisen that the question of an MHPS investigation may have been delayed even further or not have arisen at all. The plans to work around Mr O Brien are likely to have continued as they had for years previously.

4.11 Mr O Brien also complained of the decision made by the case manager to classify the case against him as a case of misconduct.

4.12 The review panel considered this aspect of the grievance, considering the full report produced and the range of options which were open to the Case Manager. We noted that in consideration of the facts established the Case Manager had taken appropriate advice and on foot on all this there was a finding of misconduct. This in our view was correct as the report clearly identifies the failings which Mr O' Brien demonstrated some of which he acknowledged in the document entitled response to the formal investigation. It is noted also that there is a limited scope for the grievance panel to challenge the determination of the Case Manager and agree that this was not the appropriate forum for Mr O' Brien to question this.

4.13 Mr O Brien also complained of the time taken to handle his grievance.

4.14 The review panel noted the significant time that was taken to progress the grievance and while recognising that this was protracted and longer than might ever have been predicted at the outset, the matters of grievance were complex. It is evident that there was a need to engage with a range of different people throughout this process. Mr O Brien was also a contributor to the lengthy timeframe and the addition of this element of his grievance to the original grievance in July 2020 did not help matters. This too served to extend this further and it is therefore understandable that progress was delayed. It is also our view that a grievance taking from July 2018 to October 2020 to report is unacceptable.

5.0 Terms of Reference 2

To Review all relevant grievance documentation provided by Mr O'Brien, the documentation gathered by the stage one grievance panel and the stage one's grievance panel's decision, as part of the review.

5.1 The review panel has examined all of the documentation gathered by the grievance panel and the statement of grievance and appendices submitted by Mr O' Brien.

5.2 In looking at the decision of the Stage One panel there are elements of this that we feel are not justifiable. In addition to reading and assimilating the information which has been used to support the decisions we accept that the panel has interviewed individuals and will have formed opinions on that basis. Our review has not extended to meeting witnesses but has relied on the detailed information provided.

5.3 We note particularly in the summary of conclusions by the panel the following:

- 6.1 Overall we do not find Mr O Brien's grievance upheld.
- It is notable that the panel use the term "overall" which suggests that they have essentially weighed the issues identified against the evidence available but in the consideration of these there is more weight given to what is "against" than "in favour of" Mr O'Brien. The panel has determined that some of the matters of which he complains are not supported by evidence which it has gathered through documents, witness statements and interviews or that the evidence of Mr O' Brien has less merit than the actions that the Trust has taken in respect of the concerns that it had in respect of his performance as a consultant.

5.4 While we accept that there are several of the issues of grievance where we accept the finding that the Trust's actions have been reasonable and justified, we find that the conclusions reached have not addressed the failures on the part of Trust managers in addressing their concerns and responsibilities in a prompt and thorough manner. This, is given "light touch" treatment in the findings and does not appear to have been influential in the "overall" outcome. We hold the view that this is a weakness in the outcome and is fundamentally unfair.

5.5 An example of this is at paragraph 6.2 which relates to the use of the MHPS framework by the Trust. While it is acknowledging that there were issues on the part of both the Trust and Mr O' Brien which compromised the operation of the Framework in the way it was intended, as regards the setting aside of the timescales, and the failure of Mr O' Brien to actively participate in the early resolution of the issues which were brought to his attention in March 2016, the finding in this regard is unjustifiably in our view, more supportive of the Trust.

5.6 It has been evidenced that Mr O' Brien had been advised at a meeting and subsequently received a letter confirming the nature of the concerns. While this letter advised that these governance issues must be addressed and asked for a response with a commitment and immediate plan to address these, it is also established that this letter brought no response. No follow up was initiated, there appears to be no-one to whom the responsibility to do that was assigned and for months nothing happened. The inaction in relation to follow up while not excusing Mr O Brien's interpretation in this regard does in our view suggest that the seriousness of this was not as was later argued and gives more weight to his inaction.

5.7 In paragraph 6.3 of the grievance panel report the failure to follow up on the March letter to Mr O' Brien is referenced, and the fact that he was not made aware of the approach being suggested by Ms Gishkori to address the problems did not take away from the Medical Directors responsibilities to have concerns examined and the "time for informal resolution had passed". We accept that the Medical Director has the right to escalate a problem that he judges merits formal investigation, however the reference to these two sets of facts in the one paragraph seems to create a diversion to the seriousness of the failure to make Mr O' Brien aware of the outcome of the oversight committee in October, the subsequent discussions which were going on around that and of the plans to tackle the problems. The Medical Directors right to act in this way in no way excuses the inaction of all parties up to this point. We would contend that where "informal resolution" of any issue is proposed it is predicated by the parties involved being at least aware of the issues.

5.8 At 6.4 in the report of the grievance panel report the delays in progressing this grievance and progressing the MHPS investigation are referenced. We have previously commented on this. It is recognised that there was a contribution to the delay by both the Trust and Mr O' Brien. In relation to concluding the MHPS investigation, we find that this should have been concluded in a timelier manner. If this investigation were as serious as it is purported to be the investigator should have been given time out of her normal commitments to carry out the interviews necessary and have the report completed. This did not happen but is not referenced. There was no one pressing the completion of these matters irrespective of the breach of the published timeframes.

5.9 While Mr O Brien complains about the timescale of these matters, he too contributed to this and while some delays are understandable and acceptable other simply are not. The Trust has contributed to this and while one might argue that the parties are equally culpable, the Trust as the Employer has the responsibility take control of the process and the timescale for completion. It's general acceptance of the slow pace and failure to seek to have the grievance closed out at an earlier point deserves mention.

5.10 At 6.8 of the findings of the grievance panel the failure of Mr O' Brien to "engage meaningfully" at an "early point" is referenced as being a significant factor in the failure to find a resolution to the concerns. It notes that any chance of resolution and support may have avoided all that subsequently followed. We do not agree that this is a fair assessment. It relies again on the March 2016 meeting with him and subsequent letter as the evidence to support this and ignores the discussions that were held subsequently at which dialogue and discussion were held by other senior colleagues and which were not shared with him.** That the panel concluded the events which unfolded may have had some opportunity for resolution is quite disturbing. To lay the responsibility for this completely at the door of Mr O'Brien is disproportionate. There was an absence of concise and proper management of the concerns held about Mr O'Brien by Trust management which was not just an issue at the time but appears to have been known of for years.

5.11 At 6.9 of the findings the grievance panel references 3 key facts as the catalyst for the initiation of the formal investigation. These were noted as:

- The absence of a response from Mr O' Brien as requested
- The lack of active follow up within the Directorate to Ms Gishkori's alternative plan in September and October 2016
- The potential for an SAI

We note these to be different to the points which were referenced at 2.2.32 in the panel report in which it is stated were the factors in the decision by Dr Wright to proceed with the formal investigation:

- The absences of assurances about progress made to manage and attend to the concerns.
- The serious adverse incident
- The information provided on the quantum of the alleged performance matters.

5.12 At 6.10 of the grievance panel findings it concludes that in the absence of an assurance of a viable alternative and given that all earlier "intended interventions" outside of the formal MHPS had failed to deliver progress let alone closure, that his actions were reasonable. We have commented earlier that we accept the right of the Medical Director at any point to initiate a formal MHPS investigation, where he feels the circumstances merit such. On this occasion it was the "potential for an SAI" that is noted, and while initially pointing to the responsibilities of others, this is changed to the absences of assurances which is nonspecific and suggests responsibility lies wholly with Mr O Brien.

5.13 Our consideration of the grievance panel's finding in this regard, again ignores an important consideration which we feel is obvious throughout this case. There is an absence of thorough and proper management of the concerns raised in respect of Mr O'Brien and of the management of Mr O'Brien himself. In this respect and as highlighted in earlier paragraphs that we conclude that the stage one grievance panel has not judged the grievance fairly. We hold the opinion that there are several of Mr O Brien's complaints that should have been upheld or partially upheld.

We would not have judged this grievance in an "overall" context but in terms of the individual aspects of it and would we believe have succeeded in achieving a more balanced outcome.

6.0 Terms of Reference 3

To review any relevant notes, data or any other relevant information as part of the review of the concerns.

6.1 The review panel sought evidence in respect of Mr O Brien's appraisals from the Trust. The reason for this was to check to see what had been raised in the years concerned and prior to 2016 relating to workload. This was referenced at various points in the documentation as contributory factors in the inability to triage and write up clinics. The documentation which was provided related to 2017 and 2018 and not to the period prior to the events which arose in 2016. In both years, the appraisal documentation demonstrated positive appraisal.

6.2 There is a reference within the documentation to the emergency, on-call and out of hours responsibilities. One of the responsibilities is noted as triaging 150-190 urological referrals received during the week (One in six- week commitment). The 2018 appraisal document expressed the difficulties in dealing with demand/ supply issues and the challenges of this for Mr O' Brien. A reduction in the job plan was recorded. It further references that the greater part of the failure of patients to receive a safe quality service has been due to its inadequacy in all its forms. Mr O Brien also notes that he is seeking clarification of roles expected of the urologist of the week and refers to a meeting with Senior management in December 2018 being cancelled. This meeting had been set up to look at the Trust's expectations of the undertakings of the Urologist of the week.

6.3 In 2017 the Job plan does not reflect the amount of work carried out although the ongoing investigation is referenced as is the period of exclusion. These documents record the impact of the issue of concerns on Mr O Brien's health.

6.4 In the years for which we had sight of the appraisal documentation it is not perhaps surprising that Mr O Brien referenced the volume of work, the triage challenges and the failure of management to engage to resolve these matters. What we would have been keen to identify is whether these matters formed any part of the previous years' appraisal or not. We cannot determine the extent of effort Mr O Brien made to bring the problem to the attention of his employer before 2016, and what if any effort was expended by management to address the problem.

6.5 This panel was invited by the Southern Trust to review the previous Grievance panels' decisions and processes. Appraisal and revalidation are the cornerstone of medical governance and allows bilateral discussions, job planning and personal development from both parties. To furnish this panel only partially with Mr O' Brien's appraisals, leaving out the most important years 2014/2015 is concerning, despite several requests.

The decision of omission has been made by the current management team.

This fact needs highlighted to the current Chief Executive and Trust Board.

6.6 While in one of the appraisal documents there is reference to a reduction in the job plan in the grievance papers the review team could find no evidence of any connection from this to the job planning process. We could not evidence if any change to the job plan had been introduced to address the administrative weaknesses.

6.7 We fully accept that Mr O' Brien had a responsibility to review his practice, be that volume of work, triage arrangements, reporting back to GP's, to ensure that he was not compromising the treatment of any patient and that the Trust had a responsibility to question this, we acknowledge that their tardiness in so doing was wrong.

6.8 In the conclusions reached in the report of the Case manager, while finding that the failings of Mr O Brien should rightly be considered by a conduct panel and action plan there was another important finding. It is reported that there were "systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O' Brien and that no one formally assessed the extent of the issues or properly identified the potential risk to patients. The review panel notes that while there is a recommendation that an independent review is undertaken of the administrative processes there was no learning identified in the processes so far undertaken, which we would have expected to be included.

7.0 Terms of Reference 4

To produce a written review outcome determining if the stage one grievance panel's decision is fair, reasonable and sound.

7.1 As a review team we acknowledge that we have not had the benefit of meeting with Mr O Brien although have had full access to his grievance submission. We have had sight of all documents which the Trust provided to the grievance panel in this matter. We requested additional information which, where it existed was provided except for the Appraisal documents as referenced earlier. Not having these documents to determine whether Mr O' Brien raised his concerns about triage/workload/ expectations of trust management we believe has not been helpful to us but is also an oversight by the grievance panel.

7.2 In the preceding sections of this report we have commented on the elements of the grievance panel's decision which give us cause for concern. Fundamentally we have accepted that there were problems with the administrative practices of Mr O' Brien which were known for years, within the Directorate and on a wider basis. While we accept that Mr O Brien's approach to this being raised was initially to ignore it, the absence of timely follow up did not affirm the seriousness with which the Trust was viewing this but supported his casual approach to it.

7.3 Mr O Brien's subsequent approach by way of raising a grievance which took some 2 years to conclude has served no-one well. While some elements in our view were appropriate to grievance processes others are not. This was commented on by the grievance panel and it is difficult to know if this was intentional. While we cannot judge intent, it had the impact of obfuscating progress.

7.4 The most troubling concern that we have in relation to this matter is that throughout this time there is little mention of patients and the degree to which the failure to triage and report and then subsequent ongoing delays in processes all served to compromise patient care. The case manager's report confirmed significant numbers of patients untriaged (783) and it was determined had this been done, 24 of these would have been to red flag status which impacted on the assessment and planning of their treatment and care. Of this 24, 5 have gone on to have a cancer diagnosis and their treatment was delayed by the failure to triage. There was an awareness even in the Medical Director's office that this was the case, yet patients continued to be compromised while this was not addressed. The Medical Director was aware of the extent Mr O Brien's misconduct in January 2016 but failed to make a practical intervention until December 2016. During this period, there was no regard to patient's wellbeing. Other doctors and nurses with managerial responsibility also failed to take action in relation to this misconduct. Indeed, these individuals also have issues in relation to their own conduct and professional obligations in relation to the safeguarding of patient's safety.

7.5. Finally, it has already been indicated that the review panel disagrees with the findings in several elements of the grievance. Their taking an "overall" approach has resulted in an outcome that is not totally fair and while acknowledging in different elements the failings of those concerned, does not appear to take this into account in the conclusion reached.

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

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 27th October 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals
Dr D Gormley, Deputy Medical Director (for Dr D Scullion)

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs L Leeman, Interim Director of Performance and Reform
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Interim Director of Medicine and Unscheduled Care
Mrs T Reid, Interim Director of Surgery & Elective Care, Integrated Maternity & Women's Health, Cancer & Clinical Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Dr D Scullion, Deputy Medical Director
Mrs R Rogers, Head of Communications

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

2. **DECLARATION OF INTERESTS**

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. Mr Beattie declared an interest in agenda item no 9 and left the meeting when this item was being discussed.

3. **MINUTES OF MEETING HELD ON 29th SEPTEMBER 2022**

The minutes of the meeting held on 29th September 2022 were approved as an accurate record.

4. **MATTERS ARISING**

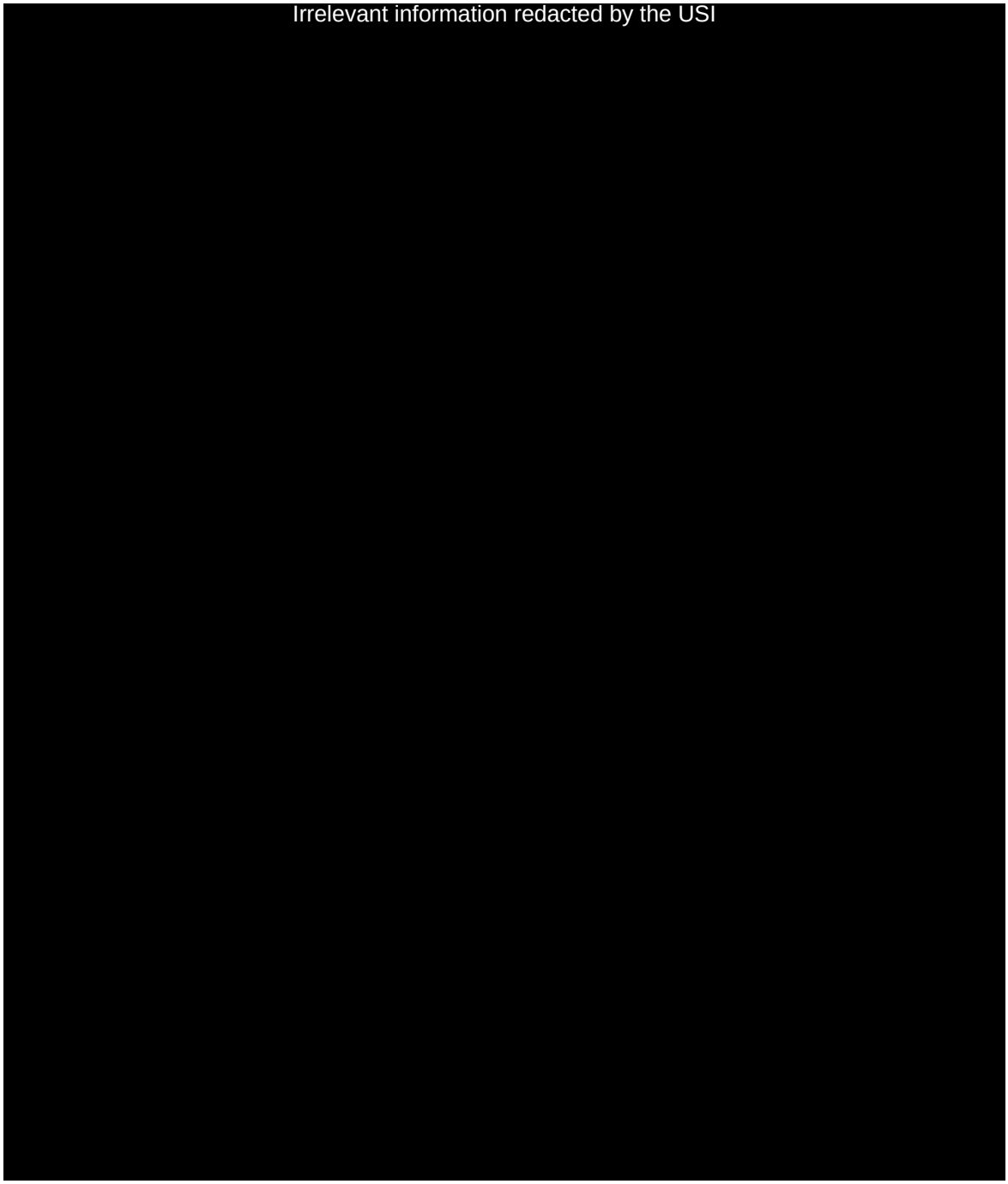
i) Adult Protection Safeguarding referrals

As requested at the previous meeting, Mrs Cathrine Reid confirmed that a paper would be brought to the next confidential meeting in January 2023.

5. Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

[redacted]



Action: Ms McGall

6. **ENDOSCOPY**

Mrs T Reid advised members that during a validation process in July 2022, it was noted that one patient on the Lower/Upper GI "over 100 day" report, was awaiting a red-flag endoscopy procedure who, when cross-referenced with the actual Red-Flag Endoscopy Waiting List, was discovered not to be on the Red-Flag waiting list. She explained

that the demand for red-flag endoscopy within the Southern Trust currently outweighs the capacity available, thus the Endoscopy Schedulers book chronologically from the Red-Flag Waiting List therefore essentially if a red-flag patient is not on this list then they will not get booked. Mrs Reid explained that this patient was being listed as requiring an urgent planned endoscopy with a free text comment stating 'Red Flag' and therefore, as confirmed by the Clinician, was listed for the incorrect waiting list.

Mrs Reid stated that a decision was taken to manually check the total Endoscopy Waiting Lists to establish the extent of the problem. The outcome of the manual check for red-flag comments on total Endoscopy Waiting List was included in members' papers. A total of 8817 patients (GI Endoscopy and Cystoscopy) were reviewed with 35 having a 'red flag' comment detailed in the waiting list free text comment box (31 GI Endoscopy and 4 flexible Cystoscopy patients). Following an extensive exercise, 5 of the 31 GI Endoscopy patients and all 4 Cystoscopy patients were established to be 'true' red-flags and had experienced delays in their treatment pathway because they had been on the incorrect Endoscopy Waiting List. As a further safety net, Mrs Reid advised that it was further decided to undertake an extended review of all the patients i.e. less than 100 days to ensure that all patients on the cancer pathways awaiting a Lower and/or Upper GI Endoscopy were also on the Red Flag Endoscopy Waiting List. The outcome of this identified another 18 patients who appeared to be on the incorrect waiting list. Following an extensive exercise, 3 of the 18 patients were established to be true red flags who have experienced a delay in their treatment pathway because they had been on the wrong Endoscopy Waiting List. Of note, all 3 patients underwent an initial endoscopy which was incomplete and thus required to have a repeat GI endoscopy at a later date. These 3 patients were added to the Urgent Planned Waiting List for a repeat procedure as opposed to being put back on the red-flag waiting list.

Lessons learned were discussed. Mrs Reid stated that PAS is an antiquated system that does not have a separate urgency code for red flag patients. One area of improvement made is that now all patients added to the red-flag waiting list also have the comment 'RF' included on the Admission Reason Field on PAS. This will allow for red-flag patients incorrectly coded on the Urgent, Routine or Planned Waiting Lists to be easily identified. Standard Operating Procedures

(SOP) on how to add patients to the waiting list have been reviewed. The monitoring of the waiting lists have been strengthened with a new member of staff appointed to provide this monitoring assurance.

Mrs Reid raised a recurring issue with regards to the addition to the waiting list for repeat procedures as these are often confused with planned procedures. There is no data definition and this has been escalated to the Trust's Data Quality Team and to the Regional Data Quality meeting. This issue has also been discussed with the Trust's Endoscopy Clinical Leads and it has been agreed that planned versus repeat procedures will be added to the next Endoscopy Users Group agenda so that an interim arrangement can be made as to how the Trust manages these patients internally whilst regional guidance is awaited.

Mrs Reid stated that the incident has been screened as a Serious Adverse Incident with the incident review meeting planned for December/January.

Mrs McCartan asked if there has been a deterioration in the patients' clinical situation as a result of being on the wrong waiting list. Mrs Reid agreed to bring the outcome of the review process to the next meeting. Mrs McCartan asked if patients would be informed to which Mrs Reid confirmed that they would be as part of the SAI process. Mrs McCartan made reference to the upgrade of the PAS system and noted that this will not occur until Encompass is progressed which she stated will take some time to implement. Mr McDonald asked for assurance that this issue is less likely to happen from hereon in. Mrs Reid referred to the areas of improvement such as the PAS system where processes have been strengthened to reduce the risk of re-occurrence. She stated, however, that there will always be an element of human error when performing a repetitive task.

Action: Mrs T. Reid

Mrs Toal welcomed the work to review the SOPs and asked if there were any plans to review those admin processes in general that support clinical work. Mrs Trouton advised that she had undertaken responsibility for Functional Support Services in September 2022 and admin services within Acute is part of that responsibility. She raised

the difficulty recruiting into admin posts currently and stated that Mrs Reid and herself were working on a proposed admin structure. Mrs Leeman spoke of work Mrs Reid and herself are progressing to develop a centralized elective access team. This will help ensure good governance processes and efficient use of resources to safely maximize available outpatient, inpatient and day case activity.

Mrs McCartan asked if there was a reputational risk to the Trust at this point. Dr O'Kane responded by advising that there has been openness and candour with those patients affected and the issues were being well managed within Endoscopy. Early Alerts have been submitted to the Department and they have not advised that the Trust needs to take further action. The Chair spoke of the importance of raising problems and issues so that action is taken and lessons learned.

7. CYTOLOGY

Mrs T Reid spoke to a paper which provides an update on the historic underperformance of two screeners within the Cervical Cytology Service. She informed members that the Acute Directorate had raised concerns with the Senior Management Team in July 2022. The two screeners had ceased reporting in early October 2021. The service was concerned that cervical cancer cases were being picked up through the annual audit of invasive cancer that related back to one of the two screeners that were underperforming. It was agreed that an assessment of the risk needed to be carried and a decision taken as to whether a lookback exercise would be required. Two meetings were held with Public Health Agency (PHA) on 4 and 11 August 2022 to discuss the issues that were raised by the Trust and to consider further actions that may be required to address the concerns.

Mrs Reid advised that in accordance with the Department of Health's Regional Guidance for Implementing a Lookback Review Process, the Trust and the PHA have established a Steering Group and commenced stage 1 of this process - *immediate action, preliminary investigation and risk assessment*. The first meeting of the Steering Group was on 20 October 2022. As part of this process, the Trust has commissioned the input and advice of cervical screening subject matter experts from the Royal College of Pathologists. In relation to

the cases of concern identified through the audit of invasive cancer for 2021 referenced in the initial early alert, it has been proposed by the PHA that these cases are externally reviewed. PHA are to confirm which laboratory outside Northern Ireland will undertake the review of these slides. The Steering Group will meet monthly. It is expected that the initial risk assessment will take around 8-10 weeks to complete.

Mrs Reid advised that on 3 October 2022, the SHSCT and WHSCT received a media query from BBC in relation to Smear Tests. This query was seeking details in relation to smear tests carried out from January 2011 to June 2022 and any underperformance issues identified and actions taken. She stated that this query may have been prompted by a Serious Adverse Incident report linked to cervical cytology, which was completed by WHSCT with input from SHSCT. A high level response was agreed with the PHA and has been provided to the BBC with the offer of a follow up meeting.

Members noted from the briefing paper that subsequent to the meetings with the PHA in August 2022, two senior staff members from the Cervical Cytology Team had a period of sick leave, however, both have now returned to work. Mrs Reid stated that there continues to be a significant backlog of smears waiting to be reported. This is partly due to reduced reporting capacity with two screeners no longer reporting smears from October 2021. Two locums have been employed and the team is working to reduce the backlog, however this will take several months.

Ms Donaghy queried the fact that the initial risk assessment would take around 8-10 weeks to complete. She also raised concern at the underperformance issue and asked how a Screener who was underperforming could then be employed by another Trust? Mrs Toal advised that from an HROD perspective, this requires a further look at how the Trust deals with underperformance going forward. . Mrs Leeson raised the issue of professional accountability and support going forward for Biomedical Scientists to which Mrs Trouton advised that in the interim period, they would report through the Assistant Director for AHP Governance until there was regional agreement under which Professional Structure they should sit .

Mrs McCartan requested that the next update to Trust Board includes actions with timescales. The Chair stated that if members have any additional questions on this item, that they forward these to her office for collation and response.

8. UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. An update report was included in members' papers.

Members noted that the formal Public Hearings will begin on November 8th 2022 at 10am when open statements will be heard over three days. The Chair of the Inquiry and Senior Counsel to the Inquiry will make the first opening statements, which are scheduled at this stage to extend over two days. Counsel for the remaining core participants - Southern Trust; Department of Health and Mr AOB - will deliver opening statements on November 10th and each have been allocated one hour. Hearings will continue w/b November 15th; w/b November 29th and w/b December 6th, for three days each week. There is a reserve day on December 13th in case of over-runs, with hearings due to resume w/b January 24th 2023. Mrs McKimm stated that the Public Hearings are live streamlined and encouraged members to log on and watch.

Mrs McKimm advised that the discovery process continues with around 30 Section 21 notice responses in progress. The Trust continues to assess the impact of staff absence during the Public Hearing process and to liaise with the SPPG on this issue to minimize the impact on patient care.

Dr O'Kane stated that the first meeting of Public Inquiry Programme Management and Assurance Board took place on 12th October 2022. Following feedback, it was agreed to further review the external assurance process to ensure it is providing a clear and independent challenge function to Trust response to the Public Inquiry. Dr O'Kane spoke of Structured Judgement Reviews to assist in a quicker learning process.

Dr O'Kane spoke of a useful visit by the Chair and other representatives from the GMC to the Trust on 25th October 2022.

Mrs McKimm left the meeting at this point

Mr B Beattie left the meeting for the next item.

9. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair presented her Remuneration Committee Chair report and sought approval of the Remuneration Committee recommendation in respect of the remuneration of Mr Brian Beattie who has been appointed as Director of Adult Community Services with effect from 1st October 2022. It was the recommendation of the Remuneration Committee that Mr Beattie would receive a 10% promotional increase on his current substantive Agenda for Change salary, in accordance with normal promotional arrangements.

Trust Board approved the recommendation of the Remuneration Committee

10. **ANY OTHER NOTIFIED BUSINESS**

None

The meeting concluded at 10.00 a.m.

Southern Health and Social Care Trust

Quality care – for you, with you

TRUST BOARD COVER SHEET

Meeting Date	27 January 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Mrs Heather Trouton	
Report Author	Name	Martina Corrigan
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

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

WORKING TOGETHER EXCELLENCE COMPASSION OPENNESS & HONESTY	*This report cover sheet has been prepared by the Accountable Director.* *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:

The Trust's has established a Public Inquiry Programme Board. The Programme Board will be convened by the Chief Executive and will oversee the work of the Public Inquiry Response Steering Group, the Urology Lookback Steering Group and the Quality Assurance Oversight Group.

Urology Lookback Steering Group
Chair – Director of Acute Services

The meetings for this group commenced in November 2021 and are held every two weeks on Monday mornings.

The Urology Lookback Steering Group will provide oversight in respect of patients identified as previously being under the care of Mr O'Brien. The Group will also be responsible for providing the DOH with assurance regarding the rigour of approach pursued by the Southern Trust and the timeliness of patient review.

Patient Involvement

Monthly meetings continue to be held with two Service Users who have asked to be involved in the Task and Finish Group for the SAI recommendations implementation. There is an action plan for the meeting which incorporates the actions for all cancer specialities not just Urology. Service users have been involved in developing patient feedback resource and have also contributed to the formatting of the letters being sent to patients and relatives. Updates from the monthly Task and Finish Super Group (monthly meeting with representation from MDT Leads) are shared with service users to provide oversight of the work progressing across all cancer sites. All baseline assessments, audit tools and supporting policies, procedures and guidelines are provided to service users also.

General Medical Council

The GMC have received all 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of their ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients and families and has shared patient casenotes with the GMC

Summary of Activity Table attached to this report

Trust Board Cover Sheet Urology Januai

Please see attached table for breakdown.

Capacity

As detailed in the attached table by end of January there will be 135 patients remaining to be seen with a plan in place to see these remaining 135 patients by end of March 2022. Three consultant urologists have committed to WLI and have displaced PA sessions and admin into own time. CNS have also committed to overtime to support these additional clinics. Patients in review backlog, those who contacted Information line and those subject to SCRR are priorities. Own consultants waiting list patients are being displaced to accommodate which is of concern to the Clinical staff. As patients are seen there will inevitably be need for further capacity for eg diagnostics as necessary. Table attached details the planned activity from January to March.

