SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of decision to treat and at least 95% of patients urgently referred with a suspected cancer should begin their definitive treatment witin 62 days.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

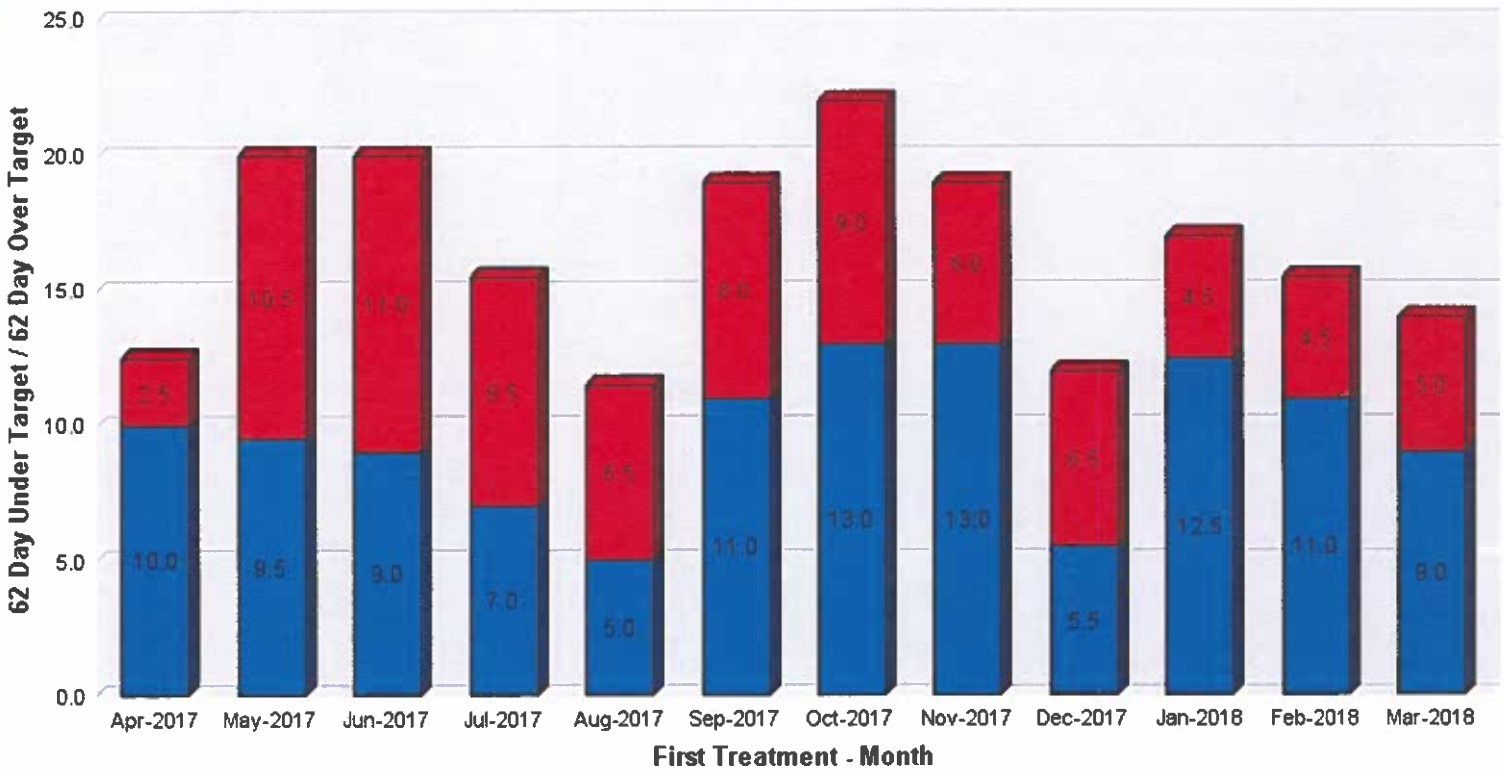
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2017 TO 31/03/2018