Private Practice

The Trust discussed mechanisms for obtaining private practice records with RQIA and the DoH on the 28th September, a revised correspondence is being developed by DoH based on the discussion with RQIA and the Trust.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

As per the above attached table there were 77 records identified as requiring an SCRR. Internal screening process has been completed and there are a total of 65 patients who will have an SCRR completed by the team who has been established for completing the SCRR. Out of the original 77 patients there are a further 6 patients who need an extensive note review to determine if they require an SCRR. There is also an additional 2 patients who have since been identified as meeting the criteria for an SCRR but the Trust have requested guidance from the DoH as to whether this process should continue for any patients identified as meeting the criteria of an SAI.

- The SCRR Process is based on the principles and methodology found in the Structured Judgement Review (SJR) process from Royal College of Physicians. It incorporates quality judgement over phases of care.

Information Line

Urology Information Line reopened from 12 December 2021. To date only two calls have been received and another three patients have contacted the Inquiry email. All of these patients had care reviewed and no concerns identified

Public Inquiry Response Steering Group

Chair – Director of Nursing, Midwifery and AHP's

The meetings for this group commenced in November 2021 and are held monthly on Friday afternoons.

This group will ensure there is an effective response to all requirements of the USI ensuring that all information as required by the USI panel will be made available and shared within the timescales requested. The group will ensure that there are robust data management systems in place to manage all information; collation, storage and transfer and in line with all information governance requirements. The group will ensure as far as is within the gift of the group that there is full openness, transparency and disclosure of all relevant documentation. It will also oversee the support of all staff involved in the Public Inquiry, ensuring that, legal, professional and psychological support is available for all staff / ex staff. The group will also ensure there is an effective communication plan in place both internally within the organisation and externally to inform the public where appropriate. The group will liaise as required with the Trust Lookback Steering group and the Quality Assurance Oversight Group. It will also link in with HSCB and DOH as required

Urology Service Inquiry

The Trust continues to work with the Urology Service Inquiry Team (USI) on providing evidence as outlined in the Section 21 notices. The Trust has now transferred evidence in relation to Section 21 notices for the three deadlines; 4 November 2021, 3 December 2021 and 10 December 2021. The Chief Executive has been serviced a Section 21 notice and is currently working with Senior Counsel in finalising this for end January 2022. The Trust met with our Senior Counsel in late December and outlined to them the difficulties that the Trust could be potentially facing in light of the ongoing pandemic and a letter was sent on our behalf to the USI detailing the predicted unscheduled and

staffing pressures that the Trust would be facing during January. The USI took recognition of this correspondence and agreed not to send any section 21 notices to the Trust during the first six weeks of 2022 without first having a discussion via DLS on the timescales.

A number of meetings with key personnel (Chief Executive, consultant urologists, managers etc) and senior counsel are currently being set up and will commence from 1st week in February 2022.

Quality Assurance Oversight Group.

Chair – Trust Medical Director

The meetings for this group will commence on 31 January 2022 and will be held monthly.

The group will ensure there are effective quality assurance processes regarding medical professional governance and both clinical urology and cancer services within the Trust. This will include the following:

- To consider the effectiveness of current systems and processes to monitor and assure the safety of our systems
- To identify areas for improvement and formulate and develop measurable actions to address same
- To develop audit and other assurance mechanisms to provide corporate level assurance of the safety of our systems

The purpose of the group is to provide assurance to the Public Inquiry Programme Board on the following

- The monitoring of continuous and measurable improvement in the quality of medical professional governance regarding medical appraisal and revalidation
- That the processes and assurance mechanisms regarding the oversight of medical private practice and paying patients remain robust and effective
- That there is continuous and measurable improvement in the quality of both urology and cancer services which supports the delivery of safe, high quality patient care.
- Ensuring that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.
- To review proposed quality improvement priorities and to monitor performance and improvement against the Trust's quality priorities
- To seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

SAI Recommendations

Weekly meetings take place on a Thursday with sub-group of the Task & Finish Group (Cancer Improvement Lead, AD of Cancer Services, HOS for Cancer, HOS for Clinical Assurance and co-chairs of super group and service user group) and this feeds into the monthly meetings with Task & Finish super- group involving leads of Cancer MDT's/ Tumour Sites.

All MDT's across all cancer sites have now had a baseline assessment completed and subsequent action plans devised for addressing deficits. MDT's Chairs have ownership of this.

The Principles document for MDT process is currently with MDT Chairs for comment and this is expected to be operational by end of January 2022.

SAI Recommendation Implementation progress is shared with Service User group as detailed above

Internal Audit

The Trust have received the final Report of Internal Audit's findings into a review of Mr O'Brien's compliance this report has now been presented to Confidential Audit Committee and Governance Committee and the Trust are now working on a range of actions that has come from this report and this will be reported back to Governance Committee in February 2022.

Grievance Appeal

The grievance review report has been discussed with SMT members of the internal urology oversight group. The report has been shared with the doctor. The report will now be shared with the Trust's Urology Quality Assurance Oversight Group for sharing of learning from this review.

Staff Engagement

Mr Donal Lunny QC and Mr Michael McGarvey, along with the Trust Solicitors met with the clinical team in November 2021 where they advised of the expected processes for the USI. The teams had an opportunity to discuss and ask any queries/concerns at this meeting.

The Medical/Acute and Public Inquiry Directors held a meeting with the Urology Team (Clinicians/Clinical Nurse Specialists/Senior Managers) on 16 December 2021 which is the regular meeting with the team when they updated the Team on progress with the Inquiry, content of Section 21 Notice and progress with collecting and collating this information. The clinical team have agreed that now that the Inquiry has started that they would take up the offer of Mr Pengelly to meet with them over the next number of months which will be organised by the AD for the Inquiry.

Communications

The Trust have not received any media enquires since the last report

2. Areas of improvement/achievement:

- The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDT's.

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

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Letter Activity as of 17 January 2022

Letters to Patients		
Letter A (for patients who have been seen and no issues)	Alive - 965 Patients RIP – 75 Patients	Posting of these letters commenced 13 Dec 2021, letter contained Information Line contact details (2 calls received).
Letter B (For patients whose records still need to be reviewed)	Alive – 358 Patients RIP – 69 Patients	Posting of these letters commenced last week in Dec 2021
Letter C (for patients whose records have been reviewed but require a follow up by the consultant team)	Alive – 174 Patients RIP – 8 Patients	Posting of these commenced on 18/19th December 2021 but letters are only being sent after the patient has been reviewed by the Consultant Team.
SCRR Patients (Original 77 Patients Identified)	Alive – 71 RIP – 6 From Review Clinics a further 2 Patients Have Been Identified for Screening, but waiting on a decision from DoH as to whether these need included or not.	There are currently a total of 65 patients that have been screened and identified as requiring a SCRR. There are a further 6 patient's notes left to screen and these patients need an extensive notes review to determine if they need an SCRR review or not. The Family Liaison Team have rang all of these patients as they wanted to alert them before the letter was sent (6 patients did not respond to call and messages left. These attempts to contact were included in the letters sent to them).
Total Letters To Be Sent	Total Letters Sent	Letters Left To Be Sent
2095	1545	550

Patient numbers to be reviewed as of 17 January 2022

Cohorts Of Patients	Total Patients In Cohort	Number of Patients Seen by End Jan 22	Planned Patients To be Seen By end March 22	Approx Patients who will NOT have been seen by end of March 22
Info Line	141	80	MH- 30 Pts (FEB) MH- 31 Pts (MARCH)	0
Review Backlog	173	133	MH- 20 Pts (Mar) JOD & MY- capacity for 20 Pts (Feb/Mar)	0
Waiting List	114	80	34 Patients will be seen Feb/ Mar	0
SCRR	12	12	0	0
Total patients	440	305	135	0

Southern Health and Social Care Trust
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Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 31st March 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Temporary Accounting Officer and Medical Director
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs L Leeman, Interim Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Ms J McGall, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms S McKinney, Boardroom Apprentice

APOLOGIES

Mr M McDonald, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. She particularly welcomed Ms McGall and Mrs Leeman and congratulated them on their recent appointments. The Chair also congratulated Dr O'Kane, appointed as the Trust's Temporary Accounting Officer.

2. DECLARATION OF INTERESTS

The Chair noted declaration of interests from Ms McGall and Mrs Leeman in relation to agenda item no. 12 'Feedback from Remuneration Committee' and advised that they would leave the meeting for discussion on this item.

3. MINUTES OF PREVIOUS MEETINGS

The minutes of meetings held on 27th January 2022 and 12th February 2022 were approved as accurate records.

4. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors.

5. NEWRY CTCC

The Chair welcomed Mrs A Turbitt, Head of Planning, to the meeting. Mrs Leeman referred members to a paper which provides an update on the current position in relation to financial affordability of the current project following further discussions with the preferred bidder and a subsequent meeting of HSC officials to agree next steps.

Members discussed the areas of concern, namely confirmation from the preferred bidder that despite their desire to see the Newry CTCC built, the current method of indexation, coupled with their assessment of construction costs in the current market, means the project is not financially viable and cannot proceed under the current 3PD model.

Members expressed their disappointment given the significant work undertaken on this project from the Trust's perspective to date. In response to a question from Mr Wilkinson on next steps, Ms Teggart advised of the offer from the preferred bidder for the Trust to buy the existing site (with planning permission) along with purchase of the design at a cost of £4.7m. Mrs Leeman stated that in recent discussions with HSC officials, all parties agreed that the offer to purchase the existing site along with the design may provide a viable solution to expedite a capital project for further exploration. To that

end, the Department has asked the Trust to complete a Strategic Outline Case (SOC) for the totality of the project including an option to purchase the existing site with design along with all other viable options based on revised and updated needs assessment being completed. Separate discussions will be required with the Capital Investment Directorate to secure the funding to deliver the scheme. Mrs Leeson asked about the Department's appetite for capital funding for this scheme. Mrs Leeman advised that the Trust would need to seek assurance from the Department that this would not impact on the Trust's other capital funding requirements.

Primary Care involvement in a new CTCC was discussed. Mrs McCartan raised the fact that Primary Care have indicated that they are not willing to move into Newry CTCC and asked if there would be a greater appetite from them for a primary care centre via capital funding. Mrs Donaghy asked if there was scope for a redesign given GP's unwillingness to move into Newry CTCC. Mrs Leeman stated that the design of the GMS space had been adjusted so it could be used as flexibly as possible going forward. Mrs Turbitt explained that the needs assessment and design will need to be revised and updated and confirmed there is scope for flexibility.

The Chair made reference to the fact that Trust Estates will urgently liaise with Land and Property Services to undertake an urgent site search in the Newry area to assess any other potentially suitable sites for development along with valuation of the site on offer for purchase. She raised the importance of Trust Board being assured that the purchase price of the site on offer has been commercially tested and asked that this assurance is included in the next update to Trust Board.

Action: Mrs Leeman

6. UPDATE ON DORSY UNIT

Ms McGall drew members' attention to the concerns restated in the paper. She stated that the focus is on actions that continue to be undertaken to improve the service and ensure the safety of patients and staff. She spoke in particular of the strengthening of Governance systems with improved community and inpatient working which has led to the successful discharge of 3 long stay individuals. In relation to

the dedicated management structure, an 8A Lead Nurse has now been appointed.

Ms McGall advised that the service would be undertaking a benchmarking exercise with the available RQIA inspection findings of the Lakeview Intellectual Disability Unit, Western HSC Trust.

Ms McGall concluded by advising of the ongoing challenges relating to workforce, cultural shift and environment, especially the seclusion room.

Members noted the actions in place to address. It was agreed that Ms McGall would provide one further closing update to Trust Board at the next meeting to include the outcome of the benchmarking exercise referenced above.

Action: Ms McGall

7. **UPDATE ON** Irrelevant information redacted by the USI Irrelevant information redacted by the USI

Ms McGall spoke to a paper which provides an update on the progress to date and the remaining challenges and risks. Ms Gall stated that a new dataset has been established and work continues on data analysis. Work also continues on the RQIA Quality Improvement Plan from the Care Inspection on 26th January 2022. Mrs McCartan asked Ms McGall if she was content with the overall progress being made in Irrelevant information redacted by the USI including the work to address the RQIA Care Inspection report.
Ms McGall stated that she was assured that progress was being made as outlined in the paper.

In relation to challenges, Ms McGall advised of the ongoing work to deliver a service which is in accordance with the Ethos of Supported Living.

It was agreed that Ms McGall would provide one further closing update to Trust Board at the next meeting.

Action: Ms McGall

8. **PSYCHIATRY OF OLD AGE AND MEMORY SERVICES IN THE SHSCT**

The Chair welcomed Dr Chris Southwell, Consultant in Psychiatry of Old Age, to the meeting to present on 'Facing the Future – Dementia Service provision.' Members were advised that the Specialist Consultant Psychiatrist who had been working in Gillis has left the post and as of 31st March 2022, there is no Consultant Psychiatry cover for the Gillis unit. A contingency decision is therefore required to ensure safe and effective care.

Members discussed the options explored by the SMT and were supportive of the preferred option (option 3) to temporarily relocate from the Gillis Ward, St Luke's site, Armagh to Willows Ward, Bluestone site, Craigavon Area Hospital. This will allow the multi-disciplinary team to access on-site medical input and support until the Trust is able to provide dedicated Consultant in Psychiatry of Old Age to this vulnerable patient group. A formal project structure will be established to develop longer term proposals for public consultation on Psychiatry of Old Age and memory services across the Trust. In response to a member's question, Ms McGall advised that an Early Alert and conversations with the Department and the HSCB have taken place.

9. **CHILDREN AND YOUNG PEOPLE'S SERVICE PRESSURES**

Mr McCafferty presented a paper highlighting the current service challenges and associated risks in Children's Services. He stated that specific focus is afforded to the Safeguarding and Family Support Division (social work) and challenges presented linked to significant numbers of substantive vacancies and the continuing impact of the pandemic on both the workforce and families. Mr McCafferty highlighted the increasing number of unallocated children's social work cases and the lack of available social workers to recruit into the service. He advised that the paper also outlines the position in respect of the impact of the pandemic on service delivery in the other key areas of the Directorate including Specialist Child Health & Disability and Looked after Children services.

Members discussed the content of the paper in respect of the high level service pressures, staffing, risks and mitigations and asked a number of questions to which Mr McCafferty responded. He stated that the specific challenge experienced in children's social work services in the Southern Trust is reflected across the region to varying degrees. The five Executive Directors of Social work have written to the HSCB to outline the current challenge and associated risk. The HSCB responded by emphasising Delegated Statutory Functions must be adhered to at all time by the respective Trust social work services. At present, there is very limited scope to curtail non-statutory social work tasks to create additional capacity to enable the service to continue to respond to urgent child protection and Looked after child referrals and case episodes. Mr McCafferty concluded by advising that it is envisaged that the current crisis in The Gateway Service and the Family Intervention Service will endure for 4-6 months and a set of mitigations are in the process of being put in place and other alternative options are being considered.

Mr McCafferty undertook to provide an update at the Trust Board meeting on 23rd June 2022.

Action: Mr McCafferty

10. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY AND UROLOGY SERVICE INQUIRY (USI)**

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm outlined the key aspects of the update report. She advised that Margaret O'Hagan, currently Director of Surgery and Clinical Services in the Northern Health and Social Care Trust, will be working with the Public Inquiry Team providing reassurance to the USI about the integrity of the response, and guarding against any perception of Conflict of Interest.

Mrs McKimm also advised that the Trust is undertaking a review of all patient information that has been issued to date, following a number of concerns raised about the accuracy of information provided to patients and families.

The completion of Section 21 notices was discussed. Mrs McKimm explained that the scope of discovery has now extended back to 2009 in some cases and staff are required to stop their normal duties to

complete these very detailed responses, which is placing additional pressure on the health system, and the Trust continues to raise concerns about staff welfare through the Department of Legal Services (DLS). Members discussed the corporate risk that due to capacity issues, the Trust may be unable to respond in a timely and complete way to Section 21 requests. Mrs McKimm advised that the further risk will be issues identified through the discovery process which may impact on the reputation and function of the Trust.

Mrs McClements emphasized the lack of capacity in the system to respond to the USI over and above managing and delivering services during the ongoing pandemic.

It was agreed that the completed risk assessment would be attached to the update paper for the next meeting.

Action: Mrs McKimm

11. DRAFT BUDGET 2022/23

Ms Teggart presented a paper which sets out the Trust's draft Opening Financial position/Draft budget for the financial year 2022/23 for approval. She reminded members that under the Trust Standing Financial Instructions, an opening budget should be presented to the Trust Board for approval each year. Ms Teggart advised that given the Trust has not received confirmation of its budget allocation for 2022-23, this paper sets out the draft opening financial position for the financial year 2022/23 pending confirmation of opening budgets from the Department of Health. The Department of Health has confirmed in writing to the Trust that the current year budgets will continue into 2022-23, however no new proposals should be undertaken unless existing recurrent funding is made available within each Trust.

Ms Teggart spoke of the risk that funding will not be made available at the same level throughout the year with the expectation on Trusts to make savings to fund deficits. She advised that the 2021-22 roll forward budget does not take account of inflation, pay increases or increase in services. In addition, the Trust does not have an equity share of funding in comparison to other Trusts. This equity gap is in the region of £37m from figures provided by HSCB and they do agree that further

investment is required in the Southern Trust area and additional funding is required across many services e.g. normative nursing. In the absence of further funding, HSCB is unable to allocate further funding to SHSCT at this point, however, has agreed to look more favourably at SHSCT by reducing savings requirements and seeking to provide funding for investment in services when funding becomes available. This will be closely monitored during the 2022-23 financial year.

Ms Teggart took members through the details of the paper. She made reference to the fact that of the allocation received to date in 2021-22, approximately £145m is non-recurrent (which equates to around 17% of the total allocation). Of this £145m, the Trust has been advised by the commissioner that c£40m can be assumed recurrent, leaving a balance of £105m. Of this balance, c£60m non-recurrent funding relates to Covid response and rebuild and c£10m for Elective Care/Waiting List Initiatives, leaving a balance of c£35m (4% of total allocation). She stated that the non-recurrent funding needs to addressed in 2022-23 as the uncertainty around this funding is destabilising the Trust with temporary staff in post, staff recruited permanently at risk and the risk that vital services could be stopped if funding is not available recurrently.

Ms Teggart advised that the opening position for 2022-23 is the baseline including assumed recurrent funding and amounts to £808m. She referred members to Table 2 in the paper which summaries the non-recurrent elements of funding that are at risk of stopping or reducing in 2022-23. The non-recurrent impact is £34.8m and, in addition to this, the Trust will continue to have savings targets\gaps rolled over from 2021/22 into 2022/23 totalling £5m. As a result, the total 2022/23 estimated opening recurrent gap is £39.8m, before considering new\emerging pressures or potential funding streams\easements. Ms Teggart advised when new/emerging pressures/additional cost pressures associated with pressures identified in 2021/22 are added to the opening recurrent deficit, the potential deficit to be addressed increases from the opening position of £39.8m to £65m. She referred members to Table 5 which outlines a remaining estimated deficit of £48.3m after income/easement assumptions.

Mrs McCartan expressed her concern at an opening recurrent gap of £48m. Ms Teggart acknowledged that to implement a savings plan of a minimum £48.3m is a risk to the Trust and will have a detrimental

impact on services and is not achievable in 2022-23. A range of measures as outlined in the report will be undertaken to address this risk in 2022-23.

Ms Teggart advised of the recommendation that the Trust's Accounting Officer sets out in writing to the Department of Health Accounting Officer the risks associated with the deficit and the equity gaps.

In conclusion, Ms Teggart advised that the final estimated Resource Budget requirement for 2022-23, excluding COVID funding and pay/inflation increase, is £856.3m which is £11m higher than the 2021-22 final budget largely reflecting the impact of Full Year Effect of services.

Trust Board approved the draft opening budget for 2022/23.

Mrs Leeman and Ms McGall left the meeting at this point

12. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair advised that on 14th March 2022, Remuneration Committee considered a proposal in respect of the commencement salaries of Ms Jan McGall, Director of Mental Health & Disability and Mrs Lesley Leeman, Interim Director of Performance and Reform.

The Chair sought Trust Board approval of the Remuneration Committee recommendation that Ms McGall would commence at the minimum point of Level 4 Senior Executive pay range and Mrs Leeman would receive a 10% uplift on promotion.

Trust Board approved the recommendation of the Remuneration Committee.

13. **ANY OTHER BUSINESS**

None

Southern Health and Social Care Trust

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TRUST BOARD COVER SHEET

Meeting Date	31st March 2022		
Agenda item	Update on Clinical concerns within Urology		
Accountable Director	Dr M O'Kane		
Report Author	Name	Martina Corrigan	
	Contact details	Personal Information redacted by the USI	
This paper sits within the Trust Board role of: **Accountability**			
This paper is presented for: **Information**			
Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care	
	☐	Supporting people to live long, healthy active lives	
	☐	Improving our services	
	☐	Making best use of our resources	
	☐	Being a great place to work – supporting, developing and valuing our staff	
	☐	Working in partnership	

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:

The Programme Director post has been appointed, with Jane McKimm taking up a 12 month secondment on February 1st. The Programme Director heads up the Trust Public Inquiry Team, supporting the Trust in the delivery of the Public Inquiry response. The Trust has also secured a secondment post to provide Independent Assurance around the response process. Margaret O'Hagan, currently Director of Surgery and Clinical Services in the Northern Health and Social Care Trust will be working with the Public Inquiry Team providing reassurance to the USI about the integrity of the response, and guarding against any perception of Conflict of Interest. Margaret most recently has been seconded to the Department of Health to work on the implementation of Rapid Diagnosis Centres across Northern Ireland.

Urology Services Inquiry

Evidence gathering for the USI is continuing. This includes the completion of several Section 21 notices, including a number which have now been issued to individual staff – 6 notices served on four staff members (including former staff). The scope of discovery has now extended back to 2009 in some cases. Staff are required to stop their normal duties to complete these very detailed responses, which is placing additional pressure on the health system, and we continue to raise concerns about staff welfare through the Department of Legal Services (DLS).

Update - Public Inquiry Response Steering Group
Chair – Programme Director of Public Inquiry

This ensures that there is an effective response to all requirements of the USI. The most recent meeting included a presentation by the DLS about the PI, the obligations of continuing discovery, advice and information on S21 requests. The group will also oversee the support of all staff involved in the Public Inquiry, ensuring that, legal, professional and psychological support is available for all staff / ex staff. The group will support internal communications. The group will liaise as required with the Trust Lookback Steering group and the Quality Assurance Oversight Group. It will also link in with HSCB and DOH as required

Urology Oversight/Lookback Steering Group
Chair – Director of Acute Services

These meetings continued to be held fortnightly on Monday mornings when an update is provided on the oversight in respect of patients identified as previously being under the care of Mr O'Brien. The original lookback for these patients is being extended from January 2019 back to 2014 and this group will continue to have oversight of this work.

The Trust is undertaking a review of all patient information that has been issued to date, following a number of concerns raised about the accuracy of information provided to patients and families.

Public Inquiry Quality Assurance Group.
Chair – Trust Medical Director

The first meeting of this group took place on 31 January 2022 and has met monthly since. The group is tasked with the following:

The group will ensure there are effective quality assurance processes regarding medical professional governance and both clinical urology and cancer services within the Trust. This will include the following:

- To consider the effectiveness of current systems and processes to monitor and assure the safety of our systems
- To identify areas for improvement and formulate and develop measurable actions to address same
- To develop audit and other assurance mechanisms to provide corporate level assurance of the safety of our systems

The purpose of the group is to provide assurance to the Public Inquiry Programme Board on the following

- The monitoring of continuous and measurable improvement in the quality of medical professional governance regarding medical appraisal and revalidation
- That the processes and assurance mechanisms regarding the oversight of medical private practice and paying patients remain robust and effective
- That there is continuous and measurable improvement in the quality of both urology and cancer services which supports the delivery of safe, high quality patient care.
- Ensuring that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.
- To review proposed quality improvement priorities and to monitor performance and improvement against the Trust's quality priorities
- To seek assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.

Patient Involvement

The Trust continue to meet monthly with the Service User group to provide updates on the SAI recommendations. A targeted Quality Improvement project has started with our service users focused initially on the information given and patient understanding of the journey they are about to go on. This is nearing the pilot stage when a questionnaire will be issued following first appointment (diagnosis) and will inevitably lead to further Quality Improvement work within the service. Service users have been very involved in the drafting of this questionnaire and the Trust have been supported by an external resource with experience in Public Involvement who had worked on the Hyponatraemia Inquiry

General Medical Council

The GMC have received all 9 SAI reports relating to Mr O'Brien. The GMC have advised that they have decided these cases will now formally be considered as part of their ongoing investigation into Mr O'Brien's practice. The Trust has informed the patients

and families and has shared patient casenotes with the GMC. The GMC are in the process of deciding on how Mr O'Brien's case will progress

Capacity

By the end of March 2022 there will be 47 patients remaining to be seen from the original cohort (January 2019-June 2020) with a plan in place to see these remaining 47 patients by end of April 2022.

Private Practice

The Trust discussed mechanisms for obtaining private practice records at the recent UAG meeting, 23rd February 2022. At this meeting the Trust has discussed with the DoH the potential role of the GMC to support access to private patient records. The Department of Health are currently considering the next steps.

Structured Clinical Record Review (SCRR) (previously referenced as SJR)

As previously advised there were 77 records identified as requiring an SCRR. Internal screening process has been completed and there are a total of 53 patients who now require an SCRR with a further 6 potential patients from this cohort. Consultants recommended through British Association of Urological Surgeons (BAUS) have commenced this work and the Trust are awaiting feedback on their findings. There have been a further 8 patients identified as meeting the threshold of an SAI and the Trust are awaiting feedback from DoH on how these and future patients are managed in terms of learning.

Information Line

Between December 2021 and March 2022 there have been 47 calls to the Information line.

SAI Recommendations

The Monthly Task and Finish Super group continue to meet and have updated key priorities of work towards a target implementation deadline of end of March/ start of April 2022. All MDT Leads continue to work through their action plans to address the findings in the MDT Baseline audits which has been completed across all tumour sites and these have been shared with Service Users.

Communications

The Trust has not received any media enquires since the last report

Update from the USI

The USI have provided an update on the progress of the USI:
https://www.urologyservicesinquiry.org.uk/news/update-christine-smith-qc-chair-urology-services-inquiry

The USI intends to hear from patients and families in mid-June. These hearings will not be in public but the legal representatives for the core participants will be in attendance and a formal written record will be kept/published.

The Inquiry intends to formally open hearings w/c 7 November 2022. The USI plans to sit for three days a week, in two week blocks, with week three used to prepare for the next set of witnesses. No information has been provided as yet about which witnesses will be heard first or which issues the Inquiry will be dealing with and when. Timings of hearings are subject to change and we will advise as more information comes available.

2. Areas of improvement/achievement:

The Trust is continuing to identify areas for improvement through the Task and Finish Group from the recommendations of the Serious Adverse Incident and are in the process of implementing these. For example, recruitment is in progress for an MDM Administrator, additional Cancer Trackers, additional clinical staff (Pathology, radiology etc) to attend the Cancer MDTs

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

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Southern Health and Social Care Trust
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Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 26th May 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy, Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services /Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates *(Item 8 only)*

IN ATTENDANCE

Mr B Beattie, Interim Director of Older People and Primary Care
Dr A Diamond, Interim Medical Director
Mrs L Leeman, Interim Director of Performance and Reform
Ms J McGall, Director of Mental Health and Learning Disability Services
Mrs J McKimm, Programme Director for Public Inquiry *(Item 7 only)*
Mrs R Rogers, Head of Communications
Mrs S McKinney, Boardroom Apprentice
Mrs S McCormick, Committee Secretary *(Minutes)*

APOLOGIES

Mrs M McClements, Director of Acute Services
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs S Judt, Board Assurance Manager

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting and apologies were noted. She particularly welcomed Dr Maria O'Kane, recently appointed as Chief Executive and Dr Aisling Diamond, Interim Medical Director. Boardroom Apprentice

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. MINUTES OF MEETING HELD ON 31ST MARCH 2022

The minutes of a meeting held on 31st March 2022 were approved as an accurate record.

4. MATTERS ARISING FROM PREVIOUS MEETINGS

Members noted the progress updates from the relevant Directors.

The Chair advised that Item 8, Finance Report would be taken next on the agenda.

8. FINANCE REPORT

Ms Teggart advised the draft outturn position at month 12 achieved break-even at year-end with a small surplus of £32k. She referred in particular to a number of key elements including the cumulative cost of Covid reported at c£64m. Payroll expenditure totals £598m at Month 12, with the main areas of spend, as in previous months within Medical and Nursing. For the financial year 2021/22 the Trust has invested £89m in agency, bank, locum, overtime and additional duty hours with 1,498 WTE's employed at 31 March 2022 on these arrangements. The most significant area of flexible spend is Agency, including Medical Agency with a wte of 775 at March 2022, equating to 52% of total flexible wtes and a cumulative spend of £58m. Non-pay expenditure at month 12 totaled £393m. The main underspend in Residential, Nursing and Domiciliary Care Income from Non-RRL sources was £49m, however

this has been offset by overspends within the Acute Directorate. Income from Non-RRL sources totaled £49m at year-end.

Ms Teggart raised concerns at the increase in agency, bank and locum spend and stated the Trust continue to monitor both vacancy rates and agency expenditure. Work continues regionally to address gaps in agency rates. The Chair asked if it was possible to have a breakdown in agency spend across each discipline and if there was any decline. Ms Teggart agreed to provide further detail and reiterated agency spend is on the increase, however there was some improvement in December 2021 as a result of the Covid payment from the DoH.

Action – Ms Teggart

Members noted with concern the absence of confirmed budget allocations across the region for the new financial year. Furthermore, Ms Teggart alluded to the challenges ahead for the Trust in terms of entering the 2022/23 accounting period with a projected deficit. Members were advised the DoH is aware of Trust's deficits and pressures for 2021/22 and all regions have been advised to continue to seek efficiencies were possible. Members noted the Health Minister's recent announcement regarding additional funding to tackle Waiting Lists, which the Trust will consider further in due course.

Ms Donaghy asked about the underspends in Residential, Nursing and Domiciliary Care to which Ms Teggart and Mr Beattie explained this was largely associated with Covid pressures and the inability to secure staff. Mr Wilkinson welcomed the additional funding for Waiting Lists, however highlighted the current workforce and estates pressures and asked if the allocation would have a real impact. Ms Teggart stated the finer detail of the funding was still to be teased out.

In response to a question from Mr McDonald on spending power in exceptional circumstances throughout 2022/23, Ms Teggart emphasized that in the absence of a functioning Executive no additional money is currently available. She alluded to the difficulties in planning health services for the future without a confirmed 3-year budget and reminded members this leaves the Organization exposed to risk. In light of this, Mr McDonald stated it was important Trust Board ensure a clear audit trail of robust discussion at every opportunity.

In concluding discussion, the Chair asked if the enhanced pay for Domiciliary Care Workers had ceased, to which Mr Beattie advised the enhanced rate of £18 per hour would continue for the remainder of the financial year 2022/23. The Chair referred to the Ministerial announcement that South Tyrone Hospital had been assigned as a new Rapid Diagnosis Centre for cancer and asked in terms of Waiting Lists, if the Trust was seeing investment to be able to deliver on the suite. Dr O'Kane advised some funding had been received for Urology Waiting Lists, however she alluded to the challenges in delivering services alongside workforce pressures. Lastly, the Chair asked if there was any movement regionally on stabilizing agency costs, to which Dr O'Kane advised various regional groups are currently in place assessing workforce issues. Locally the Trust continues to develop the People Plan and promote the Southern Trust as a better place to work.

The Chair stated that the Chief Executive and herself would further discuss how the Trust ensures the public understand the challenges we face with not having a budget.

Ms Teggart left the meeting at this point

5. DORSY UNIT – CLOSING UPDATE

Ms McGall reminded members she had previously agreed to undertake a benchmarking exercise with the available RQIA inspection findings of the Lakeview Intellectual Disability Unit, Western Trust (WHSCT), however this was superseded by a RQIA unannounced inspection of Dorsy Ward in April 2022 covering a 3 day period. Members noted the final written report from RQIA is awaited; however, initial verbal feedback reports welcomed improvement and a request for areas of good practice to be shared with other Intellectual Disability services across the region. No areas for senior escalation were noted. Ms McGall stated a Quality Improvement Plan will be in place to take forward a number of key themes, many of which the Trust was already aware of through the Dorsy Oversight and Improvement process.

In relation to the Safeguarding Investigation, Ms McGall said the Public Prosecution Service (PPS) have directed no criminal prosecution in the case of patient alleged assault by a Trust staff member. The Trust is now proceeding with a single agency Adult Safeguarding and Human Resources Disciplinary Investigation process. In light of this, Ms McGall

stated it would be important to have a further update to a Confidential sitting of Trust Board once the process has concluded to provide assurance on the findings and address the concerns brought to the Boards attention initially.

Mrs McCartan welcomed the strengthening of the Governance processes highlighted within the update along with the positive verbal feedback from RQIA. She emphasized the importance of Trust Board having oversight of vulnerable groups to ensure openness and transparency and said she would welcome regular updates on progress. Ms McGall welcomed this approach and stated she was content to provide an update on areas of concern and improvement at the next Trust Board meeting and then schedule in, with the Chair's consent, regular updates in the future. Ms Donaghy asked about the expected timeframe to complete the internal process, to which Ms McGall stated she would envisage the review to complete within a 4-8 weeks period dependent on whether there is further exploration of allegations required.

In conclusion, Dr O'Kane recorded thanks to Ms McGall and associated staff for their work to date in terms of the swift change in relation to the improvements implemented at Dorsy. The Chair agreed the item would remain on the Confidential agenda for future meetings to provide assurance that improvements have been carried through.

Action – Ms McGall

The Chair advised that Item 7, Update on Clinical concerns within Urology and Urology Service Inquiry (USI) would be discussed next on the agenda.

7. UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY AND UROLOGY SERVICE INQUIRY (USI)

Mrs McKimm, Inquiry Director attended to provide an update on progress in response to the Public Inquiry into Urology Services in the Southern Trust. She referred to the Risk Assessment, which clearly outlined the pressures being felt as intensive evidence gathering continues. Members noted, as at May 18th 2022, there were 46 active individual S21 notices requiring response by June 2022, covering a range of former and current staff. Members noted the scope of discovery has extended back to 2007 which is adding to the complexity of the

process and current staff are balancing the need to maintain normal business with completing these very detailed responses. Mrs McKimm emphasized staff recognize the importance of the S21 process and the care required to comply with the S21 requests, however this is placing added pressure on the health system. The Trust continues to liaise closely with the Department of Legal Services (DLS).

Members were advised the Trust had written to the USI and Dr O'Kane provided an overview of correspondence to date outlining the risks to the Organization and concerns around business continuity along with the request from some Trust staff for an extension of time for the submission of their statements in response to the recent S21 Notices. The Chief Executive advised Ms Smith, Chair of the Urology Inquiry has demonstrated a willingness to work along with the Trust in relation to the current pressure and extensions to all of the S21 notices issued has been very helpful. Members acknowledged the process brings with it a huge cost to people's time and energy along with balancing keeping patient's safe.

Moving forward Mrs McKimm stated that once the current tranche of S21s is complete within the extension time, the Trust will seek to move on in terms of structures and processes, which have been stalled. She also referred to working towards a more considered position with the USI in terms of enhancing communication channels.

Mrs McCartan asked, what support Trust Board can offer in terms of the emotional wellbeing of the team and secondly, on foot of discussion with the Permanent Secretary, is it the Ministers intention to send a letter directly to the Chair of the Urology Inquiry supporting the Trust in terms of the significant pressures facing staff. The Chief Executive stated it was her understanding the DoH are sympathetic to the Trust's position and are aware of the challenges. In relation to staff welfare, the Senior Management Team feel supported and Psychology is in place where needed. Ms Leeson asked if the scope of discovery was likely to extend back further than 2007, to which Mrs McKimm responded by explaining the Trust archiving systems are limiting, however no definitive timeframe has been set out and urged the need for more collaborative working in the future to better frame and enhance the overall quality of the Inquiry. Mr Wilkinson emphasized it was important to look after those staff who are directly involved with the USI but also those who are providing a

supporting role. In conclusion, the Chief Executive stated issues will continue to be brought to the attention of Trust Board on a regular basis.

Mrs McKimm left the meeting at this point.

6. Irrelevant information redacted by the USI

FACILITY – CLOSING UPDATE

Ms McGall spoke to an update paper on Irrelevant information redacted by the USI, advising a further Unannounced RQIA finance inspection had been completed on Irrelevant information redacted by the USI. The report, just issued to the Trust, identifies no issues for senior escalation; however there were some areas for Quality Improvement and these are being addressed. Ms McGall stated Director oversight continues to support the work on the ground at the facility and she referred in particular to Mr McCafferty's view regarding the need for a robust supervision audit of Social Care staff to develop staff in their role and stated this is progressing. Work on Medicines Management and the administration of medication, is being supported by the Learning Disability Nurse Leads. A bolstering of staff support through additional recruitment to enable a roll out of extended Band 6 cover to commence initially in Irrelevant information redacted by the USI from 1 June 2022 with further roll out to other supported living facilities thereafter was welcomed.

In light of discussion earlier in the meeting ensure openness and transparency, Ms McGall requested that Directors' oversight of Irrelevant information redacted by the USI Irrelevant information redacted by the USI would continue until the supervision element had concluded and further exploration of the medicine management process and staff support piece takes place. She suggested that given discussion around Dorsy and the vulnerable adults within the facility, it would be helpful if a summary progress position for assurance purposes was provided to Trust Board at a future meeting.

Mr McCafferty reported on significant progress achieved through the oversight group particularly around the areas of staff supervision and support.

Mr McDonald referred to the new data set referenced within the paper, which had been developed following shared learning from the Dorsy Oversight Group and Muckamore Abbey Hospital (MAH). He asked if members could have sight of the information and pointed out it could be

useful in assisting in other areas of the system. Ms McGall agreed to provide the data set for a future meeting.

Action – Ms McGall

Mrs McCartan welcomed the progress to the working environment at the [redacted] and asked if formal feedback on the results of the RQIA Finance Inspection could be reported back to Trust Board in due course. Ms McGall agreed to provide to a future meeting.

Irrelevant information redacted by the USI

Action – Ms McGall

In closing, Mr Wilkinson welcomed the intention to continue Directors oversight into the future. He also welcomed the provision of regular updates, however emphasized the need for Board members to be visible and alert in terms of what is going on right across the whole area of Trust business and added this required further attention. The Chair and Chief Executive agreed to further discuss leadership walks.

Action – Chair / Chief Executive

9. ANY OTHER BUSINESS

None

The meeting concluded at 9.45 a.m.

HSC Business Services Organisation

Directorate of Legal Services
Practitioners in Law to the
Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ

FAO Eoin Murphy
Urology Inquiry

Date: 13/05/2022

Dear Eoin

Re: Urology Services Inquiry

I refer to the above matter and to the 40 Section 21 Notices served for the attention of current and former Southern Trust Staff on Thursday 28 April and Friday 29 April.

The Trust's priority is patient safety and they are committed to working with the Urology Services Inquiry to deliver fully on the Terms of Reference and are clear about the need for the Inquiry to obtain information in a timely manner through an open and transparent process of discovery.

The Trust is also cognisant of the psychological impact of the Inquiry on the welfare of staff, and is striving to ensure that all current and former staff are supported in terms of completing their statements in response to each S.21 Notice, (as you are aware, some members of staff have received more than one S.21 Notice, both of which are to be completed by 10 June).

Given that the level of responses now required by the Inquiry has expanded significantly over the last two weeks, it is becoming increasingly difficult to give the process the significant time and attention required to respond fully to the requirements of the Inquiry, while at the same time continuing to provide safe services for patients currently in the system. As you are aware, Health and Social Care is well recognised as a safety sensitive system that does not operate in discreet parts but relies on all aspects of the system to function well.

The Trust appreciates that the Inquiry has been flexible to date in response to requests for extension of time for service of S.21 Notice Statements, and the Trust also recognises the fact that Inquiry has moved from seeking Statements within 6 weeks rather than 4 weeks, however, even with these accommodations the Trust still considers it necessary to write this letter to the Inquiry.

In addition, the extended timeframe inherent in some of the S21 Notices, outwith the original discovery timeframes, has added significantly in some cases to the complexity of

information retrieval and thus to the time required to acquire and assimilate that information.

Having taken detailed instructions from the Trust over the last week or more on this issue, I shall attempt to set out below some of the Trust's particular concerns in respect of different affected areas of its operations before going on to provide a brief explanation of the spreadsheet attached to this letter.

However, the key point to note at the outset is that this letter (and the attached spreadsheet) together form a request for an extension of time for compliance with a number of the aforementioned S.21 Notices.

Acute Services Directorate

1. Around 140 staff affiliated to Urology were issued with questionnaires shortly in advance of the 40 Section 21 Notices being served (although these are not all for acute-based staff). A proportion of these are clinical staff who have cancelled clinics to complete these thus adding to oncology and other patient waiting times.

In addition to this other clinical staff have been served Section 21 Notices at a time when Southern Trust, along with all other Health Trusts, faces significant challenges in the tail of the Pandemic coping with seriously ill cancer patients requiring lifesaving and palliative surgeries. The consideration of whether to prioritise responses to the Inquiry over surgery is, as you would expect, causing significant worry and moral dilemmas and a real concern that patient safety is being significantly compromised if these surgeries are stood down. In this regard it has not been possible to acquire locum consultant cover for the Urology specialty.

The Trust has an on-going agency recruitment process to secure Locum Consultant cover, but there is a lack of suitably qualified Locum Consultants available.

There have been multiple attempts to fill 2 full time permanent Consultant posts and so far the recruitment process has not been successful.

The Trust has made offers to other local Trusts to pick up some Urology workload but there is no regional capacity to provide the required support.

Furthermore, all of the staff involved must be part of the Trust's improvement plan in learning from and implementing improvement as a result of their findings in the course of the Inquiry process. The demands on their time are such that the capacity to undertake this is greatly slowed.

2. Moving on to management, it is currently the case that five out of six Assistant Directors within the Acute Services Directorate are required to respond to S.21 Notices. For the reasons outlined in the following paragraphs, this creates a serious risk to business continuity and the provision of the service at a time when acute services across Northern Ireland are under extreme pressure (not least because of 2+ years managing an unprecedented pandemic).

3. The Director of Acute Services, Melanie McClements, is tasked with running a busy operational service across 2 acute sites, Craigavon Area Hospital and Daisy Hill Hospital,

which necessitates a range of management roles and is essential for smooth running of the patient services. Ms McClements was also served with a S.21 Notice on 5th May. Ms McClements has advised that removing any of her Assistant Directors from their daily roles to enable them to complete their S.21 Statements will have an impact on the operational service of the Acute Directorate across the 24 hour period including nights and weekends. However, removing five Assistant Directors from their roles for significant periods of time across the same 4-5 week period will cause patient safety concerns and significant service risk, including in the following respects:

- Ongoing governing of the Trust's services;
- workforce support, recruitment, retention, HR procedures, absence management, ensuring safe staffing levels with daily senior decision making regarding risk, safety and affordability across all disciplines ;
- response to all escalations;
- oversight of all operational services across Emergency Departments, ambulatory departments, in patient wards, speciality areas, ICU, theatres, day procedure units, outpatients, laboratories, radiology, cancer services, secretarial/administrative systems and procedures and all catering, domestic, laundry, central sterile supplies department;
- ensuring patient flow into and out of the hospital to enable acute admission capacity;
- high level strategic and operational communication;
- implementing the Trust's rebuild plan including addressing backlogs, waiting lists, increasing elective pathway access to outpatients and theatres, cancer pathway management and oversight and red flag/priority responses for patients;
- dealing with crisis and service risk/breakdown daily;
- significant input to manage infection prevention control of covid-19 and Healthcare Associated Infections whilst maintaining core business;
- representation on regional groups to report on and influence services;
- response to major incidents and emergency plan implementation;
- decision making and risk managed permissions which other grades of staff are not able to make/give.
- Every Assistant Director is critical to the maintenance of operational services within the Trust and if this operational service is diminished, this has the potential seriously to impact on patient flow, meaning that the care of patients in and out of the system could be compromised, as well as an impact on interfaces with community prevention of admission and early discharge facilitation. The last two years in particular has evidenced that our system works best when our ADs work corporately to problem solve across service interface areas that impact across the whole of the patient journey. The Assistant Directors participate in daily key service meetings, such as patient safety meetings, complaints, and 3-daily flow meeting, as well as the daily Trust operational meeting.
- The Trust has already had to postpone some clinical sessions to free up Clinical Staff to enable them to have time to complete their statements, and other clinical sessions may also be postponed. Regrettably, this could result in longer waiting times and reduced access to care. For example, the maintenance of Emergency Department services given continued and on-going extreme pressures is dependent on the support of key managers together with cross-Trust liaison, for instance, with NIAS to rebalance Ambulance Services

In light of the above, the Directorate team have considered how the S.21 Notices can best be provided and are proposing the following adjusted timetable for the USI's consideration:

1. Mr Haynes will require a significant extension to his Section 21 Notice. He has oncology patients booked weeks in advance who cannot safely be cancelled. He also has

planned annual leave for 2 weeks at the end of May for an important family event. Mr Haynes will be writing separately to the USI in this regard.

2. Anne McVey will proceed to complete her notice in the timeframe specified, i.e., between issue date and June 10th. Anita Carroll already has a week's leave booked in starting on May 28th) and has requested an extension until June 20th.

3. Barry Conway has commenced his S.21 response and does not seek an extension of time for service of his S.21 response . Barry will continue with on-call commitment, cancer Multi-disciplinary meetings and service improvement work plan linked to urology/governance and cancer services (with Heads of Service taking delegated responsibilities for key aspects of divisional workplan)

4. Ronan Carroll – who has just completed his initial S.21 Notice – has been issued with a second Notice to complete by June 10th. He requests an extension to 24/06/22 to allow him time to focus on his services, recover, and then have a plan in place to oversee his Division with HOS support and retaining on call commitment.

5. Wendy Clayton, also issued with a S.21 Notice due on June 10th, is the Head of Service for Urology reporting to Ronan Carroll. She also requests an extension to 08/07/22 to allow her to commence now and then rotate duties in conjunction with Ronan Carroll.

6. Mary Burke (AD) and Melanie McClements (Director) are requesting extensions to 30/06/22 to allow them to support the service over the next few weeks with ADs predominantly being dedicated to S.21 work.

7. Mr McNaboe and Mr Weir both aim to complete within existing deadlines.

Human Resources

Three senior members of the Human Resources team, in the same management line, have been issued with S.21 Notices, namely, Vivienne Toal (Director), Siobhan Hynds (Deputy Director), and Lynne Hainey (Head of Service, Litigation).

The Human Resources Directorate is currently working according to their business continuity plan in a number of teams due to reduced staffing levels caused by a combination of sick leave, maternity leave, vacancies and increased workload as a result of organisational challenges. In the Employee Relations (ER) team alone the Head of Service is on maternity leave, the Band 7 ER Manager is on maternity leave, and two Band 6 ER Case Managers are on maternity leave. Temporary cover has been secured but the temporary staff recruited are all inexperienced and/or new to the Trust with one member of temporary staff yet to start, so significant operational responsibility is carried by the Deputy Director to keep service continuing at present. Additionally, Siobhan Hynds (Deputy Director) along with the acting Employee Relations Head Of Service (Maternity Leave Cover), are currently working daily to put a [redacted] Commercially Sensitive Information redacted by the USI

[redacted] Commercially Sensitive Information redacted by the USI

[redacted] Commercially Sensitive Information redacted by the USI

There are two Deputy Directors in Human Resources – one has just commenced maternity leave, and cover is in place by someone who is new to this role. However, they require significant support from the Human Resources Director. The second Deputy Director is Siobhan Hynds. If the Director and Deputy Director are required to complete a S.21 Statement at the same time as indicated, there will be limited cover to keep the Directorate functioning. This poses a significant additional risk to the organisation.

Additionally, Vivienne Toal, the Director of Human Resources is currently carrying a significant workload which includes her involvement in getting the Trust Senior Management Team stabilised and structures sorted following the appointment of the Chief Executive, Dr Maria O'Kane. If the Director is absent for significant periods during the next 4-5 weeks to complete a S.21 Statement, this will delay all of this work, unless some level of support can be sourced from the Leadership Centre. However, there are currently limited numbers of people available through the Leadership Centre at the level required. The Southern Trust has currently 6 Director roles to be recruited in the next number of weeks and months.

Finally under this heading, I understand that Lynne Hainey (Litigation Manager) is already operating at a reduced staff capacity within the Litigation Department due to sick leave and significant workload demands. The service is under extreme pressure with limited support available from senior staff, given Ms Hainey's manager is Siobhan Hynds and Ms Hainey is scheduled to be involved in an upcoming Inquest which is listed for Hearing from 6th June 2022 and lasting for 3 weeks. In addition, Ms Hainey has received a conditional offer for a post outside of the Trust and subject to pre-employment checks, Ms Hainey will be leaving the Trust at the end of June 2022.

In the circumstances, the Trust respectfully makes the following proposal for an extension of time for Vivienne Toal's Statement until 30th June. Vivienne Toal has annual leave planned at the beginning of July and Siobhan Hynds will be required to provide cover for Vivienne Toal's annual leave. Siobhan Hynds would therefore seek an extension of time for the submission of her statement until 31 July 2022, to ensure operational cover. Both Siobhan Hynds and Vivienne Toal will be working to complete their S21 Notices ahead of deadlines if workload pressures allow.

Medical Director's Office

Corporate Clinical and Social Care Governance is held by Trust Board and the lead Director for this area is the Medical Director.

Dr O'Kane was the Trust Medical Director from the 1st December 2018 until the 14th February 2022. In addition to her substantive post, she was acting in a covering capacity for the Chief Executive from 14th February and took up this post substantively on the 1st of May 2022. The Deputy Medical Directors are covering aspects of the Medical Director's role on a rotating basis until a new Medical Director is formally appointed, a process which usually takes up to 6 months. Dr O'Kane is also continuing to support the directorate until a permanent appointment is made.

There is significant demand being made on governance staff to provide information and to drive improvement on the basis of findings. As the dynamic shifts to having to provide large swathes of information to various and numerous individual Section 21 notices in a

relatively short space of time with the ongoing tail of requests, the capacity to continue to monitor the system for patient safety concerns and to drive improvement is reduced. There is a national shortage of adequately trained experts in these areas and recruitment cannot keep up with demand.

In order to collate information and to drive improvement the governance team depends heavily on the senior managers and clinicians involved in also servicing the inquiry currently with S.21 requests and as such are less able to support the system .

The Trust will manage the safety of the governance environment through the adoption of feedback from daily huddles / feedback from SMT meetings and adjust activities accordingly while continuing to recruit staff particularly in clinical audit and Quality Assurance oversight to advise on safe organisational functioning in key areas.

This is relevant to the completion of S.21 notices by the Chief Executive – please see below.

Chief Executive/Director impact

The Trust has been without a permanent Chief Executive since 14 February 2022. Dr O'Kane's appointment as Chief Executive was confirmed on 28th April 2022 and commenced on 1st May 2022. During this time, the Trust was working with an interim Chief Executive/Interim Accounting Officer arrangement, which was less than ideal. This Interim arrangement has contributed to a lack of confidence and stability in the organisation, both internally and externally, while managing the consequence of the on-going pandemic.

The Trust does not have a Deputy Chief Executive post.

As mentioned above, Dr O'Kane, as the newly confirmed Chief Executive, continues to have significant oversight of the Medical Director post, until a new Medical Director appointment can be made and, in the interim period, Dr O'Kane also has oversight of the Medical Directorate and will be required to support the new Medical Director, once appointed.

As a result of the recent election process, it is anticipated that a new set of elected political representatives will wish to meet with, and be assured by, the permanent Chief Executive about the capacity of the Southern Trust to deliver its services. Health has understandably been a major focus of the election campaign and the Trust will need to be in a position to respond to the significant delivery and organisation challenges of the coming months.

The Trust Senior Management Team already has a number acting posts, which could not be progressed through an appointment process without a permanent Chief Executive in place. There is an urgent plan in place to support the Trust as it rebuilds following the impact of the last two years. This needs clear leadership from the Chief Executive.

There are plans to restructure the organisation and appoint 6 new directors in the next few months. This is necessary to stabilise the Trust in the longer term but in the short term will require significant time and resource from the Director of HR and the Chief Executive to secure.

In order to provide support to previous Chief Executives who have also now received their Section 21 notices, the Chief Executive PA is being stepped out of her role and replaced

by temporary and less experienced staff which in turn is adding to the demands on the Chief Executive.

Similar to the Human Resources Director mentioned above, the Chief Executive is also currently overseeing the response to major organisational risks. These include the relocation of mental health services from the Gillis Unit, Armagh to the Craigavon site; the relocation of Emergency Surgery from the Daisy Hill to the Craigavon site; the pressing need radically to reduce waiting lists in mental health and surgical specialities; and the impending release of the ministerial directed review of 29 Covid19 nosocomial patients in the Southern Trust.

For the purposes of stabilising the system and assisting the CEO throughout the lifetime of the Inquiry the Assistant Director for Systems Assurance post will now be developed into 2 posts concentrating on different aspects of delivery of the role.

Another administrative assistant will be appointed temporarily to the office of the Chair and Chief to support this office during the lifetime of the Inquiry.

In the circumstances, to require Dr O'Kane to step away from the service for significant periods during the next 4-5 weeks to complete statements in respect of two Section 21 notices adds to the real risk of service de-stabilisation. In the circumstances we respectfully request an extension of time for Dr O'Kane's statement in response to both S.21 Notices until 23rd June 2022.

Other issues relevant to provision of operational and corporate services

Having received the S.21 Notices on 28 And 29 April, and in light of all of the operational issues discussed in this correspondence, the Trust has issued an Early Alert to the Department of Health about the potential service impact of these S.21 Notices, and we attach a copy of the Early Alert for your information.

Generally, all staff in the Trust (and across all Trusts in Northern Ireland) will be required to use their Annual Leave this year – two years of COVID provision has allowed staff to carry unlimited leave forward year to year, or to be paid for unused leave. This COVID provision no longer applies and staff will need to use their leave or risk losing it. Indeed, given the pressures on staff over the last two years, they are now being encouraged to ensure that they take their annual leave for the good of their physical and mental wellbeing. This is considered essential in relation to staff welfare and avoiding future dilution of what is already a compromised workforce in many key services areas as outlined above.

There remain high levels of staffing vacancies across all areas of health and social care in NI. This is the case in senior medical and nursing posts, but also across administration and management areas. There is, in short, no slack elsewhere in the system that can be diverted to support services in the Southern Trust.

The Trust also has to factor in the time taken to support each individual S.21 response, the sourcing of documents, indexing same, etc. which from recent experience can be extensive. It is also the Trust's experience that retired staff/staff no longer working in the Trust, require high levels of support, for example, in accessing old emails and documents to which they no longer have access.

What is also becoming increasingly apparent to the Trust is that, while the Trust's original document search focused upon the period 2016 – 2020, S.21 Notices are requiring information going back as far as 2007 which requires widening search parameters and significantly more documents to be retrieved, categorised, and provided as part of discovery.

The Trust is also currently supporting Urology nursing and medical staff to complete the questionnaires issued by the Urology Services Inquiry before Easter. This, again, has proved to be a difficult and time-consuming process as staff endeavour to provide the level of response required by the USI, and has impacted on some provision of clinical services. Understandably, staff recognise the significance of their responses and need the time and support to complete these responses fully and accurately.

Given the weight and importance of the Section 21 statement process, the Trust believes that each member of staff deserves adequate time, space, and support to complete their statements.

In light of all of the matters raised above, some Trust staff seek an extension of time for the submission of their statements in response to the recent S.21 Notices. To that end, and in ease of the Inquiry, the Trust has attached a spreadsheet which contains the names of the Trust's current staff who received S.21 Notices in the recent batch of 40 Notices. As you will note, the spreadsheet contains suggested alternative completion dates in respect of some of the Trust witnesses and we would respectfully invite the Inquiry to give favourable consideration to this request (in light of all that has been set out above). As you will see from the attached Spreadsheet, as well as the issues canvassed in this letter, some staff have other commitments/personal reasons for seeking an extension and these personal reasons are highlighted where appropriate in the spreadsheet.

Whilst we appreciate that it may not always be possible or perhaps appropriate to provide notice ahead of the issuing of s.21 notices, it would be of great assistance to the Trust if some advance notice could be provided to it in future if large numbers of simultaneous requests are likely to be made of the Trust. For example, although the Trust is now taking steps to expand further its legal team, this will likely take some further weeks and this is a process which could perhaps have been started sooner had the Trust been aware in advance of the extent of the requests that were going to be made across 28 and 29 April 2022.

As always, if the Inquiry requires further information on any issue canvassed above, please let me know and I shall endeavour to obtain and provide it.

I look forward to hearing from you further in due course.

Yours faithfully,

Avril Frizell
Consultant Solicitor

Direct Line: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Personal Information redacted by the USI

Received from Eileen Mullan on 26/09/2023. Annotated by the Urology Services Inquiry.

Encs

Trust Risk Assessment Form for Risk Register

SOUTHERN HEALTH & SOCIAL CARE TRUST		
RISK ASSESSMENT FORM	**Risk ID No**	
Directorate: Chief Executive's Office	**Facility/Department/Team** Public Inquiry Team	**Date:** Updated 09/05/2022
Where is this being carried out? **(e.g. Trust premises/home of client/staff/ private nursing home etc)** Trust-wide impact Primarily Acute Directorate	**Objective(s)** 1. Promoting safe, high quality care; 2. Supporting people to live long, healthy active lives; 3. Improving our services; 4. Making the best use of our resources; 5. Being a great place to work – supporting, developing and valuing our staff; and 6. Working in partnership.	

1. Risk Title: (Threat to achievement of objective)

Response to Statutory Public Inquiry into Urology Services in the Southern Health and Social Care Trust (USI):

There is a risk that due to capacity issues, the Trust may be unable to respond in a timely and complete way to Section 21 requests from the USI;

There is an risk to the delivery of Trust services due to the response requirements of the Section 21 (S21) process and the high volume of S21 currently being managed. This may impact on patient safety through, for example longer waiting times, access to red flag surgery;

There is a risk to staff well-being due to the additional pressure and workload required to respond in a timely and complete manner and the impact of the resulting public exposure;

There is a risk that the S21 process, and the extended timeframe now covered by the Urology Services Inquiry, will require significantly higher levels of discovery material than originally specified and this has a resulting impact on the wider Trust.

The further risk will be issues identified through the discovery process which may impact on the reputation and function of the Trust

2. Description of Risk:

This assessment details the risk to the Trust and to individual members of staff, current and former, from the Urology Services Inquiry (USI).

Health Minister Robin Swann, in a statement to the Assembly, on 24 November 2020, advised Members of his intention to establish a Public Inquiry, under the Inquiries Act 2005, into the circumstances surrounding Urology Services in the Southern Health and Social Care Trust.
The Urology Services Inquiry began on 6 September 2021.

The Inquiry is being chaired by Christine Smith QC. A Public Inquiry is a major investigation – set up by a government minister - that can be gifted special powers to compel testimony and the release of other forms of evidence. The only justification required for a public inquiry is the existence of "public concern" about a particular event or set of events. In announcing the Urology Services Inquiry on November 24, 2020, the Health Minister said: 'The remaining issues to be addressed relate to the management of all past, present and future cases that would meet the threshold for an SAI review; as well as establishing why this happened, and whether action could have been taken earlier by the Southern Trust to identify and address the apparent deficiencies in the consultant's clinical practice. Given the large number of cases already identified as meeting the threshold for an SAI review and my concerns that there may be more to come, a different and specific approach is required ….. therefore, I intend to establish a statutory public inquiry, under the Inquiries Act 2005.'

The initial stage of the Inquiry involves evidence gathering by the Inquiry team.

Section 21 of the 2005 Act provides the Chair of the Inquiry with various powers, requiring a person to:

- Attend to give evidence
- Produce any *document or documents in his/her custody or under his/her control that relate to a matter in question at the Inquiry:
- Produce any other thing in his/her custody or under his/her control for inspection, examination or testing by, or on behalf of, the Inquiry Panel,:
- or Provide evidence to the Inquiry in the form of a written statement.

*document in this context includes information recorded in any form including, for instance, correspondence, notes, emails, memoranda and text communications.