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2017	10.0	2.5	12.5
May-2017	9.5	10.5	20
Jun-2017	9.0	11.0	20
Jul-2017	7.0	8.5	15.5
Aug-2017	5.0	6.5	11.5
Sep-2017	11.0	8.0	19
Oct-2017	13.0	9.0	22
Nov-2017	13.0	6.0	19
Dec-2017	5.5	6.5	12
Jan-2018	12.5	4.5	17
Feb-2018	11.0	4.5	15.5
Mar-2018	9.0	5.0	14
Sum:	115.5	82.5	198

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

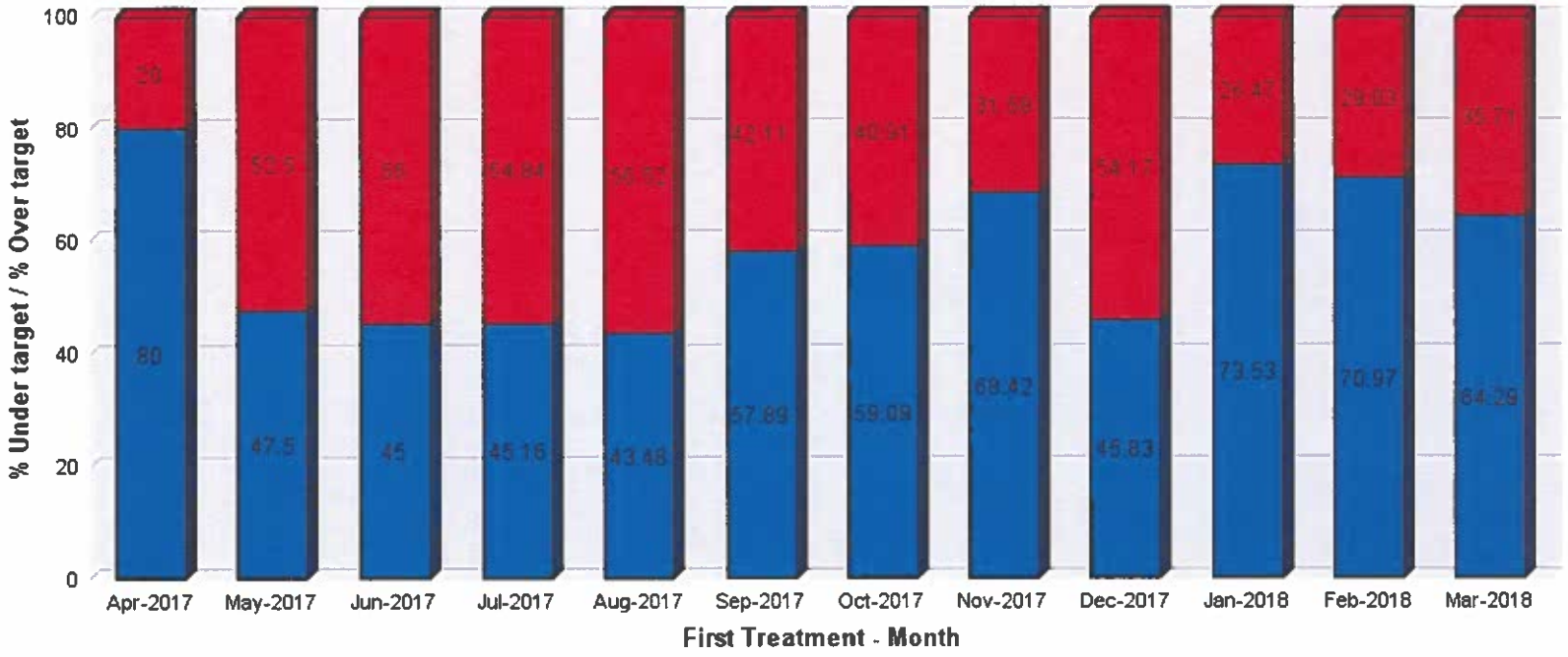
FROM 01/04/2017 TO 31/03/2018

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2017	80	20
May-2017	47.5	52.5
Jun-2017	45	55
Jul-2017	45.16	54.84
Aug-2017	43.48	56.52
Sep-2017	57.89	42.11
Oct-2017	59.09	40.91
Nov-2017	68.42	31.58
Dec-2017	45.83	54.17
Jan-2018	73.53	26.47
Feb-2018	70.97	29.03
Mar-2018	64.29	35.71