The USI will hold a series of hearings in public at a date yet to be determined.

3. Outline the potential for harm: (Consider injury to patients, client, staff, litigation, etc.)

There is an risk to the delivery of Trust services due to the response requirements of the Section 21 (S21) process and the high volume of S21 currently being managed.

This may impact on patient safety through, for example longer waiting times, access to red flag surgery

There is a risk to staff well-being due to the additional pressure and workload required to respond in a timely and complete manner and the impact of the resulting public exposure.

There is a risk of increased litigation cases as a result of the clinical lookback process.

Provision of information to USI

Over 30,000 pieces of information – emails, correspondence, minutes etc - have so far been transferred to the USI. The timeframes for compliance have been challenging and there is a wide scope of discovery. This has been a huge undertaking, and involved trawling through archive emails, personal accounts, etc. There is a risk of not achieving full compliance with the S21 notices. This maybe be due to incomplete historical information being available; the Trust's IT storage and retrieval systems capacity; the Trust's network capacity and the process for transfer of large amounts of data across to the USI. The Trust has also had to comply with requests for information to be provided in a specific format for the USI, which is time-consuming and has required use of a document transfer system which has capacity limitations. Acting on instructions from the USI in relation to timeframes for response, the information that has already been released has not been fully assessed or reviewed due to time constraints and the high volume of information requested.

The extent and scope of the original discovery request as expanded back to 2007 in some cases. It is anticipated that if wider discovery in the 2007 – 2015 timeframe is required, it would more than double the level of discovery already provided. This will push significant additional and unplanned workload on to the Trust which may necessitate the stand down of other work priorities and create additional cost as additional staff resources may be required.

Staff impact

Staff are required to provide high volumes of historical information in response to Section 21 (S21) notices received from the USI. This primarily relates to staff in the Acute Directorate who must also manage services during the on-going pandemic. This also has a significant impact on support directorates who hold/manage information required to inform responses. Timeframes for return of information have to date been four weeks which is extremely challenging and although extending out to six weeks in recent S21s, remains a challenging timeframe. The Trust has provided around 30,000 documents as part of initial discovery process.

Responding to S21s is time consuming, requiring research, consultations with legal team and sufficient time to properly complete a legal document. Staff will in some cases receive multiple S21s, relating to various areas of work.

The USI teams are currently collating the documentation provided by the Trust and it is anticipated that this will generate further queries which the Trust will be expected to respond to within short timeframes.

In the next stage of the USI, any staff deemed of interest to the Inquiry will receive individual S21 notices. These will detail specific questions and will require a witness statement along with supporting evidence. The Trust must ensure these staff have capacity and support to fulfil their S21 obligations. This has the potential to have a detrimental impact on staff and is likely to have an adverse impact on the delivery of normal services.

The Trust has received a number of S21 notices, covering current and former staff.

Around 140 staff working in Urology In-patients and out-patients received detailed questionnaires immediately prior to Easter.

All former Chief Executives, Directors of Acute Services and Medical Directors have now received S21 requests.

A total 40 S21 notices were issued on the 28/29th April, all with response timeframes of six weeks.

The scope of discovery is likely to impact on all areas of the Trust, and have secondary impact on those areas required to provide information eg. the HR department. This may impact on the delivery of general Trust services.

Staff wellbeing

It is widely recognised that the on-going response to the Covid19 pandemic has placed significant pressure on staff over a sustained period of time since March 2020. The ongoing demands of the pandemic, has impacted on the wellbeing of many staff, and we continue to manage a high volume of staff absences, as the number of unavailable staff remains at a high level. This all adds pressure into an already stretched system. Whilst responding to the Public Inquiry itself will be stressful for staff given the historical nature of the information, the level of detail required and the legal standing of the documents, this presents a significant risk that on staff well-being for those involved, as many of the staff most directly impacted have also been at the forefront of the Covid-19 response.

There are limited options available in terms of additional resource eg lack of consultant locum cover.

Reputational risk

Reputational risk to the Trust exists with the production of information in the Public Inquiry which relates to Urology Services. This will include witness statements, evidence from staff, patients and families, and other external bodies. As the hearings will be held in open session, this is likely to attract high and sustained levels of media interest.

Organisational risk/business continuity

There is a high level of organisational risk to the function of the Southern Trust, which is a key and underpinning part of the Health Service in NI. Staff who are involved in providing evidence to the USI are likely to have to be relieved of normal duties. This

presents a risk to service delivery, with potential service retraction if it is not possible to backfill key posts. Given the public attention on Trust urology services, it may be difficult to attract and retain staff. Accessing support from elsewhere in NI is unlikely as all services are under pressure.

The challenging timeframes to supply S21 responses, and the likely extent of required disclosures, will add significant personal stress on staff who have managed services through the pandemic and may result in staff absences with the potential resulting impact on patient care.
The Trust would welcome the opportunity to work with the USI team to frame a process that can deliver the requirements of the USI while at the same time protect patient care, maintain services and support staff welfare.

Staff diversion to comply with S21 notices may impact on Trust's pandemic rebuilding process adding further stress into an already stressed system.

Capacity of Trust to support multiple individual S21s simultaneously is creating additional pressure in the system as staff are cognisant of the importance of the process but may not have sufficient time or legal support to deliver their response. . This will be in addition to the on-going risk posed by Covid-related staff absence continues on staffing levels across the Trust.

As the extent of discovery requirements widens, the direct and secondary impact is felt across all areas of the Trust. To comply with existing deadlines, other work will need to be set aside which impacts on the delivery of patient services.

Individual risk and responsibility of staff
Individual staff will be responsible for their own witness statements and may be required to give evidence in open hearings. It is essential that all staff complete their own statements and are fully aware of all information released to the USI. It is estimated that between 20-30 staff will be issued with S21 notices. It is likely that staff will have to provide responses to more than one S21 notice, as the USI gathers and assesses evidence. Non-compliance with any S21 notice carries a risk of sanction. The Trust will need to provide significant support for individual staff to complete their S21 responses which may impact on the maintenance of services. There is a reputational risk to individuals who are part of the USI process, to their professional reputation and their personal wellbeing.

The number of staff receiving S21s/questionnaires is now close to 200. Each member of staff carries the personal responsibility for their responses and all staff require the support of the Trust. This level of on-going support is necessary and significant.

Staff engagement/communication
In an already busy and pressured environment, staff will need to make time to understand the requirements of the USI and the legal standing of the PI. There is a risk of staff being unaware of their obligations, or potential consequences of non-compliance. As this is likely to be the first exposure to a Public Inquiry for staff, lack of acknowledgement or understanding of the process will be a risk.
Staff engagement with so many competing important agendaes is difficult, and the legal imperative of a S21 creates significant anxiety.

Finance
There is no currently identified funding currently earmarked to support the Public Inquiry. The costs of supporting the PI response are likely to be considerable, including direct staff costs, backfill, staff support, legal representation, etc.

Governance

Operational governance arrangements to support the Trust response will require further development and resource to ensure robust oversight and assurance to manage the risks.

Information Governance is also a risk as the high volumes of information which are being ~~provided have not been risk assessed, and may contain confidential information~~processed.~~.~~

Patients – risk of increased litigation / rise in complaints as a~~-~~ result of the outworkings of the Inquiry itself or due to the impact of slowed workload as staff respond to the Inquiry demands.

Lookback exercise
The Urology clinical and operational teams have worked to identify, assess and review the first cohort of patients reviewed as part of the Public Inquiry. The Trust is currently waiting for the Royal College of Surgeons' report on 100 patients which is expected by the end of June. If this report signals the need for a further lookback, this will likely have an impact on already very long waiting lists due to capacity within the clinical teams. This has the potential to cause further stress and anxiety to patients.
The Lookback process requires ~~significiant~~ significant time and support, and requires a level of independent input, which has been difficult to source.

Quality assurance agenda
Due to capacity and resource issues the Trust may be unable to implement the full raft of recommendations contained in the Urology SAIs potentially delaying the improvement agenda identified.

Summary of current control measures: (Consider equipment, staffing, environment, policy/procedure, training, documentation, information – this list is not exhaustive).

Human resource mitigation measures

- Resource Public Inquiry Team are co-ordinating responses to USI, liaise with DLS and the USI team and provide repository for organisational information.
- Directorate teams providing backfill where possible to release staff to comply with S21 notices – backfilling key posts is a challenge.
- Public Inquiry team working to ensure good communication with impacted staff and wider organisation
- Work ongoing to identify resources for staff psychological support

- Work ongoing to identify former staff who may be impacted, explain and engage with offer of full support

Provision of information to USI demand and organisation

- Public Inquiry Team alert DLS as required to any issues/concern re: discovery and ensure that USI are kept fully informed.
- IT enhanced support regarding retrieval of information through email system, and access to Kofax for data transfer to facilitate USI data transfer requirements.
- DLS support to review information provided by Trust as part of the discovery process
-

To analyse, collate and assess information which has so far been retrieved, the Trust will need to employ additional staff. This will facilitate access to information for individual staff members, alert to any data protection issues and validate completeness of archive.

Reputational risk

- To ensure that all discovery is delivered on time, is complete and there is full co-operation with the USI team the Trust Public Inquiry team has recruited additional staff
- To ensure that the Trust has knowledge of information shared with the USI and the likely consequence of its release the Trust Public Inquiry team has recruited additional staff
- To ensure that all participants in the Inquiry are fully supported for full disclosure of all relevant information the Trust Public Inquiry team has recruited additional staff
- To ensure that all learning is incorporated and shared as appropriate in a continuous and timely way the Trust Public Inquiry team has recruited additional staff
- To ensure that any patients/families identified as impacted through the Lookback process are supported by the Trust a dedicated clinical assurance manager has been appointed to oversee the task.

Given the volume of simultaneous S21s, the further widening of discovery, and the on-going discovery process, staff recruitment needs to enhanced.

Organisational risk-

- The Public Inquiry team are working to support the earlier identification of staff required to complete S21s, review impact and provide backfill where possible
- The Public Inquiry team are alerting DLS/USI where there are patient implications in complying with S21 deadlines and seek to find an agreed way forward.
- The Public Inquiry team / DLS are working to anticipate S21 requests and collate relevant information to assist with full disclosure
- Public Inquiry team will issue early alert to HSCB/Dpt in the event of service disruption due to demands of USI. This concern has been flagged to HSCB.

Individual risk and responsibility for staff

- The Public Inquiry team will provide targeted support for staff receiving individual S21 notices.
- The Public Inquiry team will create time for S21s to be completed – through backfill, work deferment/retraction, or other appropriate means
- The Public Inquiry team will ensure psychological support available to staff
- DLS will provide expert legal advice for staff, to ensure they are aware of obligations, and potential for sanctions in the case of non-compliance.
- All services will work to identify former staff likely to be impacted, and ensure they are fully supported by the Trust, if that is their wish.

Staff engagement / communication

- The Public Inquiry team will develop a pro-active communication strategy developed
- The Public Inquiry team will develop a suite of information assets to support staff
- The Public Inquiry team will develop a targeted communication for those staff most impacted
- The Public Inquiry team will develop support systems for discovery phase and preparation for open hearings to be developed in conjunction with staff.
- The Public Inquiry team will work to make available psychology support – informal support networks

Finance

- The Trust did bid for funding to cover expenditure in 2021-22 at the October monitoring and this wasn't accepted. However it was funded from "general pressures" non-recurrent funding. The Trust has informed the HSCB and DOH that the cost of the Inquiry will give rise to pressures in future years and the Trust will seek funding from the DOH each year when they arise.

Governance

- Programme Board established chaired by Chief Executive to oversee Trust response, provide assurance to Trust Board and ensure learning is shared
- Establishment of three sub-groups of Programme Board to manage Trust response:
    - Public Inquiry Steering Group
    - Lookback Group
    - Quality Assurance group
- Mechanisms developed to ensure timely response to patient/family complaints arising from Urology concerns
- Development of effective support processes in place for patients/family impacted by PI
- Escalation to HSCB/commissioner identifying funding requirements to implement recommendations of Urology SAIs.

Are these controls: (b) Require Further Action **Please list control measures considered but discounted and why (where appropriate)**			
Assessment of Risk	**Likelihood** **e.g. Likely**	**Consequence/ Impact** **e.g. Moderate**	**Risk Rating** **L and C = RR e.g. Likely and Moderate = YELLOW**
	Likely	**Major**	**High (4x4)**
Inability to deliver multiple S21 responses to timeframe specified by USI			
Risk to patient services			
Risk to staff welfare			

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

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 23rd June 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals
Dr A Diamond, Deputy Medical Director

IN ATTENDANCE

Mr B Beattie, Acting Director of Older People and Primary Care
Mrs L Leeman, Interim Director of Performance and Reform
Mrs M McClements, Director of Acute Services
Ms J McGall, Director of Mental Health and Disability Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)
Ms S McKinney, Boardroom Apprentice

APOLOGIES

Mrs H McCartan, Non-Executive Director

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting. The Chair acknowledged that this was Mrs Melanie McClements' last Trust Board meeting as she would be retiring from the Trust in July 2022. She

advised that there would be an opportunity to pay tribute to Mrs McClements at the end of the open meeting.

The Chair also acknowledged that this was Ms Susan McKinney's last Trust Board meeting as her tenure as SHSCT Boardroom Apprentice ends on 31st August 2022. On behalf of members, she thanked Ms Kinney for her attendance and contribution to Board meetings over the past year.

2. **DECLARATION OF INTERESTS**

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. **NEWRY CTCC**

Mrs Leeman referred members to the update paper on the current position in relation to Newry CTCC, which includes further clarification on queries raised by members at the confidential Trust Board meeting on 31st March 2022. Mrs Leeman specifically updated on recent discussions with both Land & Property Services and the Preferred Bidder on the sale of the existing site in Newry. She advised that the preferred bidder has indicated a sale price of £4.7m (to include the design). The Trust has explained that only the market value to the site can be paid in the instance where it is agreed that this is the best option for delivery of the scheme. Land and Property Services (LPS) have undertaken an evaluation of the site and returned their valuation of the site and advised of a market value of £1.5m. This has been communicated to the preferred bidder who is disappointed at the perceived low evaluation outcome and sought a further meeting with LPS to understand the basis of the valuation and any potential for negotiation within normal tolerances. The Trust awaits the outcome of the discussion between the preferred bidder and LPS to be able to firm up the options for inclusion in the Strategic Outline Case. The Trust will be guided by the LPS position when formalized.

The areas of concern and risk were discussed, particularly the negative press and media backlash. Mr Wilkinson spoke of the importance of open and transparent communication with the public on this matter. Mr McDonald concurred with Mr Wilkinson's comments and suggested that the Trust meets face to face with its partners in

the Newry area with a clear communications message. Mrs Rogers advised that due to the commercial sensitivities associated with this matter, any communications must be referred to the DoH in the first instance.

4. **THE FIRS, BALLYGAWLEY**

Ms McGall spoke to a briefing paper in relation to the closure of an independent sector residential and short-break facility, The Firs Residential Home, Ballygawley, with whom the Trust contracts service provision. Ms McGall explained that the owner of the facility has indicated her intention to retire, as of 24th June 2022 and thus the services provided by her business will no longer be operational. There are no confirmed interested parties / potential buyers for The Firs.

Ms McGall made reference to the significant local elected representative and family lobbying, along with local newspaper coverage of this issue and coverage on the televised Nolan show in recent weeks. Family representatives of residents of the Firs have made contact with the Chair and Chief Executive of the Southern HSC Trust asking that all members of Trust Board and Directors are made aware of their concerns and issues. A detailed communication timeline was provided in members' papers as well correspondence to and from the Chair/Chief Executive. The Trust has sought DLS view and is liaising regularly through Early Alerts and telephone discussions with the Department of Health, who remain supportive of the Trust's position.

In relation to the current position, Ms McGall stated that there are currently 5 residents within the home with 1 residential bed remaining vacant over the last 3 years and 1 individual recently having moved out of The Firs. She advised that the vacant bed spaces are evidential of the level of demand for residential services within the local area. All of The Firs residents are assessed as requiring a non-complex level of care. The Trust clinical staff are working intensively with remaining families to identify suitable alternative placements prior to the home closure on 24th June 2022. There are plans for each of the residents. There is one individual and family who are not engaging with relocation planning, although having assessed this individual's current needs, the Trust is satisfied that these assessed needs can be met in an alternative available placement within the Trust area.

Ms McKinney asked about staff transfers. Ms McGall confirmed that the Trust held two contracts with the Firs: one for the provision of domiciliary care and one for the provision of residential care. Staff of the Firs employed to provide domiciliary care have been offered TUPE to Trust employment in Trust Home Care (Note: TUPE does not apply to staff providing residential care). The remaining staff, the Trust understands, are either retiring or seeking alternative employment. No concerns have been raised with the Trust in relation to staffing. Mr Wilkinson asked if the Trust has an appetite to purchase and manage The Firs. Ms McGall advised that this has been given considered thought and was considered in the Option Appraisal in relation to the Firs, however was not the preferred option. Dr O'Kane stated that this was an opportunity to progress towards more modern, person centred provision for clients with Learning Disability.

Mrs Toal asked if the letters from relatives would be reviewed for learning. Ms McGall acknowledged that the impact and learning was a piece of work that needs to be taken forward. She advised that she would be meeting with the relatives of one of the residents that afternoon to listen and take their feedback on board.

5. **UPDATE ON CLINICAL CONCERNS WITHIN UROLOGY AND UROLOGY SERVICE INQUIRY (USI)**

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm outlined the key aspects of the update report, primarily focusing on progress against the S21 notices.

The Chair and Chief Executive had attended two days of the Private Hearings that week. The Chair stated that she valued the time spent and was encouraged by how safe the environment was for patients and their families. Patients and families shared their journeys, which included the compassionate care shown to them in parts of the Trust.

Mrs McKimm advised that the Independent Neurology Inquiry report has now been released which she encouraged members to read as there is relevance and learning for the Trust as regards the Urology Service Inquiry.

Mrs McKimm spoke of the USI Panel visit to the Craigavon Hospital site on 15th June 2022. The visit was at their request, and to help familiarise themselves with areas pertinent to the Inquiry.

As part of the Urology Review lookback exercise, members noted that the Trust is continuing to progress with contacting and updating patients

Mrs McKimm stated that the correspondence sent to patients in December 2021 and January 2022 referred to the work of the USI, however, some of this information in the letter was subsequently found to be inaccurate regarding dates of announcement of the Public Inquiry and the purpose of the inquiry. The Trust has liaised with the USI to inform them of the Trust's intention to write formally to correct this information. This process has now commenced and the Trust has prioritised the order in which they are sending these update and / or correction letters.

6. **MAINTAINING HIGH PROFESSIONAL STANDARDS (MHPS)**

Dr Diamond reported on the recent discovery that a Consultant in Obstetrics and Gynaecology had performed a procedure, allegedly without obtaining full consent of the patient. The procedure was a sterilisation, which occurred during a non-elective caesarean section. Preliminary investigations have suggested that this was an isolated incident. The doctor is now subject to MHPS processes and the doctor and the service will be subject to a Level 3 SAI. The GMC have been notified and the patient has been notified of the above.

The Chair advised that a quarterly report on the MHPS process will be provided to the Governance Committee with the first update scheduled for the September 2022 meeting.

Action: Medical Director

7. **FINANCIAL STRATEGY UPDATE 2022/23**

Ms Teggart presented an update paper to the Draft Budget paper discussed at the Trust Board meeting on 31st March 2022. This sets out the latest iteration of the draft opening financial position for the financial year 2022/23 pending full confirmation of opening budgets from the Department of Health.

Ms Teggart stated that whilst there is not full certainty of an approved Budget for 2022-23, the Strategic Planning and Performance Group (SPPG) in May 2022, developed an agreed set of financial planning principles to support the Trust for 2022/23. These principles provided the Trust with a draft position to consider against its opening financial plan and identified commitments to funding for 22/23 which allowed revision of the opening financial position. Ms Teggart advised that an indicative allocation from SPPG has just been received and the Trust is in the process of reviewing same – PHA Indicatives have yet to be confirmed. The opening financial plan will be subject to revision on an iterative process, however, the Trust has been asked to submit a revised financial plan to SPPG by 30th June 2022.

Ms Teggart reminded members that as was noted in the Draft Budget paper in March 2022, the total 2022/23 estimated opening recurrent gap was £39.8m. After the consideration of new/emerging/additional cost pressures, the gap increased to some £65m. Ms Teggart referred members to Table 2 in the paper which takes account of the funding commitments, any additions to pressures previously noted and additional savings to be achieved. She advised that when all are considered, the potential deficit is reduced down to £16.3m.

In relation to savings plans, Ms Teggart advised that it is expected that the Trust will achieve the same level of savings that were achieved in 2021/22 - £7.2m. She stated that the £16.3m gap assumes that the additional savings can be achieved but firm savings plans need to be agreed and then monitored closely to ensure achievement going forward. The DoH are expecting a downturn in discretionary spend again in 22/23 and this will have to form part of the Trust's savings plans.

Cost pressures associated with the Urology Public Inquiry and the new management structures were raised. In response to a query from Ms Donaghy on the £1m estimated cost of the new management structures, Ms Teggart clarified that whilst the new management structures had been approved, the funding had not yet been received. The Trust was proceeding at risk to implement the new structures. Mr McDonald commented that there had been an indication when the new management structures were presented to Trust Board previously that these were cost neutral. Ms Teggart advised that this investment was required in terms of patient safety. In response to a question from Mr

Wilkinson on the £0.6m for Carrickore and Oaklands, Ms Teggart advised that the DoH is aware of the cost pressures and the Trust's requirement for this funding. She added that the DoH has sent a clear message to Trusts to not spend in excess of the 2021-22 allocation given the magnitude of the current deficit unless Trusts can fund within their current funding allocations.

Ms Teggart stated that the need for funding to address Covid-19 remains in 2022-23. Currently there is a commitment to fund Quarter 1 Covid costs, but for planning purposes, the Trust is assuming that all Covid costs will be funded in full non-recurrently during 2022/23.

In concluding, Ms Teggart stated that whilst at this stage the Trust does not have clarity on its total allocation for 2022/23 and whilst the DoH has provided confirmation to continue spending at 2021-22 levels in the absence of a confirmed budget allocation, the potential deficit of £16.3m is a significant risk to the Trust and she referred members to a series of measures as outlined in the paper to address this risk in 2022-23.

The Chair spoke of the need to build in more time at Trust Board meetings for more in-depth discussion on the 2022-23 budget allocation and opening financial position.

Action: Chair and Chief Executive to further discuss

8. **FEEDBACK FROM REMUNERATION COMMITTEE**

The Chair presented her Remuneration Committee Chair Report of the 19th May 2022 meeting and members noted the areas considered.

The Chair sought retrospective approval of the implementation of the Pay Award Circulars in respect of 2017/18, 2018/19 and 2019/20.

Trust Board retrospectively approved the implementation of the Pay Award circulars.

The Chair sought approval of the Remuneration Committee's revised Terms of Reference.

Trust Board approved the revised Terms of Reference.

9. **ANY OTHER BUSINESS**

None

The meeting concluded at 9.50 a.m.

Southern Health and Social Care Trust

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TRUST BOARD COVER SHEET

Meeting Date	Thursday 23rd June 2022	
Agenda item	Update on Clinical concerns within Urology	
Accountable Director	Dr Maria O'Kane Chief Executive	
Report Author	Name	Jane McKimm
	Contact details	Personal Information redacted by the USI
This paper sits within the Trust Board role of: **Accountability**		
This paper is presented for: **Information**		

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

	This report cover sheet has been prepared by the Accountable Director. *Its purpose is to provide the Trust Board with a clear summary of the report/paper being presented, with the key matters for attention and the ask of the Trust Board.* *It details how it impacts the people we serve.*

1. Detailed summary of paper contents:

This paper outlines a brief update on the progress in response to the Public Inquiry into Urology Services in the Southern Trust. Given the short timeframe since the last update, it focuses on progress against the S21 notices.

Urology Services Inquiry

Evidence gathering for the USI is continuing. A total of 56 Section .21 Notices have been served on Trust witnesses since 14 April. Of these, 55 are being dealt with by SHSCT/DLS with one former member of staff instructing alternative legal representation.

By Friday 17th June, 18 S.21 Notices had been submitted, with a further 16 Statements to be submitted by 1 July. Two S.21 notices are currently in abeyance – ie. not currently being progressed with agreement from the USI.

USI site visit to Craigavon Area Hospital site.

On Wednesday June 15th, the USI panel visited the Craigavon Hospital site. The visit was at their request, and to help familiarise themselves with areas pertinent to the Inquiry.

They visited Trust Board HQ, Urology Wards, Admin offices in CAH, the Thorndale Unit among other areas.

Panel Members and legal representatives in attendance: Christine Smith (chair), Damian Hanbury (assessor), Sonia Swart (panel member), Martin Wolfe (senior counsel), Laura McMahon (junior counsel) and Eoin Murphy (solicitor).

Patient Lookback Process

As part of the Southern Trust Urology Review lookback exercise the Trust is continuing to progress with contacting and updating patients affected by this.

In December 2021 and January 2022 the Trust wrote to approx. 2114 patients to inform them of the Urology Lookback Review and advise them that their care was being reviewed at this time. The Trust was able to advise many patients (approx. 1300) that there were no concerns with their care. Other patient were informed that the review was ongoing.

The correspondence sent to patients in Dec / Jan referred to the work of the Urology Services Inquiry (USI) however, some of this information in the letters was subsequently found to be inaccurate regarding dates of announcement of the Public Inquiry and the purpose of the inquiry. The Trust has liaised with the USI to inform them of the Trust's intention to write formally to correct this information.

This process has now commenced and the Trust has prioritised the order in which they are sending these update and / or correction letters as follows:

1. Patients who received initial correspondence that their care was being reviewed and this is complete with no clinical concerns found – their letter will advise this and correct inaccuracies and should not be controversial **(week commencing 6 June and continuing 13 June)**
2. Patients who received initial correspondence that their care was being reviewed and this is now complete – and clinical concerns were identified - their letter update on findings and next steps and correct inaccuracies **(week commencing 13 June)**
3. Patients who review remain incomplete – their letter will be advise there is still no update and inaccuracies will be corrected **(week commencing 13 June)**
4. Patients have had no correspondence to date at all (all correspondence with patients stopped in February '22 when the errors were discovered so some patients didn't get any letter) – their letter will introduce them to the Urology Lookback Review and advise of USI – **(week commencing 13 June)**
5. Patients who have has Structured Clinical Record Review (i.e. the processes which is being conducted in place of the regional SAI process) returned – their letter will update on SCRR and offer patient meetings to discuss further. It will also correct the inaccuracies **(week commencing 13 June)**
6. Patients who receive an original letter with no concerns but included inaccuracies – their letter will correct the inaccuracies (**week commencing 20 June**)

The sending of update and correction letters will continue over the coming weeks in the order detailed above and will cease when complete. All letters will signpost patients / families to the Trust Helpline for extra support.

Update from the USI

In a statement issued on June 13th, Chair of the panel outlined progress on discovery and plans for the patient/family hearings on June 21st, 22nd and 23rd of June.

The full statement can be found here:

Statement from Christine Smith QC, Chair of the Urology Services Inquiry providing an update on the Inquiry's work and planned hearings for June 2022 | Urology Services Inquiry

2. Areas of improvement/achievement:

Work continues in implementing recommendations from the Serious Adverse Incident process.

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

Corporate Risk Register	
Board Assurance Framework	
Equality and Human Rights	

Southern Health and Social Care Trust
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Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 29th September 2022 at 8.45 a.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals
Dr D Gormley, Deputy Medical Director (for Dr D Scullion)

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs J McConville, Assistant Director of Corporate Planning *(for Mrs L Leeman)*
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Interim Director of Medicine and Unscheduled Care
Mrs T Reid, Interim Director of Surgery & Elective Care, Integrated Maternity & Women's Health, Cancer & Clinical Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs P McKeown, Communications Manager *(for Mrs R Rogers)*
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Dr D Scullion, Deputy Medical Director
Mrs L Leeman, Interim Director of Performance and Reform
Mrs R Rogers, Head of Communications

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting, in particular Mrs C Reid and Mrs T Reid following their recent appointments as Interim Directors. On behalf of members, the Chair congratulated Mr B Beattie on his appointment as Director of Adult Community Services.

The Chair referred members to the new Report Cover Sheet and stated that she would welcome their feedback at a further point.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. MINUTES OF MEETINGS HELD ON 26TH MAY & 23RD JUNE 2022

The minutes of the meetings held on 26th May 2022 and 23rd June 2022 were approved as accurate records.

4. MATTERS ARISING

i) Update on Irrelevant information redacted by the USI Irrelevant information redacted by the USI

Ms McGall spoke to a paper which provides an update on the service model currently being provided at Irrelevant information redacted by the USI Irrelevant information. This includes:

- RQIA Finance Inspection 27th April 2022: Findings and recommendations
- Medicines Management
- Staff Supervision
- Staff recruitment, retention and induction
- the Governance data set as requested by Trust Board

Ms McGall informed members that an unannounced RQIA Inspection was undertaken in Irrelevant information redacted by the USI Irrelevant information redacted by the USI and the final report is awaited. She stated that while there were areas of good practice identified, RQIA have raised concerns regarding failures in improving compliance levels in staff training as noted as a quality

improvement recommendation in a previous inspection. A Serious Concerns Meeting hosted by RQIA with the Trust took place on 23rd September 2022. The Trust has provided a robust action plan to RQIA which they have accepted. A monthly report on staff training will be provided to RQIA.

Mrs McCartan welcomed the fact that Irrelevant information redacted by the USI is to introduce and implement the new Appraisal Conversation. She referred to the improvements made to date, but stated that a positive culture and sustained change will take time to embed and it was important to keep a focus on this. She stated that the Directors Oversight Group was key to this work.

Mr McDonald welcomed the Governance data set in the papers as requested by Trust Board members. He stated that he looked forward to the triangulation of the data to identity trends and target areas for improvement.

Ms McGall agreed to bring an update to a future meeting.

At this point, the Chair took the Update on Governance concerns within Urology on the agenda.

5. UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. An update report was included in members' papers. Mrs McKimm provided a verbal update on recent developments as regards the Public Inquiry as follows:

- The discovery process continues, with an additional 33 Section 21 notices served. Mrs McKimm emphasised the importance of staff adhering to the response deadlines.