CUMULATIVE

% Under target	% Over target
58.33	41.67



SOUTHERN HEALTH AND SOCIAL CARE TRUST

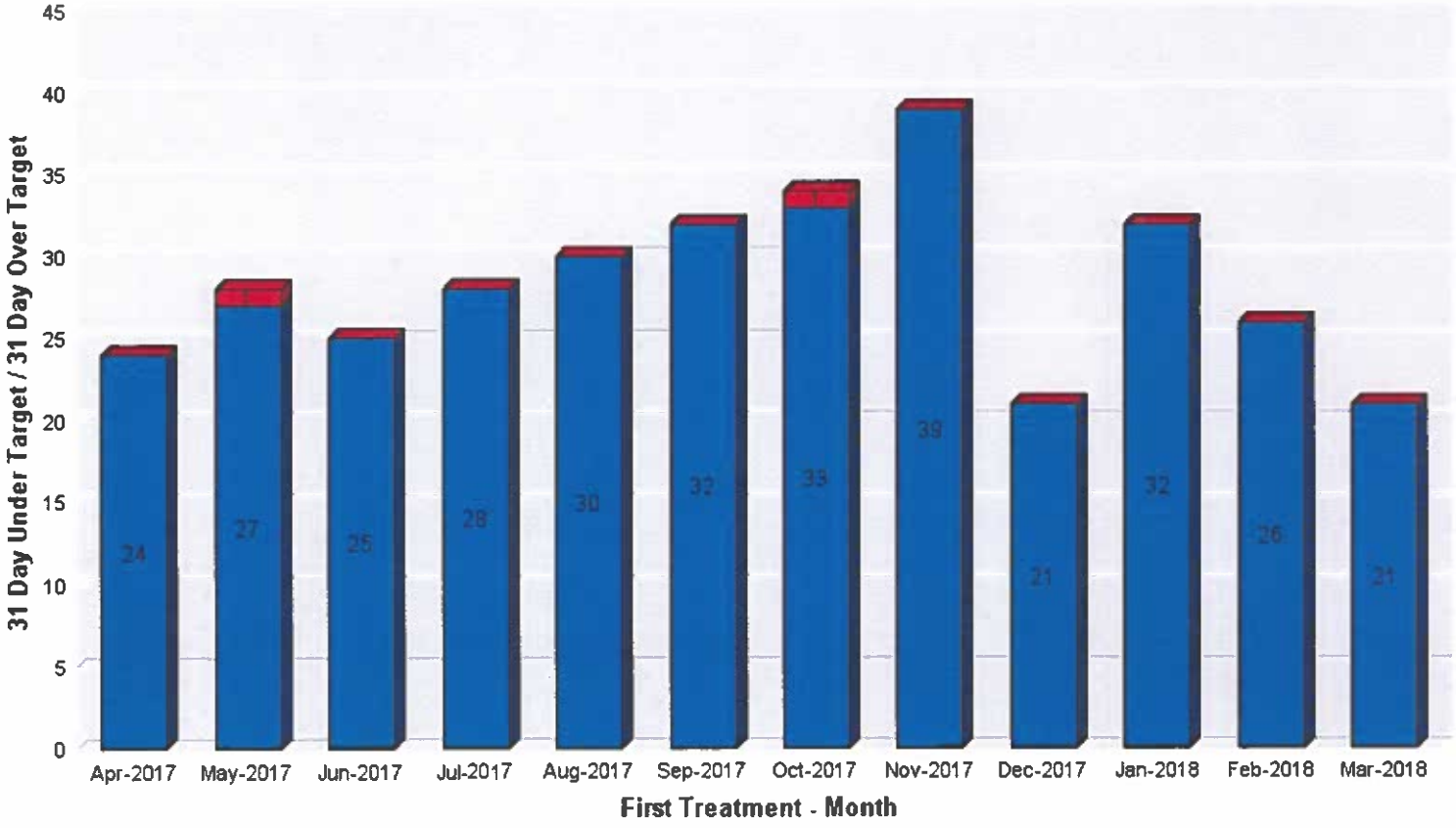
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2017 TO 31/03/2018