- Private Patient Hearings took place on 27th and 28th September 2022 attended by Trust representatives. Those Directors who had attended provided verbal feedback on their experience.

- The formal Public Hearings will begin on 8th November 2022 with Opening Statements from core participants. As the Hearings continue, further Trust witnesses required to attend will be

notified. At this point, the Chair raised the impact that staff absence, particularly at senior leadership level, will have during the Public Hearing process.

- In evidence released to the USI, it has become clear that meetings involving Mr AOB and Trust staff, were recorded without the knowledge of all parties. between himself and Trust staff. Mr Wilkinson, as one of the individuals involved in these meetings, voiced his concern and stated that these covert recordings undermine trust within the Trust. He asked if the Trust was going to seek legal advice on this matter. Mrs McKimm advised that a process is now in place whereby permission has been granted for the transcripts of those meetings to be shared with staff involved in the meetings for their review. Staff involved will be consulted on the issue to establish what steps are now required to raise issues with the USI.

Mrs McKimm left the meeting at this point

6. NEWRY COMMUNITY TREATMENT AND CARE CENTRE (CTCC) UPDATE

Mrs McConville spoke to a paper which provides a further update for Trust Board since its last meeting on 23rd June 2022.

Mrs McConville informed members that the Land and Property Services (LPS) valuation on Abbey Way site has been returned and LPS and the Preferred Bidder have agreed a valuation sum for the site. The Department of Health has indicated informally that a funding amount has been 'reserved' pending approval of a business case. The Trust has developed a new revised Strategic Outline Case and this was submitted to the Department on 15th September 2022 which includes options to purchase the land and design in year. In response to a query from Ms Donaghy on the utilisation of the building, Mrs McConville stated that the Trust continues to keep its needs under review and has reinstated its internal Newry CTCC Project Group to progress timely actions and ensure robust oversight.

The Chair welcomed the developments and spoke of the importance of building a facility that meets the service needs of the population of Newry and Mourne. She referred to the risk of negative press and media backlash due to the requirement to manage this process in commercial confidence and noted that a full and open communication will be made once the case is approved, including clarification on next steps.

7. **INFORMATION ON ADULT PROTECTION SAFEGUARDING REFERRALS IN THE DIRECTORATE OF MEDICINE AND UNSCHEDULED CARE**

Members were advised of the significant increase of Adult Protection Investigations involving allegations against staff within the Trust two Acute Directorates. The Chair invited Mrs Cathrine Reid and Mrs Trudy Reid to speak to the papers from their respective areas of responsibility.

Mrs Cathrine Reid informed members of the unprecedented increase of Adult Protection investigations involving allegations against staff within Acute Medicine and Unscheduled Care. She referred members to a paper on Medicine and Unscheduled Care Adult Protection Safeguarding Referrals in which the alleged perpetrators are staff employed (Core / Agency / Bank staff).

8. **INFORMATION ON ADULT PROTECTION SAFEGUARDING REFERRALS IN THE DIRECTORATE OF SURGERY, INTEGRATED MATERNITY & WOMEN'S HEALTH, CANCER AND CLINICAL SERVICES**

Mrs Trudy Reid referred members to a paper on Adult Protection Safeguarding referrals in the Directorate of Surgery, Integrated Maternity and Women's Health, Cancer and Clinical Services in which the alleged perpetrators are staff employed (Core/Agency/Bank staff).

Discussion ensued in which members expressed concern at the significant increase of Adult Protection investigations. Ms Donaghy asked if there was a process in place within the Trust to supervise and appraise agency staff. Mrs Toal advised that training of agency staff is the responsibility of the respective agency. However, when agency staff are working a shift within the Trust, they are subject to managerial oversight and supervision. In terms of appraisal, the Trust's Annual Appraisal Policy does not apply to agency staff due to the ad hoc nature

of agency staff , but if issues did arise around performance, the Trust has processes in place to respond and refer them back to the agency.

Mrs Trouton stated that as regards nursing, if there are issues around performance, there are two options – one is a referral to the NMC and the other is via the CNO alert process for core staff. For agency staff, the responsibilities for these processes lies with the Agency itself, following referral of any concerns by the Trust. However , if the Agency does not choose to refer the staff member to the NMC and the Trust feels that such a referral is warranted, the Trust has and will refer the staff member .

Ms Donaghy stated that in her view supervision and appraisal of agency staff was a gap and risk to the Trust. Mrs Leeson stated that adult safeguarding is a huge emerging issue to which Dr O'Kane advised that it is in the Trust's direction of travel to appoint a separate Executive Director of Social Work.

Mr McCafferty and the Chair asked if there was any particular theme emerging that would account for the increase in referrals during July and August. They were advised that deeper intelligence was required to understand this spike. Mr McCafferty referred to thresholds and advised that the Adult Safeguarding Board has a regional workstream looking at developing guidance around consistent thresholds for safeguarding.

Mr McDonald emphasized the point that the Trust has a managerial oversight responsibility. Mrs McCartan reinforced the need for regular audits, training and managerial oversight and asked that timeframes to complete actions are included in the action plan.

Mr Wilkinson raised the importance of looking after staff who are involved in a HR process as a result of allegations made. Mrs Toal advised that management guidance on supporting employees' wellbeing through HR workplace processes had been discussed by the SMT the previous week.

Dr O'Kane stated that the ask of staff is enormous and we need to consider how psychologically we get them to talk about their experiences as a means of supporting them with difficult and stressful experiences with patients. She added that reflective practice may help staff and agency workers verbalise how difficult the work is as a means of preventing incidents like these.

Following discussion on items 7 and 8, the following actions were agreed:-

i) Timeframes against actions to be included;

ii) Further intelligence to understand the particular increase of adult protection safeguarding referrals during the Summer months.

iii) A broader paper to Trust Board at a future meeting as to what action the Trust is taking.

Mrs T Reid and Mrs C Reid left the meeting for the next item.

9. FEEDBACK FROM REMUNERATION COMMITTEE

The Chair presented her Remuneration Committee Chair report of the 25th August 2022 meeting and members noted the areas considered.

The Chair sought approval of the Remuneration Committee recommendations in respect of the remuneration of the new Medical Director, Dr Stephen Austin, and the remuneration of two Interim Directors, Mrs C Reid and Mrs T Reid. The Chair advised that the Remuneration Committee had considered Circular HSC (F) 26-2022 'The Payment of Remuneration of Chairs and Non-Executive Directors Determination (NI) 2022' which sets out details of payments to be made to Chairs and Non-Executive members of specified bodies in respect of service after 31 July 2020 and after 31 July 2021. Members also considered a calculation of Arrears due. The Chair sought approval of the Remuneration Committee recommendation that the Arrears due to the Chair and Non-Executive members would be paid in October 2022. At Mrs McCartan's request, the above-named circular was subsequently issued to members.

Trust Board approved the recommendations of the Remuneration Committee

10. ANY OTHER NOTIFIED BUSINESS

The Chair advised that a briefing paper on issues within cytology and endoscopy would be brought to the next meeting.

The meeting concluded at 10.00 a.m.

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board September 29th, 2022	
Title of paper	Update on Governance Concerns within Urology	
Accountable Director	Name	Dr Maria O'Kane
	Position	Chief Executive
Report Author	Name	Jane McKimm
	Email	Personal Information redacted by the USI
This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Information

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

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

1. Public Inquiry Update

- The Trust continues to respond to information requests from the USI, with currently over 50 S21 notices completed by current and former Trust staff.

- The second round of patient hearings is scheduled for September 27th – 29th. These will be held in private, with redacted transcripts made available on the USI website.

- It is expected that the Public Hearing will begin in the week of November 7th. At this stage the Trust is awaiting confirmation of witness attendance requirements and are making plans to manage the impact of staff absence across operational services.

- The Trust Urology Service is currently operating at 50% of its funded consultant level, so any reduction in consultant capacity will have a potential patient impact as there is limited scope to pick up deferred clinical workload. Whilst the Trust had recently secured the services of two additional consultants, we have now been advised that these persons do not now wish to take up the posts. In addition an experienced and valued member of the clinical team who works as a Staff Grade Doctor handed in her notice within the last two weeks.

- The Trust will continue to liaise with the Department re: patient impact and details of staff witness schedule when this becomes available.

2. Urology Lookback Review - summary

Stage 1 – Cohort

- January 2019 – June 2020
- 2112 patients identified

Stage 2 - Review

- 278 outstanding for return.
- These will be triaged and actioned accordingly.
- Analysis has taken place of reviews that had indicated sub-optimal care – themes have emerged in the following categories – diagnostics, medication, treatment, communication inc. recordkeeping and referral

.

Stage 3 - Recall

- This remains a challenge due to capacity to see patient – progressing but slowly
- Currently only 1 consultant undertaking these clinics
- Gaps in medical team 3 consultant vacancies (of 7post) – very significant pressures on core service as well as ability to service the Lookback Review
- Utilising expertise of CNS as part of the LBR to triage through only patients for whom there is no alternative to seeing the consultant.

Cases Closed

- For the 2112 cohort 1060 patient cases are closed.

SCRR Screening

- Now total of 91 – 53 original plus 38 additional – more expected when remaining (278) review from Professor Sethia
- Of original 53 – all allocated to an SME
- The 38 additional have not been allocated – no SME

SCRR Reporting

- As above no SME capacity to undertake SCRR reporting
- Attempts made via BAUS to secure additional SME – no success.
- Support from IS cannot be secured
- Of the 53 allocated - 23 returned. Regular prompting of SMEs have failed to result in more SCRR returns.
- A comparative analysis has been undertaken on the 23 returned SCRR reports i.e. reasons patient was screened into SCRR is compared to the themes identified in the returned SCRR report.

RQIA - SCRR

- The report - *"RQIA Review of the Urology Structured Case Record Review*" was received 13 September 2022 – attached for information.
- Action plan to be drafted and progressed
- Trust to consider SCRR options in the light of that report – as well as the comparative analysis on the reports returned to date.

Lookback Review Outcomes Report

- Cannot be finalised until 2112 patient have been considered within the lookback and their cases closed.

Extending the Urology Lookback Review

- Remains under consideration (sitting within Stage 1 of the Lookback Review Guidance)
- Options paper detail 7 options currently being drafted for consideration / appraisal. This will include an impact assessment on the core urology service.
- Two separate pieces of work as also required to inform any extension to the Lookback Review. these are:
    - Royal College of Surgeon invited review of 100 charts from 2015 due end of September
    - Trust audit into treatment of bladder cancer

Other Lookback Review Information

- Verbal update on 2 separate administrative incidents
  - Postal Error affecting 462 patients (June)
  - Date Error affecting 46 patients (August)

3. Areas of concern/risk/challenge:

- Postal error impacting 462 patients (June 2022)
- Date information error impacting 46 patients (August 2022)
- Finance- The Trust is compiling information pertaining to the current and future costs of the Public Inquiry Programme, including the Lookback Review and Assurance and Learning.

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.

Corporate Risk Register	Urology Services Public Inquiry (USI) on Corporate Risk Register
Board Assurance Framework	
Equality and Human Rights	

The Regulation and Quality Improvement Authority

RQIA Review of the Urology Structured Case Record Review Southern Health and Social Care Trust

September 2022

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating, inspecting and reviewing the quality and availability of health and social care services in Northern Ireland. RQIA's reviews identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest. Reviews are supported by a core team of staff and by independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health and are available on our website at www.rqia.org.uk.

RQIA is committed to conducting inspections and reviews, taking into consideration our four key domains:

- Is care safe?
- Is care effective?
- Is care compassionate?
- Is the service well-led?

Membership of the Expert Review Team

Professor Aneez Esmail	Professor of General Practice (Emeritus), Centre for Primary Care and Health Services Research, University of Manchester
Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority
Dr Leanne Morgan	Clinical Lead, Regulation and Quality Improvement Authority
Mr Brian O'Hagan	Lay Representative and Independent Expert Advisor to the review

Membership of the Project Team

Mr Hall Graham	Professional Advisor, Regulation and Quality Improvement Authority
Helen Hamilton	Project Manager, RQIA
Emer Hopkins	Interim Director of Improvement, RQIA
Dr Leanne Morgan	Clinical Lead, RQIA

Contents

Section 1 Introduction

1.1 Background and Context

On 31 July 2020, the Southern Health and Social Care Trust (SHSCT) contacted the Department of Health (DoH) to report an early alert concerning the clinical practice of a Urology Consultant (referred to in this report as Consultant A).

An initial review, which considered cases over an 18-month period of the consultant's work in SHSCT from 1 January 2019 to 30 June 2020, focussed on whether patients had had a stent inserted during a particular procedure and if the stent had been removed within the clinically recommended time frame. The initial review identified concerns with 46 cases out of a total of 147 patients who had the procedure and were listed as being under the care of the consultant during the period addressed by the initial look-back exercise[i]. The findings were significant and led the Minister for Health, Robin Swann MLA, to announce on 24 November 2020 that a statutory public inquiry would be established under the Inquiries Act 2005. The Urology Services Inquiry, which is currently ongoing, is chaired by Ms Christine Smith QC.

In parallel, yet separate, to the work of the public inquiry, SHSCT subsequently established a review group to assess the further findings of the initial review exercise and to explore the need for a further look-back review in the context of additional concerns.

Areas of concern were identified relating to:

- Elective and emergency activity;
- Radiology;
- Pathology and cytology results;
- Patients whose cases were considered in multidisciplinary team meetings;
- Oncology; and
- The safe prescribing of an anti-androgen drug outside established NICE guidance in the management of prostate cancer.

Nine cases were identified that met the threshold for a Serious Adverse Incident (SAI) review. Following the completion of these initial nine SAI reviews in 2021, the Trust was advised by DoH that the SAI process should not be used to review subsequent potential issues in care identified by the lookback process.

As a result, SHSCT developed a Structured Case Record Review (SCRR) process based on the Structured Judgement Review methodology as developed by the Royal College of Physicians. The aim of the SCRR process was to identify any areas of learning where patient safety could be improved.

In March 2022 SHSCT asked RQIA to undertake:

[i] Ministerial Statement by Health Minister to the Northern Ireland Assembly, 24th November 2020

- A review of the choice of Structured Judgement Review methodology to underpin their SCRR process.
- A review of the Trust SCRR process in relation to its effectiveness in identifying learning.

It was further agreed that, in the event that the SCRR process was not considered to be appropriate the Trust would like RQIA to suggest an alternative approach.

1.2 Terms of Reference

Although RQIA was requested to review the suitability of the Trust's SCRR process, we considered that the scope of the review should be wider. It would not be appropriate to only assess the tools involved but we should also assess the surrounding process within which the SCRR operates. Therefore the following Terms of Reference were agreed with SHSCT.

1. To assess the suitability of the Structured Judgement Review methodology as the basis for the Trust SCRR process.

2. To assess the specific Trust SCRR methodology in relation to its effectiveness in identifying learning.

3. To assess the overall trust process/framework for conduct of its record review.

4. To make recommendations in relation to the overall process and if the SCRR process is not considered to be appropriate suggest an alternative approach.

1.3 Review Methodology

RQIA used a PRINCE project management approach to underpin this review. The review utilised a range of methodologies to obtain supporting information to inform our assessment:

- We undertook a review of the literature around the use of the Structured Judgement Review Method to help identify key themes and areas of focus.
- We designed and issued structured questionnaires to the Southern Health and Social Care Trust.
- We analysed information returned to us and used this to develop Key Lines of Enquiry for meetings with the Trust.
- Our Expert Review Team (ERT) conducted focus groups and meetings with the independent panel of reviewers, senior staff and other relevant staff from the Trust.
- We analysed the information gathered through our structured pre review questionnaires, meetings, focus groups and staff questionnaire responses in order to determine our key findings and recommendations.

Section 2 Findings

In assessing the effectiveness of all aspects of the SCRR process we considered the overall process in respect of a number of component parts.

2.1 OVERALL TRUST PROCESS AND FRAMEWORK FOR SCRR

2.1.1 Background to the Structured Case Record Review

The provision of background and contextual information is vital to the understanding of the rationale and purpose of the Structured Clinical Records Review process. This information was provided by SHSCT, in conjunction with a Structured Case Review proposal document and was explored further by the Expert Review Team during fieldwork sessions with Trust representatives.

During fieldwork, the Expert Review Team heard how the Inquiry was announced unexpectedly in November 2020 during what was a difficult time for SHSCT, when it was grappling not just with the emerging issues within Urology Services but also with the COVID-19 pandemic and its associated pressures for service; this contextual information provided the Expert Review Team with a valuable insight into the challenges faced. At the point of announcement of the Inquiry Terms of Reference (see Appendix 1) SHSCT had already commenced a Lookback Review and through this had identified a significant number of patients meeting the threshold for an SAI review under the regional SAI procedure[1].

Due to the volume of patients identified, the time and resource required to progress SAI reviews, and the limited additional value of repeatedly reviewing the same type of incident via the SAI process, it was suggested that an alternative methodology is used to derive learning from these cases. The decision to use the SCRR approach, as an alternative to SAI methodology, was taken in conjunction with SPPG and DoH's Urology Assurance Group. The Expert Review Team considers that this decision was the correct one, and that Structured Judgement Reviews methodology, such as that developed by the Royal College of Physicians, is a robust method of assessing the quality of care and treatment of individual cases, when applied as intended. As such, the Expert Review Team endorses the decision to adopt an alternative approach to undertaking repeated SAI reviews in such circumstances.

Although the decision to proceed with the SCRR was taken prior to the announcement of the Public Inquiry, the Expert Review Team noted that SHSCT continually referenced the SCRR process within the context of their broader work to meet the requirements of the Inquiry. However, the Expert Review Team considers that the Inquiry and the SCRR are separate processes.

The Inquiry is an independent statutory process, supported by underpinning legislation, to deliver on its Terms of Reference; whereas the SCRR is a Trust and DoH-initiated process to establish themes of learning with a view to improving Trust systems to reduce the likelihood of similar incidents happening in the future. Whilst running in parallel to the Inquiry, the SCRR should not be influenced by the Inquiry's agenda or timescales, but instead should be focused on the need to derive learning and implement the necessary improvement.

During fieldwork, Trust representatives accurately described this distinction between the differing roles and purposes of the Inquiry and SCRR, the relationship between the differing processes and the arrangements for sharing information with the Inquiry Team. However, upon reviewing Trust documentation, although the rationale for the SCRR is clearly stated, the Expert Review Team identified a lack of clear documentation explaining the role, purpose and remit of the SCRR and, in particular, that it is an entirely separate process to the Inquiry.

Similarly, SHSCT SCRR documentation does not make clear whether the cases selected for SCRR are being reviewed on behalf of the Inquiry, or whether all or some of these cases could be subject to a second review by the Inquiry team, and whether patients and families are aware of the potential for conflicting findings. This is likely to cause confusion since the Inquiry Terms of Reference (ToR) include:

> (c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within SHSCT's urology specialty.

The Expert Review Team considered that, although Trust representatives demonstrated a good understanding of the distinction between these two processes, which is further mitigated by the fact that at the time of drafting this report, the Inquiry methodology for ToR (c) has not yet been announced, and the patient / family information materials and Trust documentation require improvement. In the current format, the versions provided to the Expert Review Team do not fully and accurately inform patients and families and, thus, have the potential to inadvertently cause confusion and compound anxiety and distress.

We were informed that SHSCT, in light of recent criticism regarding factually inaccurate information contained in patient letters, regarding the Inquiry's purpose, has sought to improve the clarity and accuracy of documentation. The Expert Review Team was provided with a copy of a "Patient Letters Investigation" report which outline a thorough investigation undertaken by an experienced Director independent from the SHSCT and is accompanied by a number of sensible recommendations. The Expert Review Team commends this report and welcomes these improvement efforts. In addition to these, the Expert Review Team is of the view that SHSCT would benefit from improving their systems for developing and quality assuring patient / family information or indeed any documentation that is publicly accessible or likely to enter the public domain. Such arrangements should include the involvement of a lay person / service user representative and those with communications expertise within SHSCT. Where there is a pending or ongoing Public Inquiry, legal input should also be considered.

Recommendation 1

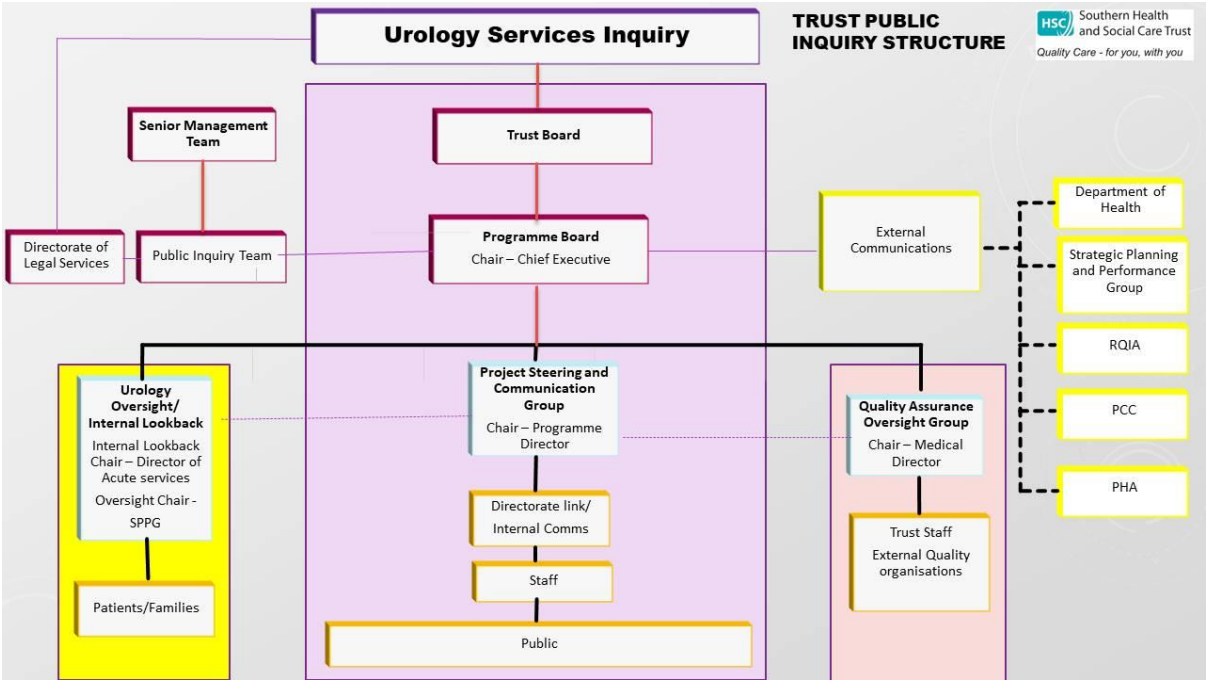
SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

2.1.2 Review Structure

Robust structures are essential for ensuring effective delivery, assurance and accountability. SHSCT provided details of the Review Structure and advised that the SCRR process sits within its current Trust governance structures.

Figure 1. Current Review Structure



We were informed that the Review Structure is presently overseen by SHSCT Internal Urology Lookback Group. SHSCT Public Inquiry Programme Board is chaired by the Chief Executive. The Programme Board members act on behalf of SHSCT Board to oversee the work of the:

- Public Inquiry Response and Communications Group;
- Public Inquiry Urology Oversight / Lookback Steering Group; and
- Quality Assurance and Improvement Oversight Group

The Lookback Review is included on the Corporate and Acute Services Risk Registers. External oversight of the process is provided by the fortnightly Service

Planning and Performance Group (SPPG) Meeting and Department of Health led Urology Oversight Group.

ToR were provided for the Public Inquiry Programme Board, Trust Internal Urology Lookback Group and Health and Social Care Board[ii] (HSCB) Urology Group. The Expert Review Team noted the broad remit of oversight and co-ordination groups and considered that some of the committees were very large, with overlapping membership. The Expert Review Team noted that the composition of the Lookback Review Steering Group (referred to as the Urology Oversight / Internal Lookback Group) does not reflect the Regional Guidance for Implementing a Lookback Review Process (July 2021)[2] which suggests inclusion of:

> "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 Public Health Agency (PHA) representative and an Health and Social Care Board (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."

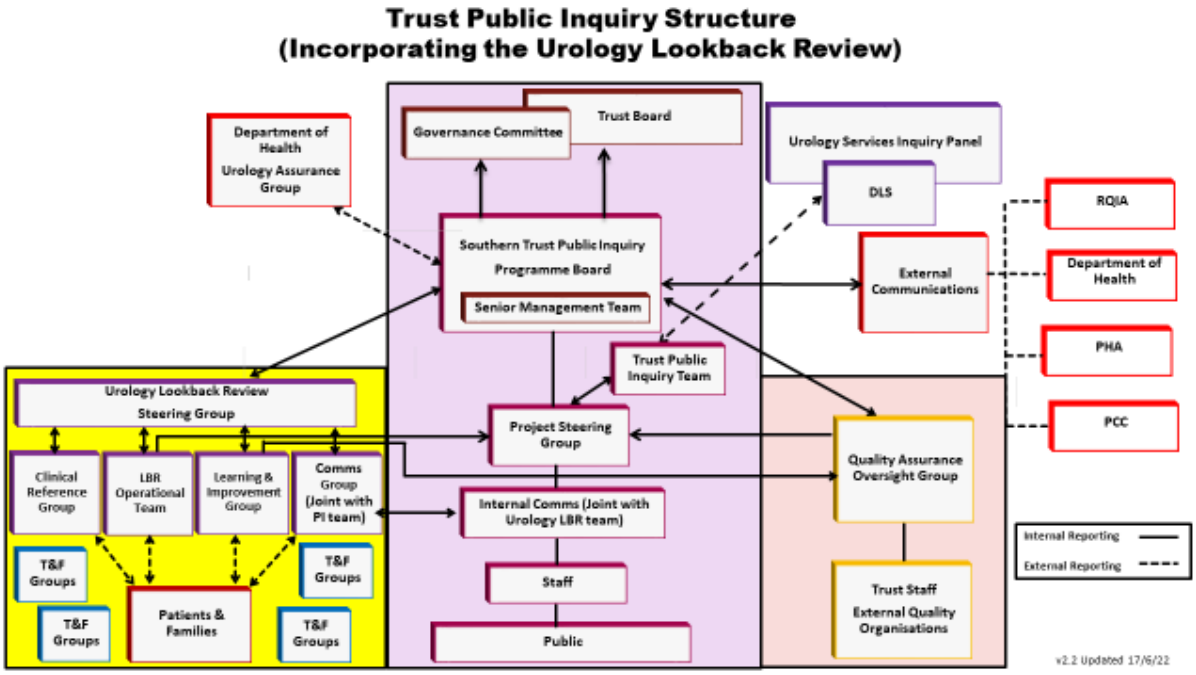
The Expert Review Team acknowledged the challenges and sensitivities of including a service user / advocacy representative who has been impacted by or has a vested interest in the matter of concern. However the inclusion of a lay member, not impacted by SHSCT Urology concerns, but nonetheless with previous experience of representing the interests of service users / the public on similar pieces of work, can be hugely valuable and should be considered by SHSCT. The benefits include enhanced public confidence in the process, improved adherence to the statutory duty of Personal Public Involvement (PPI), provision of advice on patient / family / public messaging and on the fulfilment of a duty of candour.

The Expert Review Team considered that there was a lack of clarity surrounding leadership / responsibility and arrangements for accountability and reporting. During fieldwork, we were advised that the Chief Executive has ultimate accountability for the SCRR and that recent work had been undertaken to improve oversight, reporting and ensure clear lines of accountability. This resulted in a proposed new structure for oversight of the SCRR process. The Expert Review Team is of the view that any new structure should also be designed to support SHSCT to fulfil its responsibilities in respect of all Urology work, to deliver on SCRR objectives and should avoid creating unnecessary duplication or complexity.

The Expert Review Team was informed that the new structure exists in shadow form at present with the Operational Team being chaired by the seconded Director in a holding position until the new Director responsible for surgery takes up post.

[ii]The Health and Social Care Board was replaced by the Service Planning and Performance Group (SPPG) April 2022.

Figure 2. Proposed New Review Structure (draft document at the time of the Review)



Although the Expert Review Team welcomes improvements to the overarching review structure, it is of the view that, given the sizeable undertaking and complexity of the work, the operational arrangements for management and co-ordination of the SCRR and potentially the Lookback Review itself, would benefit from the establishment of a dedicated project team. It was noted that one individual was seconded from another Trust to support SHSCT with its work and this was a welcome development; however, no other Trust representative attending the fieldwork sessions reported having experience of conducting Lookback Reviews. This represents a considerable lack of skill and experience, which can occur when there has been recent turnover or change within the management structures of an organisation. In light of this shortfall, the dedicated project team should include people with previous experience in undertaking similar work, who can draw upon a wide network of 'critical friends' to provide support, advice and guidance.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

2.1.3 Project Management

Effective project management is crucial in ensuring a well-co-ordinated delivery of objectives within acceptable timescales; this is best implemented with the support of a project manager accredited in using validated project management methodology such as PRINCE / PRINCE 2.

SHSCT SCRR project is currently managed as a sub-workstream of SHSCT corporate lookback process rather than by an individual with project management expertise supported by dedicated project team. Furthermore, the process does not use a specific project management methodology and has followed an iterative approach in terms of its design, signoff and deployment.

To ensure identified project actions are undertaken, minutes are kept of screening and lookback meetings and these are carried forward into future meetings. Individual case records for SCRR are tracked to the relevant Expert Reviewer; ensuring updates can be sought on progress.

The Expert Review Team considered that, whilst these arrangements might suffice for small numbers of cases, they are not sufficiently robust for managing a large volume of work. The Expert Review Team is of the view that a dedicated project team for the co-ordination and management of the Lookback Review and SCRR process, should include a Project Manager; ideally such an individual should have previous experience in managing a Lookback Review or, in the absence of previous experience, should have an understanding of the process and should be supported by a network of people who have the requisite skills and expertise.

The Expert Review Team was advised that a proposal paper outlining an updated Lookback Review structure, process and accountability has been submitted to SHSCT Programme Board. In this paper it states that the Urology Lookback Review is a project and should be constructed as such in terms of purpose, ToRs, reporting lines, risk register etc., including the identification of / clarity on who is the Senior Reporting Officer (SRO) for the project; suggesting this should sit at Director level.

SHSCT further advised that this includes a review of the associated Project Management arrangements in order to ensure that the project progresses swiftly and with clear accountability. The Expert Review Team welcomes this approach.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

2.1.4 Terms of Reference / Objectives of the SCRR

A clear Terms of Reference (ToR) or, in lieu of a ToR, a set of specific objectives serves to focus the minds of those undertaking the Structured Clinical Record Review process on the purpose, remit and what needs to be achieved during the

course of the process. Providing a framework for monitoring progress and accountability for delivery, it is also helpful in communicating the scope of work in a clear, open and transparent way; a Terms of Reference can also assist in conveying information about the process to interested parties, such as DoH, SPPG / PHA, Health and Social Care (HSC) Trusts, patients / families / carers and the public.

Unfortunately, there were no ToR / Objectives provided by SHSCT relating to the SCRR process itself. The Expert Review Team considers that a ToR should be drafted and agreed as soon as possible. Trust representatives were keen that this should adequately convey the clinical elements of the SCRR.

In light of this, a possible ToR could include:

1. To assess the quality of care and treatment provided by Consultant A, using Structured Judgement Review methodology which gives specific consideration to the following:

- Triage;
- Initial assessment;
- Diagnostic investigations;
- Outpatient care;
- Inpatient care;
- Perioperative care;
- Care during any medical or surgical procedure (excluding IV cannulation);
- Communication with colleagues, MDT and primary care;
- Communication with patient and families; and
- Discharge plan and follow-up arrangements.

2. To review the findings of the individual Structured Judgement Reviews and produce a thematic analysis report.

3. To identify learning and make recommendations for improvement.

The Expert Review Team also considered that it would helpful for SHSCT to explicitly state the purpose of the SCRR. It is referenced within the Review Methodology Section of the proposal document provided by SHSCT that “the objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well and to identify points where there may be gaps, problems or difficulty in the care process”. This is closely aligned to the purpose of the SCRR, which is ultimately for SHSCT to define, but may best be described as serving “to assess the quality of care and treatment, in order to identify learning and implement improvement”. Clearly setting out the purpose in this way would also help to differentiate the SCRR from the Inquiry.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

2.1.5 Time period for inclusion of cases for SCRR

All cases reviewed as part of the current Lookback Review undergo screening for consideration for inclusion in the SCRR process; those meeting the SAI threshold are 'screened in'. The scope of the Lookback Review pertains to all patients that were under the care of Consultant A during the time period 1 January 2019 – 30 June 2020. The Expert Review Team explored the rationale for this time period with Trust representatives. When concerns first came to light, this period was chosen as it was believed that this was when patients were most at risk from aberrant clinical practice.

The Expert Review Team acknowledges that no lookback exercise can review all cases at once, that there has to be a starting point, and that a phased approach is preferable in order to expedite learning and facilitate reflection; furthermore, to start with those patients identified as being most at risk is sensible, justified and in keeping with regional guidance. However, the Expert Review Team was informed that since then, it has been identified, by examination of historical care through the Patient Casenote Review process, that patients treated by Consultant A prior to 2019 may also have received substandard care. This is unsurprising; it is the Expert Review Team's experience that problems with a clinician's practice tend to be longstanding and not restricted to a particular period of time. We were advised that in light of this finding, the Royal College of Surgeons (RCS) is currently undertaking a review of a sample of 100 cases from 2015 in order to identify whether there were problems present at this stage

The Expert Review Team is of the view that if there is already enough evidence to inform a risk assessment that patient groups receiving treatment prior to 2019 are at risk of harm, SHSCT should not wait for the RCS work to conclude and should proceed as a matter of urgency to extend their Lookback Review to identify and recall at risk patients under the care of Consultant A prior to 2019. This can be done using a phased, risk-stratified approach based on the learning gathered to date. It can then be extended and scaled up further, following receipt of the RCS findings, should this be required. However, regardless of the approach adopted, given the risk posed to live patients, it is imperative that a further phase of the Lookback is commenced as a matter of priority.

Since this is likely to be a considerable undertaking, requiring suitable expertise to offer advice and guidance, it is vital that SHSCT is adequately supported by its partners across the HSC system, including DoH/ Urology Assurance Group / SPPG and PHA. As this work is scaled up, an independent assessment of the current Urology Lookback Review arrangements would serve to provide assurance regarding its effectiveness and identify any areas that need strengthened; this assessment could be undertaken by RQIA as a 'Part 2' to this review of the SCRR. Assurance of the current lookback arrangements would serve to strengthen the

foundations in place for extending the time period and scaling up to include additional patient subgroups.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

As there is a need to prioritise the Lookback Review, to ensure that patients at risk are promptly reviewed and that ongoing care and treatment is arranged, it may be preferable for an external body, such as the Royal College of Physicians, to undertake the SCRR on behalf of SHSCT. Not only would this allow Trust teams to focus on the Lookback Review whilst maintaining a safe level of care provision for its current and new patients, it would mean that the SCRR is conducted by an independent organisation that has the requisite expertise, governance structures, well tested processes and quality assurance mechanisms in place to support this type of work; consequently, the output may be more expedient and performed to a higher standard. However, the Expert Review Team acknowledges that commissioning an independent body may not be possible either due to a lack of agreement, resources or time, in which case the recommendations outlined in this report should support SHSCT itself to facilitate the SCRR.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

2.1.6 Case selection

Appropriate case selection is important to ensure effective use of time and resources, which should be prioritised towards cases where there is likely to be learning.

During fieldwork, Trust representatives outlined the process for case selection. All service users who were under the care of Consultant A between January 2019 and June 2020 were reviewed using a 10-question Patient Review form either internally by SHSCT or an external consultant urologist commissioned for this purpose. This 10-question Patient Review Form explored current as well as historical care. At a point in time, this list of questions was shortened to 4 questions which explored current care, following discussions with SPPG (formerly HSCB) who were keen that it mirror the approach used by the Belfast HSC Trust Neurology recall. It reverted back to 10 questions at the request of the Trust (and with agreement by SPPG) with all relevant case notes being assessed retrospectively to ensure consistency.

Where concerns regarding the quality of care are identified, these cases are then considered at a screening meeting, attended by the Trust's acute directorate governance and clinical staff, to establish if the concerns meet the threshold set out in the regional SAI procedure. Where the case meets the criteria for an SAI, it is progressed as an SCRR.

The Expert Review Team considered that if the aim is to identify all cases where there is likely to be learning, the use of SAI thresholds may not be the most effective method. This was explored with Trust representatives who were in agreement. We were advised that cases considered for inclusion in the SCRR included the following:

1. SAI threshold met; concerns around the care and treatment in keeping with a theme already identified
2. SAI threshold met; concerns around the care and treatment in keeping with an emerging theme, not previously identified
3. SAI threshold not met; nonetheless, learning identified
4. SAI threshold not met; care and treatment "reasonable"

The Expert Review Team is of the view that it is acceptable to include cases from Group 3. Although a case may not meet the criteria for an SAI review, it may still contain valuable learning from a patient experience or service quality perspective.

To date, 53 cases have been identified that meet the criteria for SCRR. This number is likely to increase further, particularly if the care and treatment of additional patient groups is going to be subject to an extension of the Lookback Review; a total in excess of 90 cases is expected to be identified from this phase alone.

During fieldwork the Expert Review Team heard that of the 53 SCRRs passed to the external SCRR urologists between February and May this year only 20 have been returned to date. This prolonged process poses challenges for the Trust as they are keen to establish the full extent of learning in relation to these cases.

Given time constraints and limited availability of expert reviewers, the Expert Review Team was keen to explore whether a sampling approach had been considered by SHSCT. Such an approach would seek to maximise learning within the constraints of available resources and may lead to improvements being implemented at an earlier stage.

During fieldwork, Trust representatives remarked on the similarity of themes across the cases that have already been reviewed. We were informed that there was very similar learning arising from 19 out of 20 cases reviewed to date. This supports an argument that a point of saturation might be reached and there may be limited additional benefit to reviewing all cases, as was initially intended.

The Expert Review Team recognises that a pragmatic approach to sampling would mark a departure from the original intention and direction of the SCRR. It would be the Expert Review Team's view that such a departure requires a clear rationale to be agreed by the DoH; this would require the purpose, scope and Terms of Reference for the SCRR review to be clearly articulated and defined. DoH should ensure that such an approach is justified when taking into consideration the wider context,

including the planned work and emergent findings of the Public Inquiry. The Expert Review Team's view is that a sampling approach would expedite learning and would allow an opportunity for earlier improvement to be implemented. However, there are ethical considerations and SHSCT should take steps to ensure that the sampling framework is robust and should be open and honest with patients and families about the approach and its rationale.

Understanding that some patients and families may be disappointed that their case is no longer going to be reviewed, SHSCT may wish to include an option for patients and families to request inclusion in the SCRR. If it is not feasible or reasonable to grant such a request, then the patient or family should be informed of the alternatives available to them, such as submitting a concern to the Urology Public Inquiry, SHSCT Complaints Department, GMC, PSNI or any redress scheme. It would be helpful at this stage for DoH / Urology Assurance Group / SHSCT to liaise with the Urology Public Inquiry to ascertain their intended approach to case identification and proposed methodology for delivering on Inquiry ToR (c). Should the inquiry intend to review all cases for those patients / families approaching the Inquiry Team, this would lessen the expectations on SHSCT, enabling the SCRR work stream to focus on applying a sampling framework with a view to deriving system learning and implementing improvement.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

2.1.7 Ethical Considerations

The application of ethical principles when conducting reviews of a complex and sensitive nature is invaluable to guide decision-making and ensure that the review is conducted in an open, transparent, fair and sensitive way. It can be helpful in ensuring a rigorous approach, adherence to a duty of candour, respect for confidentiality but also autonomy (i.e. right not to know) and in ensuring that specific patient groups are not inadvertently disadvantaged. It is also helpful when considering specific ethical issues that may arise from the process of reviewing patient cases, such as circumstances where previously undiagnosed or undisclosed hereditary conditions are identified.

SHSCT advised that no Clinical Ethics issues were identified for discussion with SHSCT Clinical Ethics Committee. The Expert Review Team is of the firm view that given the scale and sensitivity of the work involved, and the potential for inadvertent harm to be caused by the process, SHSCT would benefit from giving due consideration to the application of Ethical Principles. Advice from SHSCT Clinical Ethics Committee should be urgently sought and, if deemed necessary, this could be assisted by the HSC Regional Clinical Ethics Committee.

We refer SHSCT to a recently issued Ethical Framework[3], developed specifically for RQIA's Expert Review of Deceased Patients of Dr Watt, which contains overarching themes that are applicable to any lookback or review of this nature:

1. Respect for Persons (which includes Privacy, Confidentiality and Data Protection, and the Right to Know and the Right Not to Know)
2. Transparency and Candour
3. Fairness
4. Responsibility

It was RQIA's experience that the process of discussing ethical principles and deliberating the potential for ethical issues is as valuable as the end product of any framework or ethical paper. In the context of the Expert Review of Deceased Patients of Dr Watt, it had wider benefits beyond ensuring that the methodology and the approach were ethically rigorous, and greatly assisted with the drafting of correspondence to families, and in the interactions with families by the RQIA Family Liaison Team.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

2.1.8 Legal Considerations

A legal perspective on review proposals and arrangements is prudent when undertaking work of this nature.

The Expert Review Team's experience is that it can be helpful across a number of areas including:

- Identifying previously unconsidered pitfalls in relation to correspondence with interested parties, proposed review methodology and approach;
- Ensuring there is appropriate indemnity for reviewers undertaking the SCRR;
- Managing data protection issues;
- Managing legal challenges from solicitors acting on behalf of patients / relatives;
- Managing legal challenges from Consultant A's legal team; and
- Requesting clinical records of patients reviewed by Consultant A in a private a capacity

Trust representatives advised that the Directorate of Legal Services (DLS) is supporting SHSCT with the Inquiry and that an opinion could be sought if required. However, SHSCT advised that legal advice had not been sought as the SCRR is being utilised as an alternative of SAI to establish learning from the situation. The Expert Review Team considered that legal input would be required in order to make this determination and also to consider the potential for future legal ramifications.

It is the Expert Review Team's view that given the significance and scale of concerns, the likelihood of negligence and that this is a departure from the regional SAI process, a legal perspective should be sought in relation to the arrangements for SCRR.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

2.2 METHODOLOGY AND IDENTIFICATION OF LEARNING

2.2.1 Patient and Family Engagement

There is a statutory duty of Personal Public Involvement as set out in the Health and Social Care (Reform) Act (Northern Ireland) 2009[4]. Best practice in involvement is to seek the input of service users and families to help shape the review process, particularly around sensitive person-centred communication, the provision of support and a mechanism for sharing concerns. There may be additional valuable information from affected service users / families that will not be evident in the clinical documentation of the clinician under investigation; information from families and carers is particularly vital in those cases where a patient has sadly deceased. Importantly, effective patient and family engagement is crucial in order to adhere to the principles of candour and 'being open'.

The regional SAI procedure stipulates the requirements for patient and family engagement. On 7 July 2022, the report of the RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland[5] was published; this has relevant findings on effective engagement and involvement of families and recommendations for strengthening the regional approach and procedure. Furthermore, a draft 'Statement of Rights' as an output of the O'Hara Inquiry may be helpful in focussing HSC Trusts on the importance of appropriate and sensitive interaction with patients and their families.

Although the SCRR is not an SAI process, the Expert Review Team is of the view that, as a minimum, patients and families should be informed of the purpose of the SCRR, and that those affected should have an opportunity to provide additional information about their care and treatment. SHSCT outlined their process for engaging and involving families. The Expert Review Team is impressed with and commends the significant efforts SHSCT has made in contacting all impacted families, which, given the scale, is a huge undertaking. However, we note recent issues arising regarding the quality of patient information and consider that the arrangements for patient and family involvement in both shaping the process and sharing concerns require improvement.

The Expert Review Team considers that SHSCT PPI team and those external to SHSCT, such as the PHA and Patient Client Council, have been underutilised in ensuring that there are robust arrangements for PPI as part of the Lookback Review and SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

SHSCT outlined its arrangements for following up and sharing the findings of the SCRR with patients and family members. Although there is a Family Liaison Officer (FLO) available to support patients and families, the findings are primarily shared through postal correspondence. Whilst this may be the preference of a large number of families, many may require additional support to understand and emotionally cope with the findings.

The Expert Review Team consider the following to represent good practice[6,7,8]:

- As far as possible, reports should be quality assured, checked for factual accuracy, and should be written in easy to understand lay language;
- Patients / families should be provided with a range of options on how they wish to receive the report; one option should be a face to face meeting. They also have a right “not to know” the findings;
- The Family Liaison Officer should be accompanied by a medical doctor in relaying the findings of the report;
- Psychological support should be made available to those impacted by the process and findings of the SCRR;
- If further medical follow-up is required by patients or relatives, there should be Trust arrangements in place to facilitate this in a timely manner; and
- There should be opportunities for the FLO to debrief with colleagues and timely access to psychological support for the FLO and any others involved in family engagement.
- Independent advocacy should be considered for patients or families, particularly when cases are complex. The PCC have extensive experience in this area through previous work on SAIs and other Inquiries.

During fieldwork, the Expert Review Team explored the support available for those staff members involved in the review and, in particular, the patient and family engagement. SHSCT described effective provision of support including: senior and peer support, psychological support and access to Inspire Wellbeing Counselling service. The Expert Review Team is content that the arrangements for support appear sufficient but cautions that a substantial proportion of the work appears to be undertaken by one FLO. Given the large number of cases identified, it may be beneficial to increase the capacity of the Family Liaison Team to provide support to those impacted by the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

2.2.2 Methodology & Tool

Structured Judgement Review methodology is a reliable, well validated tool that has been developed by the Royal College of Physicians. It allows for the blending of traditional, clinical-judgement based, review methods with a standard format. The approach requires reviewers to make safety and quality judgements on particulars of care, to make explicit written comments, and to assign a score for the quality of care at each phase. This produces a rich set of information about each case in a form that can be aggregated to produce knowledge about clinical services and systems. SHSCT discussed the use of this tool with the Royal College of Physicians and opted for this methodology to underpin the SCRR process.

The Structured Judgement Review methodology was adapted for the SCRR in order to take into consideration the relevant phases of care. The phases of care assessed are:

- Triage;
- Initial assessment or review;
- Review of Diagnostics;
- Ongoing Outpatient Care;
- Admission and Initial Management;
- Ongoing Inpatient Care;
- Care during a procedure (excluding IV cannulation);
- Perioperative care; and
- Discharge plan of care.

The Expert Review Team is not privy to all the specific clinical concerns therefore cannot be certain that the tool adequately scrutinises all relevant aspects of care. With this caveat in mind, the SCRR tool generally appears reasonable. However, the Expert Review Team did note some areas that SHSCT may wish to address. There is some divergence from the RCP methodology in terms of the data collection instrument. There is no section to assess:

- Quality of documentation in the records;
- Communication between Consultant A and the patient / carer / family; and
- Communication between colleagues, MDT and primary care.

Whilst we were advised that deceased patients are included in the review, there are no sections outlining a review of the death certification or whether a referral to the coroner's service was required.

Of particular value in relation to deceased patients, but of great value for all cases, is the consideration of patient and family concerns. In general, there is a lack of patient

and family input into the SCRR process. Patients and families were not engaged with in order to shape the review. Equally, there is no consistent mechanism to proactively seek the concerns of patients and families for consideration as part of the individual SCRR. This marks a considerable deficit in the information available to formulate findings. The experience of the Expert Review Team is that, where concerns from patients and families are taken into account, this greatly enhances the learning process and provides information and context that is often not present in the notes. RCP has successfully incorporated patient / family concerns into its review process by asking expert reviewers to review the notes firstly without knowledge of the patient / family concerns and then a second time taking the patient / family concerns into consideration. The complaint can then be judged to be 'upheld', 'partially upheld' or 'not upheld'.

RQIA's experience from the Expert Review of Deceased Patients of Dr Watt is that there is a close correlation between the views of family members and the judgement of the structured judgement tool (SJR), strengthening the argument that there is great benefit in attaining patient and family input. Where there is little or no correlation between the patient / family story and the clinical picture documented in the records, the Review Panel may determine that the family concern is 'not upheld'; of note, this only occurred for two (out of 44) patients included in Phase 2 of the Expert Review of Deceased Patients of Dr Watt.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Whilst Structured Judgement Tools provide an objective assessment of the care and treatment documented within the clinical records, it can only allow for a partial systems perspective. For example, it may tell a story of care and treatment according to the national standards of the time, of the standard and quality of documentation, multidisciplinary involvement, communication between colleagues and communication with family members. Of direct relevance, it will not examine factors such as caseload, working relationships and peer review.

Furthermore, it will not tell us about the governance systems within Urology Services or within SHSCT as a whole. It will not examine the role of external bodies and the wider system in providing oversight and assurance of quality and safety of care.
With this in mind, DoH or SHSCT Board may wish to commission RQIA to undertake a Review of Governance within Urology in Southern Health and Social Care Trust. This would provide an opportunity to identify and remedy any deficits, and to share learning within SHSCT and across the system so that governance systems may be strengthened and future harm prevented.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

2.2.3 Expert Reviewers

Each case is reviewed independently by a 'Subject Matter Expert' (or Expert Reviewer) utilising the SCRR methodology. SHSCT provided details of Expert Reviewers, including a description of the job role and a copy of the guidance provided to reviewers at the outset of the work. The Expert Reviewers are nominated via the British Association of Urological Surgeons (BAUS) for their subject matter expertise. SHSCT ensures that each reviewer is appropriately registered and of good standing with their professional regulator, the General Medical Council (GMC). The Expert Review Team is content that reviewers appeared suitably independent and qualified.

In total, SHSCT approached 13 reviewers of which four Expert Reviewers have been recruited to support this work. Given the difficulty recruiting Consultant Urologists and the time consuming nature of the SCRR process, the Expert Review Team considered whether specialist nurse reviewers or urologists in training could be used instead. A clearly defined protocol with consultant oversight of the process would facilitate this. It was considered that a hierarchical culture within HSC, associated with perceptions amongst the Northern Ireland public that attaches particular significance to reviews undertaken by a consultant, may be a barrier to implementing a non-consultant review process. Therefore, if the work cannot supported by specialist nurses or trainee urologists, consideration should be given to the use of doctors working outside the specialty of urology.

The Expert Review Team noted that no training was provided to Expert Reviewers, who instead were stated to be familiar with SJR tool methodology. In addition, there was no specific manual provided to reviewers; albeit the following guidance was provided:

- Using the Structured Judgement Review method - A guide for reviewers; National Mortality Case Record Review Programme 2019[9]; and
- Structured Judgement Review - Frequently Asked Questions 2019.

Additionally, the process had not been piloted and there was no method of calibration between reviewers to ensure inter-reviewer reliability and consistency. Importantly there is no mechanism for quality assuring the work of reviewers, either by assigning two reviewers to each case or by second-reviewing a sample of the cases.

The Expert Review Team notes that 20 SCRRs had been completed at the time of fieldwork; and while we understand the challenges in delivering quality assurance of reviews within the current limited pool of reviewers it may be beneficial to conduct an independent review by a second expert reviewer to ascertain the degree of reliability and consistency in assessing the quality of care. A panel should then be convened

to discuss any significant discrepancies in judgement, to gain consensus and provide expert reviewers with an opportunity to standardise their approach.

Even in the absence of discrepancies, it can be helpful for clinical reviewers to have a forum to discuss cases, debrief and avail of emotional or psychological support. Although it was reported that each reviewer can contact SHSCT Deputy Medical Director for Quality and Safety if issues arise, the Expert Review Team is of the view that SHSCT is missing an opportunity to proactively support reviewers, seek feedback on the process and seek reviewers' views on the learning arising.

Recommendation 14

SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feed back and avail of emotional / psychological support if required.

A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

2.2.4 Review Panel

Good practice dictates that in undertaking a review, an expert panel to deliberate findings and attain consensus on recommendations is preferable to the judgement of one individual expert. A forum for discussion between panel members allows for a sharing of expertise and perspective, brings a deeper and broader understanding of issues, mitigates bias and derives learning more effectively.

SHSCT stated that there is no specific review panel for the SCRR; however, the Trust Lookback Group oversees the overall lookback process that includes the SCRR. On completion of the initial batch of SCRRs, an independent Consultant Urologist will develop a thematic report on the findings.

The Expert Review Team considered that, as SHSCT has rightly identified that a key outcome of the SCRR is a thematic analysis in order to identify learning and inform system improvements, the process would benefit from a dedicated review panel rather than relying on the professional judgement of one individual to collate findings, identify themes and make recommendations. This was explored with Trust representatives during fieldwork, who advised that the RCS and BAUS had both been approached to undertake an independent quality assurance of the SCRR but SHSCT had not been able to secure agreement from either of these bodies. Subsequently SHSCT considered convening a multidisciplinary panel comprising eight individuals but due to limited resource and availability of staff this had not progressed. The Expert Review Team considers that a smaller panel, including

urology, governance and lay expertise would suffice; encouragingly, Trust representatives were amenable to this model.

The Expert Review Team is of the view that any learning and evidence-based recommendations made by the review panel would require a commitment from SHSCT to implement a clear prioritised action plan within acceptable timescales.

Recommendation 15

A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel should include individuals with expertise in urology and governance, and include a lay member.

2.2.5 Identification and Dissemination of Learning

Dissemination of learning is crucial in order to improve systems for delivery of care both within SHSCT and across the region. Any strategy for the dissemination of lessons learned should be supported by DoH / SPPG / PHA and should incorporate an action log of the system improvements required, along with timescales for follow up and review.

SHSCT stated that each SCRR report will be reviewed by a Trust clinician who will identify if there is any previously unidentified learning. The thematic analysis report will also be considered by SHSCT in respect of broader system issues.

SHSCT advised that returned SCRRs are reviewed by a Trust clinician who will decide on the appropriateness of sharing learning more widely; this includes learning that should be shared beyond Trust boundaries. Mechanisms for sharing learning were stated to include:

- Using SHSCT local shared learning template;
- Regional shared learning template;
- Morbidity and Mortality Meetings (Patient Safety Meetings);
- Acute Governance Meetings (Directorate wide); and
- Urology and Cancer Services team meetings.

The Expert Review Team considered that the arrangements for identifying, implementing and disseminating learning required strengthening. The reliance on the professional judgement of one clinician to undertake a thematic analysis, in the absence of a mechanism for the reviewers to discuss and feedback, compounded by the lack of quality assurance of individual reports, risks that important system issues may go unidentified. Similarly, the reliance on a Trust clinician to determine whether learning should be shared wider, lacks independence, and runs the risk that one person acts as a gatekeeper to the implementation of improvement and dissemination of lessons learned.

As stated previously, a review panel with representation from urology, governance and a lay member would serve to ensure that there is a robust mechanism for deriving, implementing and making determinations on the dissemination of learning.

Where learning is derived, the Expert Review Team would expect that recommendations are made and clear prioritised time-specific action plans are put in place with arrangements for monitoring and accountability. A follow-up review, with defined parameters for assessment around implementation, would provide assurance around the implementation of sustainable improvements.

The information provided by SHSCT indicates that the consideration of dissemination of learning is confined to within Trust boundaries; although a regional shared learning template is referenced, it is not clear whether this in itself would be sufficiently robust to disseminate learning to the relevant stakeholders across the system. SHSCT representatives were of the view that the previous HSCB process for sharing learning from SAIs needs to be adapted or replicated for the SCRR process but that this had not yet commenced. The Expert Review Team is of the view that the mechanisms for sharing learning should be discussed urgently with DoH / SPPG / Urology Assurance Group. Recipients should include Public Inquiry, SHSCT Board, Urology Assurance Group, DoH / SPPG, PHA, and RQIA; under duty of candour principles, it should be considered whether there is an onus to share learning with the public. In any case, an effective strategy for communication with stakeholders would serve to underpin arrangements for the effective dissemination of learning.

Recommendation 16

SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is shared regionally with all relevant stakeholders and the public is effectively informed under duty of candour principles.

2.3 GOVERNANCE OF THE SCRR

2.3.1 Risk Management

Effective risk management relies on the identification, assessment, mitigation and monitoring of risk. All projects incur risks, such as risks associated with timescales, available expertise, budgetary constraints and data protection vulnerabilities. However, projects of this nature can carry considerable additional risk, such as the risk of causing harm to patients / families / public and reputational risk to the health service. It is vital that the structures, systems and processes in place support effective recognition and management of such risk.

The Expert Review Team was advised that the project does not keep a formal risk log; however, risks are recorded and discussed through meetings. At the time of review, there were three risks identified with mitigation actions identified for each.

When the Expert Review Team explored the issue of risk it was advised that the risks associated with the SCRR had progressed to both the directorate risk register for Acute Services and to the Corporate Risk Register.

The Regional Guidance for Implementing a Lookback Review Process (July 2021) states that:

> "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 Expert Review Team was further advised that SHSCT is currently transitioning to a revised organisational structure, designed to fully support SHSCT to fulfil its function in respect of the SCRR objectives; this is currently operating in in shadow form. As a consequence, the project will operate under more robust governance structures with a live risk register maintained specifically for the Lookback Review. Issues of risk will also be included in the ToR for the new Urology Lookback Review Steering Group and SHSCT Public Inquiry Programme Board (note these are working titles which may change when the new structure is finalised). The Expert Review Team welcomed these improvements which will serve to strengthen the current arrangements for risk management.

2.3.2 Records Management

Effective management of clinical records requires protocols for retrieving, scanning and sharing records, underpinned by strong governance arrangements. SHSCT described robust arrangements for accessing and sharing of clinical records, which was in keeping with good information governance.

A list of patient names and health and care numbers of those cases identified for SCRR is shared with a dedicated administrator. When a decision is made to proceed with SCRR, the relevant patient records are obtained through normal hospital processes by request of hardcopy notes via the medical records team. Notes in patient charts which are not available on NIECR are copied, scanned and uploaded to Egress Secure Workspace, an electronic platform, for sharing with expert reviewers. Expert reviewers also have secure access to NIECR.

There is a dedicated member of the clinical governance team assigned to support the SCRR process, who is responsible for obtaining the charts, extracting the records for scanning and who also uploads to Egress Secure workplace and notifies and liaises with the external expert reviewers. The Expert Review Team considered this approach to be acceptable.

2.3.3 Data Considerations

SHSCT outlined their arrangements for data protection. Document transfer is managed via SHSCT Egress document sharing platform and also via secure VPN access to NIECR records. Each Expert Reviewer is required to complete a Trust confidentiality agreement and Data protection agreement prior to accessing records.

The Expert Review Team identified a potential General Data Protection Regulation (GDPR) issue with the arrangements for contacting families. SHSCT would benefit

from further consideration of information governance, and in particular, data protection issues in relation to SCRR.

Given the sizeable number of patients involved, a database is beneficial to track progress of the Lookback Review / SCRR, to analyse demographic and clinical information, and to monitor outcomes. SHSCT is presently developing a new database to store and analyse information in relation to the selected cases. Unlike the previous database which relied on manual population, the new database allows for automatic population, reducing the risk of input error. The Expert Review Team welcomes this development and advises that a statement of purpose should be drafted for the new database, outlining the rationale for transferring data; a copy of the old redundant file should be retained in case it needs to be examined at a later stage. If deemed to be helpful, SHSCT could be signposted to regional experts who recently developed a database as part of the neurology live patient recall.

Recommendation 17

SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.

2.3.4 Communication with Stakeholders

Effective communication with stakeholders ensures that there is clear, consistent messaging on the purpose, remit, progress and findings of any review. It also facilitates liaison and co-operation regarding specific aspects of the work where external input is required in order to achieve a particular outcome. The need for robust stakeholder communication is referenced within the Regional Guidance for Implementation of a Lookback Review which highlights that the principle of 'no surprises' should be adopted and outlines that there should be:

- An agreed communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected;
- An agreed media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries; and
- Engagement with PSNI and coroner's service in line with standard procedures.

In addition to the above stakeholders, there should also be a channel of communication established with the GMC via the HSC Trust's Responsible Officer. All these elements are best considered as part of a comprehensive Communications Strategy developed for the specific Lookback Review.