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2017	24	0	24
May-2017	27	1	28
Jun-2017	25	0	25
Jul-2017	28	0	28
Aug-2017	30	0	30
Sep-2017	32	0	32
Oct-2017	33	1	34
Nov-2017	39	0	39
Dec-2017	21	0	21
Jan-2018	32	0	32
Feb-2018	26	0	26
Mar-2018	21	0	21
Sum:	338	2	340



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2017 TO 31/03/2018

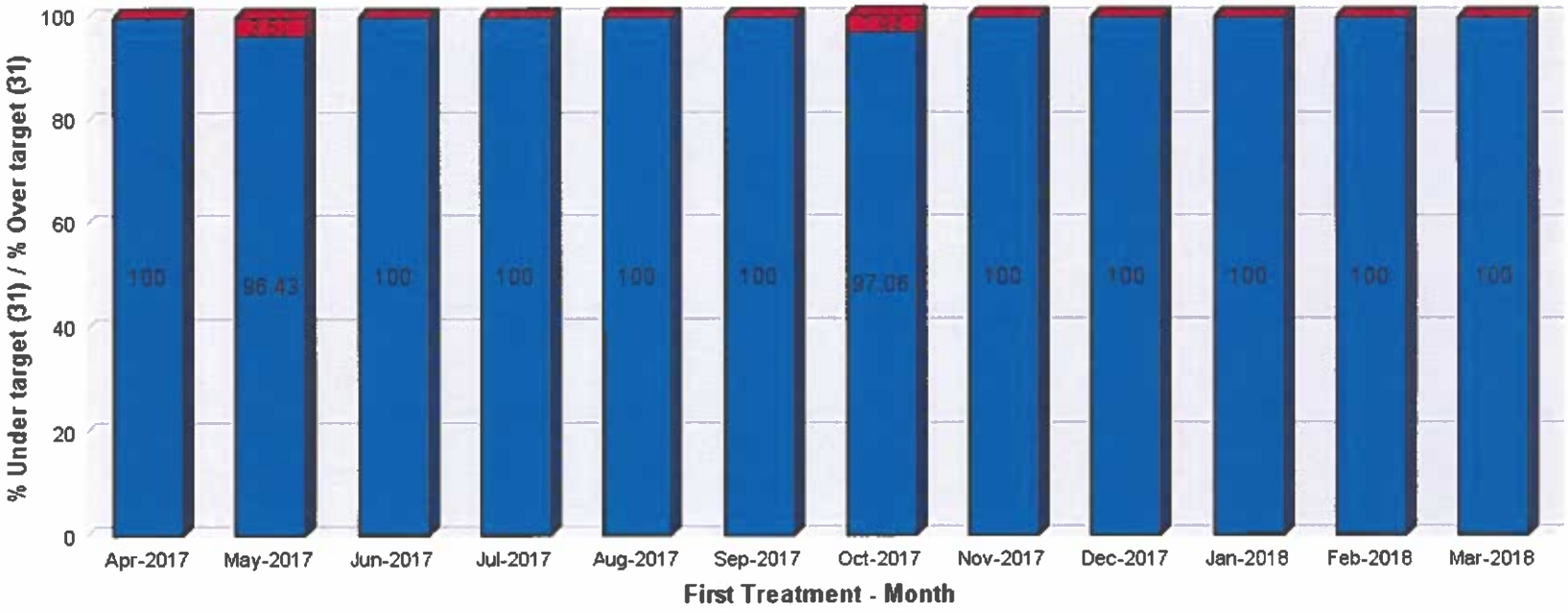
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2017	100	0
May-2017	96.43	3.57
Jun-2017	100	0
Jul-2017	100	0
Aug-2017	100	0
Sep-2017	100	0
Oct-2017	97.06	2.94
Nov-2017	100	0
Dec-2017	100	0
Jan-2018	100	0
Feb-2018	100	0
Mar-2018	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
99.41	0.59



Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of decision to treat and at least 95% of patients urgently referred with a suspected cancer should begin their definitive treatment witin 62 days.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

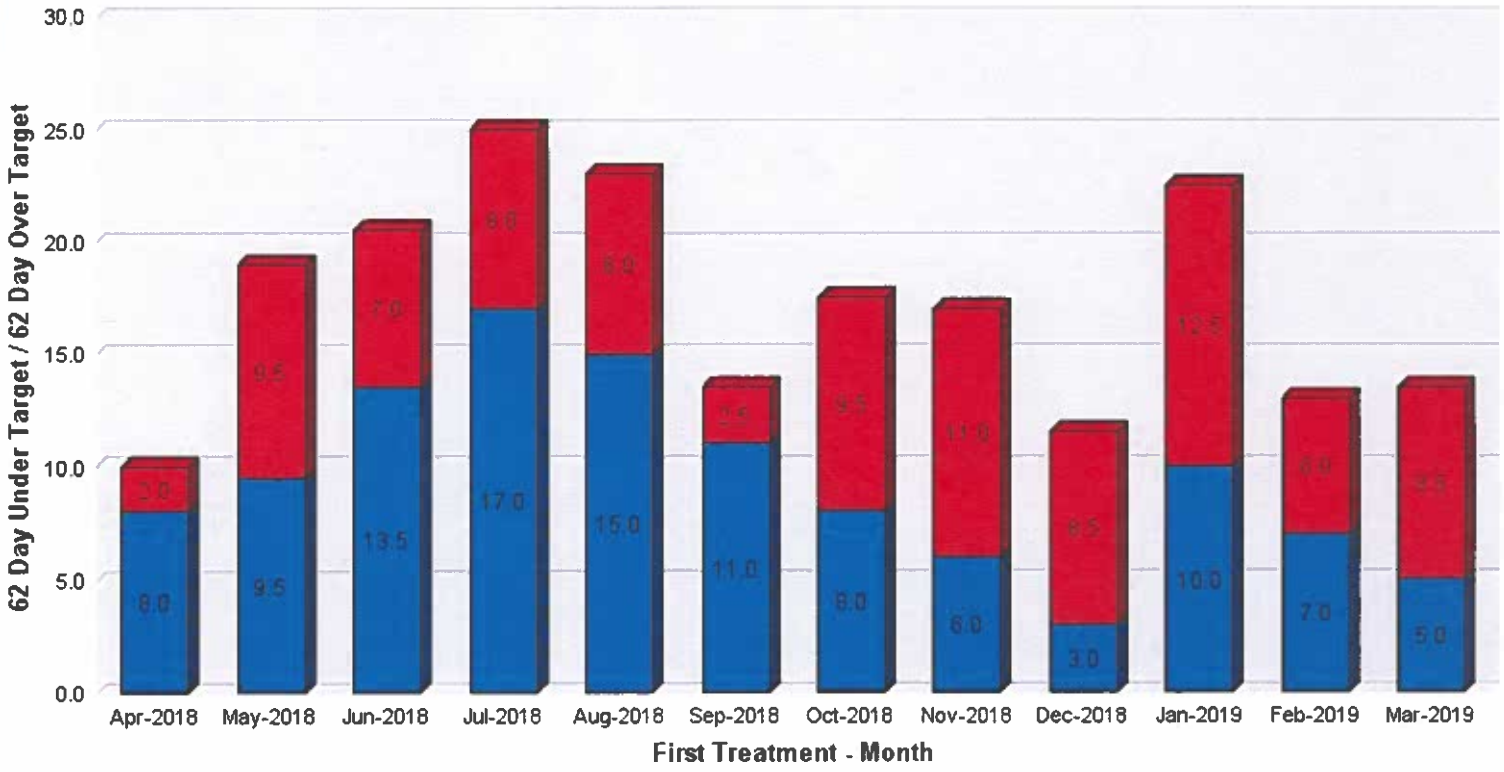
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2018	8.0	2.0	10
May-2018	9.5	9.5	19
Jun-2018	13.5	7.0	20.5
Jul-2018	17.0	8.0	25
Aug-2018	15.0	8.0	23
Sep-2018	11.0	2.5	13.5
Oct-2018	8.0	9.5	17.5
Nov-2018	6.0	11.0	17
Dec-2018	3.0	8.5	11.5
Jan-2019	10.0	12.5	22.5
Feb-2019	7.0	6.0	13
Mar-2019	5.0	8.5	13.5
Sum:	113.0	93.0	206