SHSCT advised that when completed, the SCRRs are planned to be shared with the Urology Public Inquiry along with the thematic review of cases. Additionally, DoH will be provided with updates on the process via the Urology Assurance Group. SHSCT advised that the Coroner will be notified if there is a potential issue identified via the SCRR processes which has not previously been identified via Trust processes.

The Expert Review Team considers that there is an absence of an overall communication and stakeholder engagement strategy. It is also noted that there is no channel of communication established between SHSCT and PSNI or GMC. The GMC is likely to be interested in the findings, which will be relevant to the Fitness to Practice (FTP) investigation of the consultant concerned. In addition, there is a possibility that the harm found could be of PSNI interest in terms of possible assault, gross negligence, or in extreme cases, manslaughter. The Expert Review Team considers that a Communications Strategy should be developed and examples from recent lookback exercises or similar review work across the region may assist SHSCT in expediting this.

Recommendation 18

SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.

A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Section 3 Conclusion and Recommendations

3.1 Conclusion

RQIA acknowledges the commitment of SHSCT to ensuring that this work is undertaken a manner that is robust and effective in deriving learning and informing improvements. This was evident, not only by the fact that SHSCT approached RQIA to request this review, with the aim of providing assurance, but also in the Expert Review Team's engagement with Trust representatives and staff during fieldwork. We acknowledge the amount of time and effort that SHSCT staff have given to this piece of work and commend their openness, candour and willingness to learn from the expertise of the Expert Review Team. This positive engagement and 'buy in' will assist SHSCT in implementing the necessary improvements.

RQIA was initially approached to provide independent assurance of the SCRR methodology. During preliminary discussions with SHSCT, we determined that this assurance should be broadened to include the wider process, governance and framework surrounding the SCRR process. This was felt to be particularly important given that the SCRR arose as a result of a significant number of SAIs which were identified through SHSCT Lookback Review, at which point the decision was made to adopt alternative methodology to the SAI process. The Expert Review Team endorses this decision. Structured Judgement Methodology, when applied appropriately, is a reliable, validated methodology which offers an effective means of deriving learning and implementing improvements.

However, when examining the SCRR process within the context of the Lookback Review, it was apparent to the Expert Review Team, that the Lookback in itself is not only a significant undertaking for SHSCT but its progression is a matter of urgent priority. An assessment of the historical care of patients, whose cases had undergone the screening process for SCRR, identified deficits in care and treatment prior to 2019. SHSCT is presently conducting a risk assessment and has commissioned RCS to undertake a review of cases relating to 2015 which should assist SHSCT in determining the future scope and scale of their Lookback. The Expert Review Team is of the firm view that SHSCT should not wait until this work concludes, and based on the evidence SHSCT has gathered to date should proceed to review and recall further groups of patients which it has identified to be at risk of harm.

Understanding that this is a considerable undertaking and that issues have already been identified regarding the availability of expertise and resource to support the Lookback Review, SHSCT will require significant support from the wider HSC system: DoH, SPPG, PHA and RQIA. A dedicated, appropriately resourced and experienced project team should be established as soon as possible to support this work. This may require secondment of additional individuals with the relevant skills and experience to SHSCT. RQIA recognises the efforts SHSCT has already undertaken to improve its lookback arrangements and is keen to support SHSCT with further improvements. As RQIA is best placed to provide assurance on the current arrangements to ensure strong foundations for scaling up and extending the Lookback time period, we recommend that RQIA undertakes a follow-up piece of assurance work looking specifically at the Lookback Review. Going forward, in order

to allow SHSCT to focus on the Lookback Review, ideally the SCRR should be undertaken by an independent body. The Expert Review Team understands that SHSCT may not be able to secure the support of an external organisation; therefore, we make a number of recommendations to strengthen the existing SCRR process and arrangements.

SHSCT should explicitly state the purpose of the SCRR and draft a Terms of Reference as soon as possible. Caveated with the fact the Expert Review Team is not privy to all specific clinical concerns, the tool itself appears reasonable, but it does deviate from the tool used by RCP and leaves a number of areas unexamined such as quality of documentation. In addition, given that a proportion of patients are deceased, it would be judicious to update the tool to take into consideration death certification and the need for coronial referral. The Expert Review Team advises that SHSCT liaise with RCP to ensure the tool is appropriately aligned and that SHSCT mirrors RCP's approach to considering patient and family concerns as part of the SCRR process.

The arrangements for patient and family involvement require significant strengthening. Inclusion of lay membership on the relevant project groups would ensure SHSCT meets its statutory duty of patient and public involvement. The Expert Review Team also provides advice on best practice in involving, listening to and supporting patients and families through processes such as these in a way that reduces the potential for further harm and serves to restore faith in the health service. Given the scale, complexity and sensitivity of the work involved, due consideration should be given to seeking an ethical perspective on arrangements through SHSCT Clinical Ethics Committee.

RQIA notes the large number of cases that have been identified for SCRR and the difficulty this poses in terms of conducting SCRRs within reasonable timescales, compounded by the limited number of expert reviewers. A sampling approach is pragmatic and effective in deriving learning within the constraints of time and resource. However, this requires a clear purpose; ToR; agreement with DoH / Urology Assurance Group; due consideration of ethical considerations; and considered and sensitive engagement with patients and families. Importantly, where cases are selected for review, this should be done to a high standard.

A document should be developed to guide reviewers through the SCRR process and there should be a mechanism for calibration between reviewers to ensure consistency and inter-reviewer reliability. Additionally, a sample of the cases should be subject to second review for quality assurance. Understanding that this is challenging to achieve within reasonable timescales with a limited number of reviewers, the Expert Review Team recommends that SHSCT considers recruiting non-urology consultants to review the cases, guided by a defined protocol and with appropriate expert oversight.

Whilst the outcome of individual case reviews will be valuable to patients and families in terms of understanding what went wrong and why, it is the overall learning derived from the SCRR process that will assist SHSCT and the region in improving its systems. Therefore, it is vitally important that SHSCT strengthens its arrangements for identification and dissemination of learning. A review panel

comprising members with expertise in urology and governance, and a lay representative should be established to deliberate findings, derive learning and make evidence-based recommendations. Equally, the mechanisms for sharing learning require an effective dissemination strategy to be agreed with DoH / SPPG and PHA. Underpinning this, communication with stakeholders including GMC, Coroner's Service and PSNI requires to be underpinned by a Communication Strategy and established channels of communication. Furthermore, the arrangements for sharing information with the public under a duty of candour and for developing patient and family information require considerable strengthening. Encouragingly this is already being explored by SHSCT in light of concerns surrounding factual accuracy of previously issued patient correspondence.

On the whole, the challenges facing SHSCT are considerable, complex and require a concerted effort with appropriate involvement of a number of organisations; DoH / SPPG, PHA and RQIA. Retaining the focus on patient safety, the Lookback Review requires urgent support and upscaling. Whilst SCRR will be valuable in establishing deficits within the care and treatment of this patient population, it is limited in terms of deriving systems and governance learning. As such, RQIA advises that a Review of Governance of Urology Services would be crucial in terms of providing assurance around the current service. RQIA is committed to providing both independent assurance and improvement support to SHSCT as it continues its efforts to urgently address deficits in care whilst improving the quality and safety of SHSCT urology services.

3.2 Summary of Recommendations

Recommendation 1

SHSCT should urgently update all relevant documentation to ensure that there is clarity regarding the SCRR including a description of the SCRR purpose, remit and process; explicitly stating that it is a separate process to any parallel Inquiries or investigations.

SHSCT should review their arrangements for developing and quality assuring patient / family information materials and publicly accessible information to ensure there is adequate lay / service user involvement, communications expertise and, where beneficial, legal input.

Recommendation 2

SHSCT should consider reviewing the composition of Lookback Review steering group to reflect that which is stated within Regional Guidance for Implementing a Lookback Review Process; in particular, consideration should be given to the inclusion of a lay representative.

SHSCT should establish a dedicated project team for the management and co-ordination of SCRR. SHSCT should recruit people with the skills and experience who, if required, can seek the advice and guidance of experts from across the region.

Recommendation 3

Considering the need for dedicated co-ordination and management of the Lookback Review and the SCRR process; SHSCT should prioritise the appointment of a suitably qualified Project Manager.

Recommendation 4

SHSCT should define and explicitly state the purpose of the SCRR process. Furthermore, a clear Terms of Reference / set of objectives should be agreed and referenced within the relevant Trust documentation.

Recommendation 5

SHSCT should give urgent consideration to extending their Lookback Review to identify and recall further groups of patients. DoH / Urology Assurance Group / SPPG, PHA and RQIA should work together to support SHSCT with the Lookback Review.

RQIA should consider undertaking an independent assessment of Trust arrangements for the Urology Lookback Review in order to provide assurance on its effectiveness and identify any areas for improvement.

Recommendation 6

SHSCT should consider commissioning an independent body to undertake the SCRR process on its behalf.

Recommendation 7

SHSCT should consider implementing a sampling approach to case selection for SCRR. Such an approach should be agreed with DoH / Urology Assurance Group / SPPG. SHSCT should be clear on the rationale, its benefits and limitations and ensure that there is openness and transparency in communication with patients, families and the public. SHSCT should engage the Clinical Ethics Committee to consider any ethical issues arising from such an approach which can then be addressed and mitigated by SHSCT.

Recommendation 8

SHSCT should request SHSCT Clinical Ethics Committee to review both current and proposed arrangements for the Lookback Review and SCRR. Where ethical issues are identified, SHSCT should give this due consideration and, where required, adapt the methodology and approach for the review.

Recommendation 9

SHSCT should engage with Trust legal representation to obtain a legal perspective on the arrangements for the SCRR.

Recommendation 10

SHSCT should review their arrangements for the involvement of patients and families to ensure that it fulfils its statutory duty of Personal Public Involvement. SHSCT should consider engaging those with Personal Public Involvement expertise and external partners such as the PHA who have PPI training resources for staff and the PCC who could provide advice and support in the involvement of patients and families as part of the Lookback Review and SCRR.

Recommendation 11

SHSCT should review their arrangements for sharing SCRR findings with patients and families giving consideration to good practice as outlined by the Expert Review Team in this report.

Recommendation 12

SHSCT should liaise with RCP and consider amending the Structured Clinical Record Review tool to include an assessment of the quality of documentation and an assessment of the documented communication with patients and families; the clinical team, MDT and primary care. SHSCT should consider facilitating the consideration of patient / family concerns as part of the SCRR to mirror the approach undertaken by RCP.

Recommendation 13

DoH should commission RQIA to undertake a Review of Governance Arrangements within Urology Services in Southern HSC Trust.

Recommendation 14

SHSCT should not be limited to consultant urologists when recruiting clinical reviewers to undertake the SCRR process. All Expert Reviewers should be provided with guidance and support, including an opportunity to debrief, feedback and avail of emotional / psychological support if required.

A document should be drafted specific to this particular piece of work to guide reviewers through the process of conducting the SCRR; this should include a defined protocol for the assessment of the quality of care and treatment.

A sample of cases already reviewed using the SCRR methodology should undergo a second review to ensure inter-reviewer reliability and consistency. Consideration should be given to quality assurance of a defined sample of cases for the remainder of the SCRR.

Recommendation 15

A review panel should be constituted, for the specific purposes of identifying learning and determining recommendations arising from the SCRR process. This panel

should include individuals with expertise in urology and governance, and include a lay member.

Recommendation 16

SHSCT should work with DoH / SPPG / PHA to develop an effective dissemination strategy for the Lookback Review and SCRR so that learning is shared regionally with all relevant stakeholders and the public is effectively informed under duty of candour principles.

Recommendation 17

SHSCT should draft a statement of purpose for the new database, outlining the rationale for transferring data and should retain a copy of the redundant file on record.

Recommendation 18

SHSCT should urgently develop and implement a communication strategy specific to the Lookback Review and including the SCRR process.

A channel of communication specific to Urology work streams should be established between SHSCT, PSNI, GMC and Coroner's office; SHSCT should ascertain the thresholds for referral in respect of specific concerns arising out of cases reviewed as part of the SCRR.

Appendix 1: Terms of Reference for the Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

(a) To review the Southern Health and Social Care Trust's (the Trust) handling of relevant complaints or concerns identified or received prior to May 2020 and its participation in processes to maintain standards of professional practice. The Inquiry shall determine whether there were any related concerns or circumstances which should have alerted the Southern Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and making complaints.

(b) To evaluate the corporate and clinical governance procedures and arrangements within the Trust in relation to the circumstances which led to the Trust conducting a "lookback review" of patients seen by the urology consultant Mr Aidan O'Brien (for the period from January 2019 until May 2020). This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the Health and Social Care Board, Public Health Agency and the Department. It also includes any other areas which directly bear on patient care and safety and an assessment of the role of the Board of the Trust.

(c) To examine the clinical aspect of the cases identified by the date of commencement of the Inquiry as meeting the threshold for a Serious Adverse Incident (SAI) and any further cases which the Inquiry considers appropriate, in order to provide a comprehensive report of findings related to the governance of patient care and safety within the Trust's urology specialty.

(d) To afford those patients affected, and/or their immediate families, an opportunity to report their experiences to the Inquiry.

(e) To review the implementation of the Department of Health's "Maintaining High Professional Standards Policy" by the Trust in relation to the investigation related to Mr O'Brien. The Inquiry is asked to determine whether the application of this Policy by the Trust was effective and to make recommendations, if required, to strengthen the Policy.

(f) To identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose.

(g) To examine and report on any other matters which the Chairman considers arise in connection with the Inquiry's investigations in fulfilment of these Terms of Reference.

The clinical practice of Mr O'Brien is being investigated by the General Medical Council (GMC) and it would, therefore, be inappropriate for the Inquiry to encroach on the GMC's remit. The Inquiry shall submit a report as soon as practicable to the Minister for Health. Should the Inquiry as part of its investigation establish any issue of concern which it believes needs to be brought to the Minister's immediate attention, then this will be done.

Appendix 2: Structured Judgement Review[10]

Case note review remains a prime means of retrospectively assessing quality of patient care. Implicit review is based on clinical judgement and is judged to be effective in identifying and recording the detail and nuance of care (both unsatisfactory and good).

Unstructured implicit review was criticised for low inter-rater reliability (high variability) and for potential reviewer bias. Structured implicit review methods require reviewers to use a judgement based structured explicit scale to rate quality of care from very poor to excellent. However, this form of review only provides a scale based quantitative result giving no indication of why a reviewer made a particular judgement. This means that it is useful for large scale monitoring or epidemiological studies of adverse events but is less effective for more detailed review at ward or hospital level of why an event occurred.

To increase the value of structured review in reviewing the whole spectrum of care quality, rather than focussing only on adverse event rates, a methodology was developed where reviewers were required to provide implicit clinical judgements and to write explicit comments to support judgement based quality of care scores: this forms the basis of Structured Judgement Review.

Structured Judgement Review requires reviewers to make safety and quality judgements over phases of care, to make written comments about care for each phase and to score care for each phase.

The objective of this review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about hospital systems where care goes well and to identify areas where there may be gaps, problems or difficulties with the care process. It can be used for a wide range of hospital based safety and quality reviews across services and specialties and not only for those cases where patients die in hospital. The quality and safety of care may be judged and recorded whatever the outcome of the case and good care is judged and recorded in the same detail as care that may have been problematic.

There are two stages to the review process.

Stage One

Carried out by ‘front line’ reviewers who are trained in the method and who undertake reviews within their own services, for example in Morbidity and Mortality Reviews.

Phases of care – the ‘structure’ part of the process.

Phases of care are shown below but may be varied depending on the type of care or service being reviewed:

- Admission and initial care – first 24 hours
- Ongoing care

- Care during a procedure
- Perioperative/procedure care
- End of life care (or discharge care)
- Overall assessment of care

Explicit Judgement Comments

Explicit judgement commentaries provide:

- The means for the reviewer to concisely describe how and why they assess the safety and quality of care provided.
- A commentary that other health professionals can really understand if they subsequently look at the completed review.

Phase of Care Scores

Care scores are recorded after judgement comments have been written and the score is itself an overall judgement of the reviewer. Scores range from excellent to very poor.

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Judging the quality of recording in the case notes.

As part of the overall assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records again using a score of 1-5.

Second Stage Review

A score of 1 or 2 is given when the reviewer assesses that care has been poor or very poor. A score at this level should trigger a second stage review through the hospital governance process.

A second stage review also uses the structured judgement method and takes place if a patient has died. If the second stage reviewer broadly agrees with the initial case review a decision may be taken to carry out a further assessment concerning the potential avoidability of the patient's death.

The judgement is framed by a 6 point scale. A score of 1,2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

1. Definitely avoidable
2. Strong evidence of avoidability
3. Probably avoidable (more then 50:50)
4. Possibly avoidable, but not very likely (less than 50:50)
5. Slight evidence of avoidability

6. Definitely not avoidable.

Structured Judgement Review can produce learning at two levels:

- The detail captured can identify both poor practice and good practice of individual clinicians.
- When multiple reviews are undertaken within a clinical area or a hospital, a thematic analysis can be performed that may highlight systemic issues in a system.

Quantitative data identify very poor to excellent care in a number of care phases. Qualitative data from explicit judgements may be analysed, for example using word detection software, to identify recurrent themes.

References

[1] Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016. Available at https://hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf Cited July 2022

[2] Regional Guidance for Implementing a Lookback Review Process (July 2021). Available at https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-reg-guide-lookback-reveiw.pdf Cited July 2022

[3] Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt April 2021. Available at b996b934-f707-4206-b1c9-1e7d706bd5ec.pdf (rqia.org.uk) Cited July 2022

[4] Health and Social Care (Reform) Act (Northern Ireland) 2009. Available at Health and Social Care (Reform) Act (Northern Ireland) 2009 (legislation.gov.uk) Cited July 2022

[5] RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents In Northern Ireland (June 2022). Available at RQIA Review of Systems and processes | Department of Health (health-ni.gov.uk) Cited July 2022

[6] IHRD Workstream 5: What you should expect in relation to a Serious Adverse Incident Review in a Health and Social Care setting (Version 2: February 2019). Available at IHRD Workstream 5 - Serious Adverse Incidents - What to Expect irt SAI Review.pdf (health-ni.gov.uk) Cited July 2022

[7] NHS Resolution: Saying Sorry (June 2017) Available at NHS-Resolution-Saying-Sorry.pdf Cited July 2022

[8] Involvement Tools and Guides. Available at Involvement Tools and Guides - Engage (hscni.net) Cited July 2022

[9] Using the structured judgement review method. Guide for reviewers (England). 2019. Available at INMCRR guide England_0.pdf (rcplondon.ac.uk) Cited July 2022

[10] Information taken from the Royal College of Physicians: Using the structured judgement review method. Guide for reviewers (England). Available at https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf Cited July 2022

The **Regulation** and **Quality Improvement** Authority

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

Minutes of a virtual Confidential Meeting of Trust Board held on Thursday, 13th December 2022 at 4.30 p.m.

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr S Austin, Medical Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs L Leeman, Interim Director of Planning and Reform (item 6 only)
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Interim Director of Medicine and Unscheduled Care
Mrs T Reid, Interim Director of Surgery & Elective Care, Integrated Maternity & Women's Health, Cancer & Clinical Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

None

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting. She particularly welcomed Dr Stephen Austin, the newly appointed Medical Director, to his first Trust Board meeting.

The Chair advised that the purpose of this additional meeting was to ensure Trust Board members were kept abreast of progress on items since the last meeting on 27th October 2022.

2. **DECLARATION OF INTERESTS**

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. Irrelevant information redacted by the USI

Irrelevant information redacted by the USI

[redacted]

4. **CYTOLOGY**

The Chair welcomed Mr B Conway, Assistant Director and Dr Clare McGalie, Consultant in Cellular Pathology, for discussion on this item. Mrs T Reid spoke to a paper which provides a further update and a timeline on the historic underperformance of two screeners within the Cervical Cytology Service. Members were reminded that the two screeners had ceased reporting in early October 2021 and the service is concerned that cervical cancer cases are being picked up through the annual audit of invasive cancer that related to one of the two screeners that were underperforming.

Members were advised of the work of the Trust and PHA Steering Group to date. As part of this process, the Trust has commissioned the input and advice of cervical screening subject matter experts from the Royal College of Pathologists. Ms Reid stated that a DAC (Direct Award Contract) was with the Department for approval. Once approved, the risk assessment process will commence and will take up to 8 weeks to complete. Mrs Reid stated that in relation to the cases of concern identified through the audit of invasive cancer for 2021, it has been agreed that these cases will be sent for external review to Leeds Laboratory in England.

Members discussed the key question to be considered through the risk assessment process as to whether the women in the screening population in SHSCT that had smears reported by the two screeners have a higher risk of a false negative report and therefore a missed opportunity to treat pre-cancerous changes.

Mrs Reid stated that in November 2022, a Freedom of Information request was received by all 5 HSC Trusts in Northern Ireland in relation to Cervical Cytology. A draft response to this Freedom of Information Request was included for reference as Appendix 1 in the update paper. Dr Austin advised of the regional approach and that the PHA is taking the lead with the Journalist. An updated FOI has now been made available and will be included in members' papers.

Mrs McCartan stated that this was a very serious issue and the Trust must do what is right for its patients even at financial risk.

Ms Donaghy asked about the number of women with a discordant screening (smear) test between 2008 to 2018. Mr Conway explained that there was a total of 38 women during this timeframe and a total of 15 women between 2019 to 2021. All women will be offered disclosure for 2020 and 2021 as part of the ongoing process. Dr McGalie stated that between 2008 and 2018, it was not clear what criteria were used for determining the definition of disclosure. Ms Donaghy asked about comparison with other Trusts to which Mrs Reid advised this data was not available to the Trust. Dr McGalie advised that overall, it is expected that discordance following cancer audit reviews should fall approximately within the range of 29 – 50%.

The discordant rate for the Southern Trust is 29% and, in response to a query from Ms Donaghy, she agreed to further check column G in the report.

Action: Mrs T Reid

Mr Conway voiced his concern at the ongoing significant backlog of smears waiting to be reported. He stated that this is partly due to reduced reporting capacity with two screeners no longer reporting smears from October 2021 and added that reporting capacity will be further impacted by the loss of one of the locum screeners by end of December 2022. It was agreed that an updated Early Alert on the cervical cytology backlog would be sent to the PHA.

Mrs Leeson acknowledged the impact on staff. She asked if governance arrangements had changed. Dr McGalie explained the governance screening programme in place within the Trust as well as the quality assurance role undertaken by the PHA.

Mr McDonald queried that just because there were not clear guidelines in place as regards the requirement for disclosure from 2008 to 2019, this should not have negated the Trust from taking action. Dr Austin stated that this was not just a Southern Trust issue, but a UK wide issue.

Dr Austin advised of a briefing meeting the following day with the PHA who have set up an Incident Management Team.

5. ENDOSCOPY

Mrs T Reid advised that the waiting lists have been reviewed and eight gastrointestinal endoscopy patients and 4 cystoscopy patients were identified as being on the wrong waiting list. These patients have now either been reviewed or are on a waiting list. One patient has to undergo one further procedure.

In terms of improvements, Mrs Reid stated that all patients being added to the Red-Flag Waiting List now have the comment “RF” included on the Admission Reason Field on PAS. This will allow for red-flag patients incorrectly coded on to the Urgent, Routine or Planned Waiting Lists to be easily identified. Standard Operating Procedures (SOP) re

how to add patients to the waiting has been reviewed, and staff responsible for adding patients to the waiting list were asked to review the SOP and asked if there are any elements they do not understand. Monitoring of waiting list has been strengthened.

In response to a question from Mrs McCartan, Mrs Reid stated that the Trust was in the process of identifying the resources required for a centralized team.

The Chair requested an action plan with timescales for the next confidential Trust Board meeting.

Action: Mrs T. Reid

6. UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm referred members to the brief synopsis of the Public Hearings to date included in members' papers. She stated that the Hearings will resume on Tuesday, 24th January 2023 on a two week on/two week off basis until Easter. The hearing on 24th January 2023 will be in private to hear patient experiences of Urology services. 25th January 2023 is scheduled to be a further day of evidence from Dr Dermot Hughes and Mr Hugh Gilbert. Hearings will then continue on from 26th January 2023 with participants not yet confirmed.

Dr O'Kane spoke of the issues which have been raised in the Hearings to date. In particular, the role of the Trust Board; Board Committees, escalation of issues, including the MHPS process; the willingness of the Board to engage, challenge, plan and improve. She advised that the Chair and herself have discussed in terms of Trust Board meetings and how to use technology to support a more transparent approach. She also made reference to the ongoing work developing the new corporate and clinical and social care governance structures. Mr McDonald raised the fact that when the Permanent Secretary was being questioned at the Public Hearing, he was asked about the chain of command in relation to clinical governance. His response was that the Department does not have the skills or the capacity to do clinical governance and the regulator is the RQIA.

Dr O'Kane agreed to raise this with the external reference group and report back at a future meeting.

Action: Dr O'Kane

7. **ANY OTHER NOTIFIED BUSINESS**

None

The meeting concluded at 6.15 p.m.

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

Minutes of a Confidential Meeting of Trust Board held on Thursday, 26th January 2023 at 8.45 a.m. in the new Boardroom, First Floor, Trust Headquarters

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs P Leeson, Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Dr S Austin, Medical Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs D Ferguson, Assistant Director, Nursing, Midwifery Workforce and Education (*deputising for Mrs H Trouton*)
Mrs L Leeman, Interim Director of Planning and Reform
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Interim Director of Surgery & Elective Care, Integrated Maternity & Women's Health, Cancer & Clinical Services
Mrs T Reid, Director of Medicine and Unscheduled Care
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mr J Wilkinson, Non-Executive Director
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

2. **DECLARATION OF INTERESTS**

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meetings held on 27th October 2022 and 13th December 2022 were agreed as accurate records.

4. **MATTERS ARISING**

Members noted the progress updates from the relevant Directors.

5. **ADULT PROTECTION SAFEGUARDING INVESTIGATIONS**

Mrs T Reid spoke to the update paper in relation to the increase of Adult Protection Investigations involving allegations directed against staff members within the Directorate of Surgery and Elective Care, Integrated Maternity and Women's Health and Clinical and Cancer Services and the Directorate of Medicine and Unscheduled Care. An update from the initial report to Trust Board in September 2022 was also provided. Members noted the summary of the current Safeguarding position within each Directorate.

Mrs T Reid stated that of the 20 cases, 6 are now closed and the remaining open cases have been themed and it has been identified that the majority are in relation to physical abuse (restraint). Within both Directorates it is recognised that there is a need for further provision of Safety Intervention Training (MAPA).

Mrs T Reid particularly highlighted the collective areas of improvement across the two Directorates, as well as the ongoing challenges and risks.
Ms McGall made reference to the fact that the data suggests the majority of investigations were associated with patients presenting with cognitive decline and/or degenerative disease. She offered assistance from the

Integrated Liaison Service in terms of training for staff when patients present with cognitive decline and/or degenerative disease.

Members discussed the fact that Agency staff account for the highest percentage of allegations against staff, the highest ratio sitting with Agency HCA staff. Ms Donaghy asked about training for Agency staff. Mrs Toal stated that with the new Agency framework, it is important that the contract with (off-contract Agencies?) is strengthened so that their processes are audited to ensure that specific arrangements such as training are in place.

In terms of the next steps, members welcomed the Adult Safeguarding Action Plan for both Directorates. Mr McDonald raised the potential for inconsistency in support to the staff involved as it is provided on an individual case by case basis. He also raised the fact that Agency staff and staff whose first language is not English have disclosed during investigations sometimes the patient who has made the allegation against them has allegedly directed racism to them. However, staff in those investigations neglected to record the incidents of alleged racist abuse. Mr McDonald suggested that the Adult Safeguarding action plan should link to the work outlined in the draft Equality Action Plan being presented by Mrs C Lavery in the public section of today's agenda as well as the QI initiative on violence and aggression. Mr McDonald referred to the report cover sheet which referenced two 'People' risks on the Corporate Risk Register and he asked that this be looked at as he felt it did not encapsulate the issues being discussed under this item.

Action: Mrs T Reid

Mrs Leeson asked about the progress in relation to the recruitment of Acute Social Work 8a Adult Safeguarding Lead to which Mrs Teggart advised that this post has been agreed to in principle by the Strategic Investment Board and has been prioritised for funding.

Mr McCafferty stated that he welcomed the focus on adult safeguarding and the more streamlined approach to adult safeguarding training. He advised that the Trust has a range of mechanisms in place to support assurances and accountability of the delivery of adult safeguarding services.

6. CYTOLOGY UPDATE

Mrs C Reid spoke to this item. She outlined the latest position advising that:

- The RCPath Direct Award Contract has been signed and the Purchase Order has been forwarded to RCPath Consultancy.
- Local Operational Sub Group including Trust and PHA has been established to coordinate engagement with RCPath with the work and risk assessment to commence week beginning 30 January 2023 expecting to last 8-10 weeks.
- A further media enquiry has been received by the Trust, as follow up to FOI 1285 and was responded to on 12 January 2023.
- A regional cervical screening stakeholder meeting was held on 19/01/2023 involving the PHA, NI Pathology Network, Health Trusts, BSO & SPPG, chaired by Dr Michael McKenna. It was unanimously agreed that:
  - By no later than 1/03/2023, all Trusts will implement co- testing of backlog samples - pending DOH / PHA / Pathology Network Board approval. This mitigation will significantly reduce all current risks within cervical screening.
  - Progress will continue to escalate introduction of primary HPV testing.
  - The PHA will scope any existing capacity in UK mainland for cytology screening on behalf of the region.
- Two early alerts will be updated and submitted in relation to the screeners and the back log.

Ms Donaghy raised the fact that there continues to be a significant backlog of smears waiting to be reported and asked about the timescale to manage this. Dr Austin explained the challenge was the availability of screeners to undertake this work. Mrs C Reid advised that this is the situation across all Trusts and the PHA has acknowledged the timescale is concerning. In response to a question from Mrs McCartan, Dr O'Kane acknowledged the concern that there was no framework for disclosure in any part of the UK until 2018. She stated that NI is out of sync with the UK as regards the use of Primary HPV screening as a step in the Cervical Screening programme. Mr McDonald raised his concern re Primary HPV testing in the absence of policy and the additional resources that would be

required. Members were advised that regional discussion to progress the introduction of primary HPV testing continues.

7. ENDOSCOPY

Mrs C Reid spoke to the written update on actions being taken following the previous update to Trust Board on 13 December 2022. Mrs Reid advised that four out of the six actions have been completed.

Mrs McCartan welcomed the action plan template which included timescales as requested at the previous meeting.

Mrs Teggart raised the suggestion of Internal Audit undertaking an audit once the process has been embedded. Mrs Teggart and Mrs C Reid to further discuss.

Action: Mrs Teggart and Mrs C Reid

8. UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm referred members to the brief synopsis of the Public Hearings to date included in members' papers. Members noted that the Hearings resumed on 24th January 2023 with two further patient representatives giving evidence in private. The sessions on 25th January 2023 were hearings continued from the end of November 2022 involving Dr Dermot Hughes and Mr Hugh Gilbert. From 26 January, the USI will hear from 16 witnesses with hearings taking place on a 2 week on/2 week off basis until the end of March. Witnesses will include a mix of current and former staff as well as two external witnesses. Mrs McKimm encouraged members to read the transcripts of the Hearings.

Dr O'Kane advised that the Public Inquiry External Reference Group met in person for the first time on 20th January 2023. She stated that the purpose of this group, chaired by Tom Frawley, is to fulfil the role of a "Critical Friend" providing challenge and support to herself and the senior managers leading on the different aspects of the Public Inquiry programme.

Mr McDonald raised two issues - the SAI process and clinical audit and felt that these were two areas that required immediate action by the Trust. He suggested that Internal Audit involvement would be useful to start to look at these areas.

Dr O'Kane acknowledged the limited clinical audit function within the Trust over the past number of years and stated that actions are being taken to strengthen and improve clinical audit. Dr Austin spoke of the improvement work to collate and progress SAI recommendations.

There was discussion on where the progress of improvement work and lessons learned should be reported. Management of Lessons Learned in the Trust is on the Internal Audit programme for next year and it was agreed that Dr Austin would discuss with Internal Audit bringing this assignment forward. Mrs Teggart made reference to the ongoing work developing the new corporate and clinical and social care governance structures. A Learning Assurance Steering Group is being established.

Dr O'Kane referred members to the summary of the Urology Lookback Review in their papers. Members noted the extensive work undertaken to date. Dr O'Kane commended the work by Ms Margaret O'Hagan, Independent Advisor to the Public Inquiry, in the lookback process.

9. **ANY OTHER NOTIFIED BUSINESS**

Dr O'Kane reported that the Chair and herself had attended the Trust's Mid Year Accountability meeting with the Permanent Secretary the previous day. This was a positive meeting with a general discussion on challenges facing the HSC system, the financial situation and performance.

The meeting concluded at 9.55 a.m.

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

Minutes of a Confidential Meeting of Trust Board held on Thursday, 30th March 2023 at 8.45 a.m. in the new Boardroom, First Floor, Trust Headquarters, Craigavon

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr S Austin, Medical Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs L Leeman, Interim Director of Planning and Reform
Ms A McCorry, Head of Pharmacy and Medicines Management (*for Mrs T Reid)*
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Director of Surgery & Clinical Services
Mrs V Toal, Director of Human Resources and Organisational Development
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mrs P Leeson, Non-Executive Director
Mrs T Reid, Director of Medicine and Unscheduled Care

1. **CHAIR'S WELCOME**

The Chair welcomed everyone to the meeting.

2. **DECLARATION OF INTERESTS**

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. None were declared.

3. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting held on 26th January 2023 were agreed as an accurate record.

4. **MATTERS ARISING**

Members noted the progress updates from the relevant Directors.

5. **ADULT PROTECTION SAFEGUARDING INVESTIGATIONS**

Mrs C Reid spoke to the update paper in relation to the increase of Adult Protection Investigations involving allegations directed against staff members within the Directorate of Surgery and Clinical Services and the Directorate of Medicine and Unscheduled Care. Members discussed the associated action plan. In response to some queries from members, Mrs C Reid and Mrs V Toal undertook to do further work on the action plan. Mr McDonald stated that Adult Protection would be a standing item at the Governance Committee going forward.

6. **CYTOLOGY UPDATE**

Mrs C Reid spoke to this item. She outlined the latest position advising that:

- Completion of risk assessment by RCPath is expected in April 2023;
- A further FOI was received into the Directorate on 21 March 2023 asking for the current backlog number of cervical smears within the Trust, which is now at 7941;
- The Trust has influenced decisions to progress with co-testing to manage the risk of the reporting backlog;

- Early alert on screeners performance has been updated and a new one about the backlog of cervical screening within the Trust has been submitted.

The Chair asked if there was a defined timescale for the lookback exercise to which Dr Austin advised that the need for a lookback would be determined by the outcome of the RCPath risk assessment report.

7. MEDICAL STAFFING

Dr Austin advised of critical medical staffing pressures. He stated that recruiting and retaining enough medical staff has been a significant issue in Daisy Hill Hospital in recent years, but the pressures have escalated recently with a number of medical staff retirements and resignations. The regional and international shortage of consultants, difficulties recruiting middle grade and junior doctors and the serious over-reliance on locum doctors are matters of great concern in meeting the increasing demands for acute medicine and providing stable medical staffing cover in the medical wards.

Dr Austin advised of discussions to stabilize the medical workforce situation with a range of options being explored. The Chief Executive stated that the Department of Health has been informed of the concerning situation.

The following actions were agreed:-

- Action plan to be developed;
- Medical staffing risk on the Corporate Risk Register to be updated;
- A strong visible leadership presence in Daisy Hill Hospital required. This will involve Non Executive Directors and Directors undertaking joint visits. Chair and Chief Executive to undertake unannounced visits;
- Trust Board meeting on 25th May 2023 to be held in Monaghan Row, Newry.

Dr Austin agreed to keep Trust Board updated.

Action: Dr Austin

8. **ENDOSCOPY UPDATE**

Mrs C Reid advised that work continues to progress the action plan. Two actions remain outstanding and an update will be brought to the confidential Trust Board meeting on 22nd June 2023.

Action: Mrs C Reid

9. [redacted]

Ms McGall provided an update on the situation within [redacted] which provides supported living for individuals [redacted]. She reminded members that [redacted] has experienced a range of difficulties in relation to culture, staffing and working practices and these had been highlighted at Trust Board confidential meetings throughout 2022. Ms McGall advised that due to ongoing senior management concerns within Mental Health & Disability regarding a lack of meaningful and embedded improvement progress, there was a decision to dedicate Collective Leadership Team resource on a fulltime basis to [redacted] from December 2022. This presence of senior leadership has evidenced significant concerns regarding:

- Staffing levels and competence to meet service user need
- Sickness absence (medically evidenced in some cases, however also following managerial instruction to staff e.g. to complete training, in respect of safeguarding concerns and staffing cover)
- Management competence and leadership
- Safeguarding: impact of staffing capability/actions on tenant's behaviour
- Long-standing cultural concerns
- Communication
- Tenant compatibility
- Systems and processes in running of the unit e.g. off-duty planning, training organisation, supervision

In terms of immediate actions, Ms McGall advised that an Improvement Team has been identified for [redacted], inclusive of a senior improvement lead (8B/8C); registered manager, HR lead, professional nursing lead and social work lead. She spoke of the plan to stabilise the workforce through Expression of Interest process for staff to transfer to [redacted];

management of sickness absence; flexible workforce (bank/agency). Safe staffing levels for each house to be established dependent on service user need.

The long standing cultural concerns were discussed and members welcomed the drive to change the culture and hold people to account. However, it was acknowledged that a positive culture and sustained change would take time to grow. Ms McGall also advised of the need to explore an appropriate model of care.

Ms McGall stated that this risk was currently being managed on the MHD Directorate Risk Register. It was agreed that the Senior Leadership Team would consider escalation of this risk to the Corporate Risk Register.

Ms McGall agreed to keep Trust Board updated on this matter.

Action: Ms McGall

10. UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY AND UROLOGY LOOKBACK REVIEW SUMMARY

The Chair welcomed Mrs McKimm, Programme Director for the Public Inquiry, to the meeting. Mrs McKimm referred members to the brief synopsis of the Public Hearings to date included in members' papers. Members noted that the current phase of public hearings, which has focused on the implementation of the Department of Health's 'Maintaining High Professional Standards' policy in relation to the investigation related to Mr O'Brien is due to complete on 30th March 2023. The Inquiry will sit again week commencing 17th April 2023 and that week will hear from Mr O'Brien. At this stage, Mr O'Brien's evidence will focus solely on the Trust's handling of the MHPS investigation. The next phase of the Inquiry will commence on April 25th and run until the end of June. This will be on the three day per week, 2 weeks on/2 weeks off basis as previously and the Trust has been advised by the Inquiry that 22 witnesses are scheduled to appear.

Mr Wilkinson commended the emotional care, support and understanding provided by the Trust to those who are required to give evidence to the USI.

The Chief Executive updated on the work of the Public Inquiry External Reference Group. She advised that time-limited groups have been established to develop action plans in relation to the following areas:-

- Culture
- Governance and Accountability
- Quality and Safety
- Analytics/Digital

An overall Improvement Plan for the Trust will then be developed.

Mrs McKimm provides an update on the USI Hearings and it was agreed that these will be uploaded to Decision Time for members information.

Members discussed the Urology Lookback Review summary.
Dr O'Kane advised that the Lookback Review – Cohort 1 was almost complete. Members noted and welcomed the extensive work undertaken to date.

11. **ANY OTHER NOTIFIED BUSINESS**

None

The meeting concluded at 10.00 a.m.

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board Confidential March 30th, 2023	
Title of paper	Update on Governance Concerns within Urology and Urology Lookback Review summary	
Accountable Director	Name	Dr Maria O'Kane
	Position	Chief Executive
Report Author	Name	Mrs Jane McKimm
	Email	Personal Information redacted by the USI
This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Information

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

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

1. Public Inquiry Update:

- The current phase of public hearings, which has focused on the implementation of the Department of Health's 'Maintaining High Professional Standards, policy.in relation to the investigation related to Mr O'Brien is due to complete on March 30th.

  The Inquiry will sit again week commencing 17th April 2023 and that week will hear from Mr O'Brien. At this stage Mr O'Brien's evidence will focus solely on the Trust's handling of the MHPS investigation.

- The next phase of the Inquiry will commence on April 25th and run until the end of June. This will be on the three day per week, 2 weeks on/2 weeks off basis as previously and we have been advised by the Inquiry that 22 witnesses are scheduled to appear.

- In this January to Easter period, 16 witnesses in total have already, or will, give evidence –a mix of former and current staff along with two external witnesses. Some witnesses have been required to attend for more than one day due to the length and complexity of the evidence.

  All hearings are streamed live, and transcripts are available at urologyservicesinquiry.org.uk along with any documents referenced during the hearings.

  The Public Inquiry External Reference Group met in person for the second time on Friday, March 10th.

  The External Reference Group is to fulfil the role of a "Critical Friend" providing independent challenge and support to the Chief Executive and sharing their expertise and knowledge in framing the Trust's response to the learning coming out of the Inquiry process. Four areas for consideration by the group have been agreed:
  - Culture
  - Governance and Accountability
  - Quality and Safety
  - Analytics/Digital

  With time-limited groups agreed to develop action plans in relation to these areas and to progress an over-all Improvement Plan for the Trust.

Independent Members:

- Tom Frawley (Chair)
- Mary Hinds
- Veryan Richards
- Robbie Pearson
- Simon Watson
- Hugh McCaughey

Trust Members:

- Chief Executive
- Medical Director (and Quality Assurance and Leaning Steering Group) (SA)
- Director of Nursing (HT)
- Chair of the PI Response Steering Group (JMcK)
- Chair of the Lookback Review Steering Group (MOH)
- Chair of the People and Culture Group (VC)

2. Urology Lookback Review - summary :

Lookback Review Stage 1 – Cohort

- January 2019 – June 2020
- 2112 patients

Lookback Review Stage 2 - Review

- 2112 completed – all patients now have a 10 question PRF complete
- Number of patients not requiring further review – **1692**
- Number of patients their care requiring further attention are **223**.
- Forty seven patients still under consideration – will be desktop reviewed by SET consultant either 15 or 16 April (these dates secured from SET to do this work)

Sub-Optimal Care Exercise

- This is now completed – 691 patient received sub-optimal care
- Summary attached as Annex B.

Stage 3 - Recall

- To date 530 patients seen already
- Current number patient awaiting appointment is 11 – these patients have been dated (30 March and 4 April.
- Another clinic is available for patients from the SET desktop review)
- LBR Team currently analysing the outcome of the recall clinic – was there a change in plan or not. This information will be contained in Outcomes Report

LBR Cases Closed

- For the 2112 cohort - 1914 patient cases are closed **(91%).**

SCRR Screening

- New total of 125 meet SCRR threshold – 53 original plus 72 additional
- 10 cases remain on the screening list – when screened this work will them be complete for cohort

SCRR Reporting

- Of original 53 forwarded for SCRR:
  - All 53 have now been returned
  - Trust connecting with an external expertise to complete a thematic review of the SCRR reports
- A comparative analysis has been undertaken by the Lookback Team of the 53 returned SCRR reports i.e. reasons patient was screen-into SCRR is compared to the themes identified in the returned SCRR report.
- Learning derived from SCRRs:
  - Incorrect treatment
  - Un-actioned MDM outcomes including onward referrals and planned reviews
  - Prescription of unlicensed medication as an incorrect form of treatment
  - Not following NICE guidelines
  - Not providing patients with options and choice in relation to their treatment pathway (informed consent)
- "New Themes" SCRRs being identified and forwarded a full SCRR.

Summary of Actions to Close Cohort 1

The actions required to close Cohort 1 are:

	CLINICAL ACTION	UPDATE
1.	Completing desk top review of clinical charts to determine if a patients needs a recall appointment (38 pts)	SET secured for 15 and 16 April
2.	Screening for SCRR Cases (10 patients)	Date still be secured from Mr H
3.	Undertake the "recall" element for current cohort (11 pts)	Current patient appointed 30 March & 4 April
4.	Relaying to NOK the outcomes of SCRR and / or issues relatives care (14 patients)	This now will be an admin action – provide feedback in writing
	NON-CLINICAL ACTIONS	
5.	No NOK Found Cases – resolution by BSO – then correspond with families	76 patients
6.	Outcome analysis of "Change or No Change" of Management Plan	150 patients + those to be seen in clinic
7.	Complete outcomes report	NA
8.	Complete SCRR exercise	Number to be determined
9.	SCRR thematic Review	
10.	Other admin work such as: ➢ Sending letters & closing episodes on database ➢ filing letters and triage forms ➢ USI discovery (Cohort 1 spreadsheet letters and activity report)	

Extending the Urology Lookback – Actions to commence Cohort 2

- Trust Cohort 2 planning group established
- Patients included in Cohort 2 are "alive cancer patients back a further 4 years i.e. 1 January 2015 – 31 December 2018" as well as private patients.
- Private patients will be ascertained via "media call" at the same time as the cohort 2 is launched.
- Validation of the number of cancer patients in this group has commenced and is shaping up as being between 250-300 patients which is less than initially estimated;
- Trust is planning to "insource" clinical time from an IS provider for the clinical aspect of the lookback. The clinical work / clinics etc will be done in Trust premises by visiting urologists employed by an IS provider;
- To maintain the integrity of the LBR process the methodology for cohort 1 and 2 will be similar with the IS providing the entire clinical aspect of the lookback exercise. This allows the Trust's lead urologist to undertake any patient-related lookback activity allowing his time to remain focused on core urology services and service improvement;
- This model will be collaborative with the Trust working in partnership with the insourcing provider in that the provider would provide the clinical expertise and the Trust would continue to provide the administration for all aspects of the Lookback process;

  The cost of this approach will not be clear until the number of patients and the scope of the work is clarified.

3. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	Included at Risk 7
Board Assurance Framework	N/A
Equality and Human Rights	N/A

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

Minutes of a Confidential Meeting of Trust Board held on Thursday, 25th May 2023 at 8.30 a.m. in the Boardroom, District Council Offices, Monaghan Row, Newry

PRESENT

Ms E Mullan, Chair
Dr M O'Kane, Chief Executive
Ms G Donaghy Non-Executive Director
Mrs H McCartan, Non-Executive Director
Mr M McDonald, Non-Executive Director
Mr J Wilkinson, Non-Executive Director
Dr S Austin, Medical Director
Mr C McCafferty, Interim Director of Children and Young People's Services/Executive Director of Social Work
Ms C Teggart, Director of Finance, Procurement and Estates
Mrs H Trouton, Executive Director of Nursing, Midwifery & Allied Health Professionals

IN ATTENDANCE

Mr B Beattie, Director of Adult Community Services
Mrs S Hynds, Deputy Director, HR Services (for Mrs Toal)
Mrs J McConville, Assistant Director, Corporate Planning (for Mrs L Leeman)
Ms J McGall, Director of Mental Health and Disability Services
Mrs C Reid, Director of Surgery & Clinical Services
Mrs T Reid, Director of Medicine and Unscheduled Care
Mrs R Rogers, Head of Communications
Mrs S Judt, Board Assurance Manager (Minutes)

APOLOGIES

Mrs P Leeson, Non-Executive Director
Mrs L Leeman, Interim Director of Planning and Reform
Mrs V Toal, Director of Human Resources and Organisational Development

1. CHAIR'S WELCOME

The Chair welcomed everyone to the meeting.

2. DECLARATION OF INTERESTS

The Chair asked members to declare any potential conflict of interests in relation to items on the agenda. Mrs C Reid and Mrs T Reid declared an interest in agenda item no. 10 and left the meeting at that point.

3. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting held on 30th March 2023 were agreed as an accurate record.

4. MATTERS ARISING

Members noted the progress updates from the relevant Directors.

The Chair asked that item no. 10 was taken next on the agenda.

Mrs C Reid and Mrs T Reid left the meeting at this point.

10. FEEDBACK FROM REMUNERATION COMMITTEE

The Chair presented her Remuneration Committee Chair report of the 11th May 2023 meeting and members noted the areas considered.

The Chair sought approval of the Remuneration Committee recommendations in respect of the remuneration of Mrs T Reid, Director of Medicine and Unscheduled Care, Mrs C Reid, Director of Surgery and Clinical Services and Ms E Wilson, Director of Planning, Performance and Informatics.

Trust Board approved the recommendations of the Remuneration Committee

Mrs C Reid and Mrs T Reid returned to the meeting at this point

Remuneration Committee noted formal issue of Departmental Circular HSC (SE) 1/2023 which provides details of the 2020/21 pay award (based

on performance year 2019/20) and HSC (SE) 2/2023 which provides details of the 2021/22 pay award (based on performance year 2020/21).

The Chair advised that Remuneration Committee approved the pay awards based on performance ratings for 2019/20 and 2020/21 as previously notified to the Remuneration Committee. Recalculation of the 2018/19 and 2019/20 pay awards was also approved due to the clarification received from the DoH.

Trust Board approved the recommendations of the Remuneration Committee

The Chair sought approval for the Remuneration Committee's revised Terms of Reference.

Trust Board approved the revised Terms of Reference

The Chair advised that in relation to strengthening leadership – SLT, a number of Job Descriptions were being finalised and would be brought back to Remuneration Committee in due course.

5. **CYTOLOGY UPDATE**

Mrs C Reid spoke to this item. She outlined the latest position advising that:

- Draft risk assessment report has now been received from RCPath. The Trust has responded with a range of comments in relation to factual accuracy. The Trust's response also includes comments from the PHA;
- Current backlog number of cervical smears within the Trust is currently 8,886 (as of 11 May 2023);
- A regional programme for primary HPV co-testing has commenced to address the backlog in reporting of smears;
- Early alert on screeners performance has been updated and a new one about the backlog of cervical screening within the Trust has been submitted;
- A new locum screener was secured during April 2023 and is now working to help address the reporting pressures. Efforts continue to be made to secure further locum support;

- Risk relating to Cervical Cytology Backlog and Performance has been added to the Corporate Risk Register.

Ms Donaghy raised the fact that of the samples co-tested to date, 350 (9%) have been HPV positive. She asked if there was guidance as to what the % should be from that sample size. Mrs Reid and Dr Austin agreed to seek clarity on the average / expected HPV positive rate of a sample size.

Action: Mrs C Reid / Dr Austin

6. DORSY ADULT PROTECTION UPDATE

Ms McGall spoke to the final update to Trust Board in relation to the Adult Protection Investigation from November 2020 on Dorsy Ward, Bluestone Unit. She reminded members that a paper outlining the findings and recommendations of the Adult Protection Investigation was presented to the confidential section in November 2022. Ms McGall drew members' attention to the final actions completed to close this issue as follows:-

- Face to face meeting took place in November 2022 with victim, mother, Director and Assistant Director to offer apology for harm caused;

- HR Disciplinary Process completed in December 2022;

- SAI investigation and report concluded in March 2023 – recommendations were akin to the Adult Protection Investigations.

- Learning: A key feature of this process was to ensure learning from both the Adult Protection and SAI process were shared to improve quality of care and prevent recurrence. Learning will also be shared via letter with patients (as appropriate), families/carers of current inpatients by June 2023.

Ms Donaghy asked if there was the potential for further engagement with patients, families/carers of current inpatients in addition to via letter. Ms McGall stated that there is ongoing engagement with

families/carers of current inpatients and it was the Trust's intention to also meet with them following issue of the letter and with patients, if appropriate. In response to a question from Mrs McCartan, Ms McGall acknowledged that there was opportunity to share learning across Directorates and she would liaise with clinical and social care governance as to the best way of doing this.

Ms McGall advised that the Directors Oversight Group remains in place in relation to Dorsy Ward (Director of HROD, Executive Director of Nursing, Midwifery and AHPs, Director of Mental Health and Disability), however, she was proposing that this will conclude following today's Trust Board meeting and the next planned meeting.

Mr Wilkinson asked about future monitoring of the situation. Ms McGall advised that there is stable senior leadership in place, regular walkthroughs, senior leadership walks and weekly review of incidents. She spoke of her intention to undertake a cultural assessment in the Dorsy Unit.

The Chief Executive paid tribute to Ms McGall and the good multi-disciplinary working that achieved the improvements in Dorsy. She noted that there are currently no difficulties in recruiting to Dorsy which she stated was a measure of improvement. Mr McDonald and Mrs McCartan had both undertaken leadership walks to Dorsy and commended Ms McGall and the team on the positive culture and engagement they encountered.

The Chair welcomed the compassion of approach. Ms McGall advised that to ensure Trust Board was kept apprised, she was preparing a report on seclusions etc. and proposed to bring updates to Trust Board for assurance.

7. UPDATE ON ACUTE MEDICINE, DAISY HILL HOSPITAL

Dr Austin advised of critical medical staffing pressures in Daisy Hill Hospital. He stated that recruiting and retaining enough medical staff has been a significant issue in Daisy Hill Hospital in recent years, but the pressures have escalated recently with a number of medical staff retirements and resignations. The regional and international shortage of consultants, difficulties recruiting middle grade and junior doctors and the serious over-reliance on locum doctors are matters of great concern

in meeting the increasing demands for acute medicine and providing stable medical staffing cover in the medical wards. Dr Austin spoke of the impact on the Consultant staffing on the allocation of trainees to Daisy Hill Hospital.

Dr Austin advised of discussions to stabilize the medical workforce situation with a range of options being explored. He stated that due to insufficient senior Consultant cover at Daisy Hill Hospital, all acute stroke patients would now be diverted to Craigavon Area Hospital.

Dr Austin spoke of the intention to hold a regional summit the following week in relation to mutual aid to identify potential medical staffing support.

The Chief Executive emphasized that the 3 key aims were to ensure patient safety, support staff's psychological safety and maintaining a 24/7 ED at Daisy Hill Hospital.

8. **FINANCIAL STRATEGY 2023/24**

Ms Teggart referred members to the following documents in their papers:-

- Financial Strategy 2023/24 which reflect indicative budgets
- Correspondence from the Permanent Secretary to Chief Executive dated 22 May 2023 on decision taken in allocating 2023/24 budget for the DoH
- Correspondence from the Permanent Secretary to Chief Executive dated 22nd May 2023 on Resource Budget 2023-24 Equality Impact Assessment
- Correspondence from Tracey McCaig, DoH, to Director of Finance, dated 21st April 2023 on draft indicative figures for 2023-24 financial planning
- Financial Sustainability and Productivity Review Action Plan

Ms Teggart advised that following notification of the draft budget received from SPPG/PHA in April 2023, the projected opening current year effect revenue resource limit budget is £852.5m. This is the net budget after a savings target associated with High Impact Savings measures is deducted. SPPG has notified the Trust that the high impact savings are currently not expected to be achieved at this point therefore

the underlying budget is £864.8m. This does not include any additional funding for growth and also includes a considerable reduction in Covid budget.

Ms Teggart drew members' attention to the concerns and risks as follows:-

- The total gross estimated opening recurrent deficit is £29.3m, before considering new\emerging pressures, Covid pressures or indeed potential funding streams\easements.
- After the consideration of new/emerging/additional cost pressures of £35.2m the gap is increased to some £64.6m.
- When the estimated deficit on Covid indicative funding of £10.7m and movement on opening pressures of £0.6m is considered it increases the gap to £75.9m
- After consideration of potential easements/funding as identified in the indicative allocation letter, he estimated opening funding gap is reduced to £47.3m
- To implement a savings plan to the value of £47.3m (in order to reach a break-even position as at 31st March 2024) will have a detrimental impact on Trust services and will be extremely difficult to achieve in 2023/24.

The Financial Sustainability and Productivity Review and associated action plan were discussed. In response to a query from Mrs McCartan as to the resource at Directorate level to examine their costs,
Ms Teggart explained that the Finance Department has analysed areas of spend and identified cost drivers that are increasing and require further analysis. An action plan has been prepared setting out actions and delivery dates. Monitoring of the action will be carried out at monthly finance focus meetings with Directors and progress reports to the Trust Delivering Value Programme Board and to Trust Board through the Performance and Finance Committee.

Members discussed the Trust's savings target of 47.3m and the difficulty to achieve this in 2023/24. Members raised the importance of raising this in the public arena. The Chief Executive agreed to include in her Chief Executive's update at the next Trust Board meeting. The Financial Strategy 2023/24 will also be presented at the Trust Board meeting on 22nd June 2023. The Chair advised that the Chairs' Forum

has written to the Permanent Secretary to express their concern at the budget allocation for 2023-24 and requesting a meeting.

Trust Board approved the Financial Strategy 2023-24

9. **UPDATE ON GOVERNANCE CONCERNS WITHIN UROLOGY AND UROLOGY LOOKBACK REVIEW SUMMARY**

The Chief Executive referred members to the brief synopsis of the Public Hearings to date included in members' papers. She advised that since the last update to Trust Board in March 2023, Public Hearings relating to the Maintaining High Professional Standards process have completed. On 25th April 2023, a new module commenced relating to the Trust's governance structures and processes/Governance in Action. She stated that more recently learning is around development of admin staff, middle management and the area of medical leadership.

The Chief Executive updated on the work of the Public Inquiry External Reference Group and advised that the group had met in person for the third time on 21st April 2023. As previously reported, 4 time-limited sub groups have been established and are working to develop action plans in relation to specific areas and to progress an over-all Improvement Plan for the Trust.

Members discussed the Urology Lookback Review summary. The Chief Executive advised that the clinical aspect of Lookback Review – Cohort 1 was now completed. The outcomes report for cohort 1 was currently being drafted – due completion by end May 2023. She stated that there is active planning for commencing cohort 2 with support from the Lookback Review Lay Reference Group - anticipate "start" date for this as end June 2023 – to be dictated by the DoH.

11. **ANY OTHER NOTIFIED BUSINESS**

None

The meeting concluded at 10.00 a.m.

Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Trust Board 25th May 2023	
Title of paper	Update on Governance Concerns within Urology and Urology Lookback Review summary	
Accountable Director	Name	Dr Maria O'Kane
	Position	Chief Executive
Report Author	Name	Mrs Jane McKimm
	Email	[redacted] Commercially Sensitive Information redacted by the USI
This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Information

Links to Trust Corporate Objectives	☒	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
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	The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report). *Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee*

1. Public Inquiry Update:

- Since the last update in March 2023, public hearings relating to the Maintaining High Professional Standards process have completed, including three days of in-person evidence from Mr Aidan O'Brien.

  On Tuesday April 25th, a new module commenced. A summary of the module was provided in opening comments by Ms McMahon, barrister for the USI –

  "…we are now moving on from evidence regarding the MHPS process and surroundings events to hear evidence about the governance structures and processes put in place by the Trust or developed by Trust staff in their attempt to ensure the smooth running of systems of operational and clinical governance. In short form, this evidence seeks to demonstrate Trust governance in action."

  (Source – Day 40 Transcript 25 Aptil 2023 (urologyservicesinquiry.org.uk))

- While this phase of hearings will largely follow the 2 weeks on/2 weeks off pattern, there are approximately three weeks of hearings scheduled for June. However, there remains a degree of uncertainty around the final schedule and it is likely to be subject to change. To facilitate some previously scheduled witnesses, there may be some Monday hearings over the next 4/5 week period.

- Public Hearings are paused through July and August, and are planned to resume in mid-September. The Trust continues to engage through DLS to the USI on mitigating the service impact while staff attend to give in-person evidence. This engagement has been positive and we continue to do all we can to support both the Inquiry process, and our staff who are required to attend in person.

- To date, 18 Trust witnesses have given evidence in-person since November 2022, with a further 18 Trust witnesses scheduled to appear by the end of June 2023. Each witness is supported through at least one face-to-face consultation with the Trust legal team, and a separate consultation with the USI legal team. Each consultation, and evidence given during the hearings, generates further requests for discovery/information to ensure the fullest possible picture is available to the USI. To date, the Trust has provided more than 50,000 documents, with regular on-going discovery provided on a monthly basis.

- Discovery includes emails, Trust reports, minutes of meetings etc, but of value to the Inquiry are also, for example, handwritten notes and comments, diary entries and personal notebooks. This level of information continues to be retrieved and provided, as the Public Inquiry Team are made aware of its existence.

  All hearings are streamed live, and transcripts are available at urologyservicesinquiry.org.uk along with any documents referenced during the hearings.