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

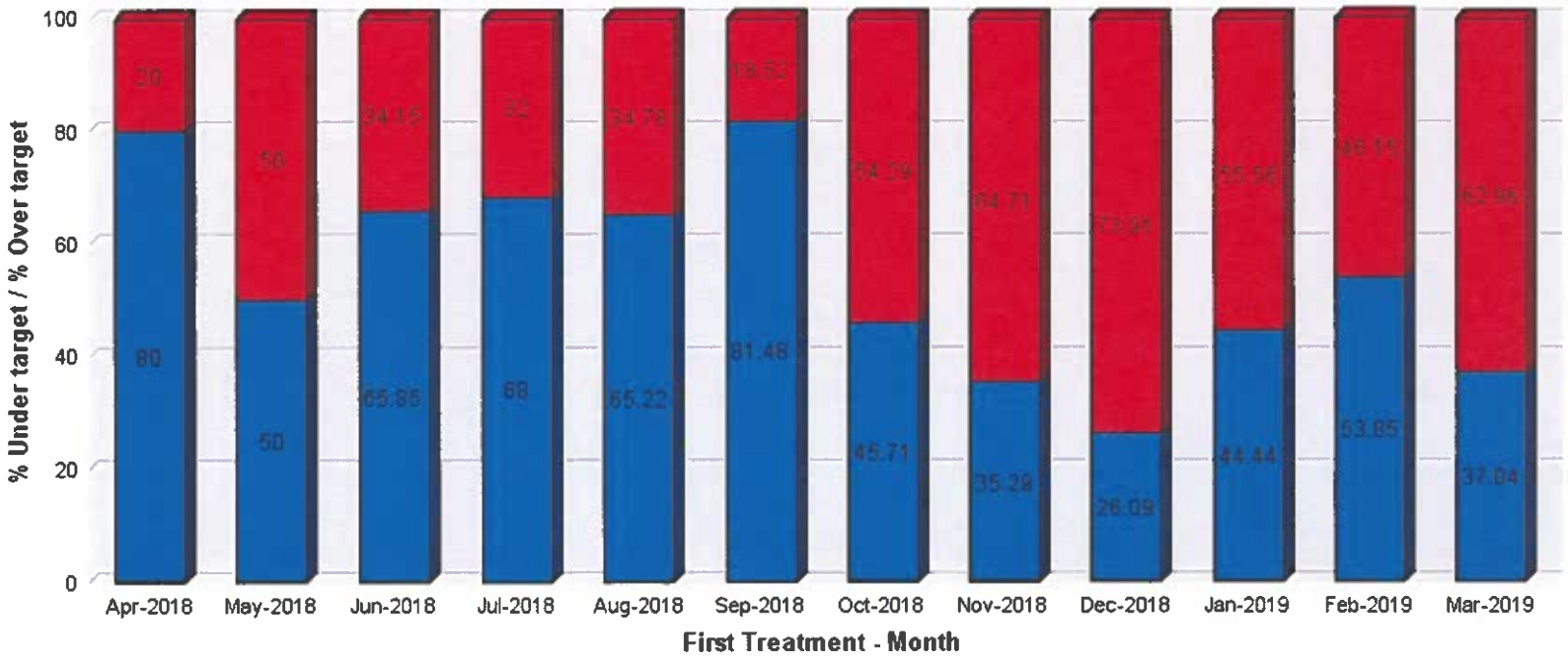
FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2018	80	20
May-2018	50	50
Jun-2018	65.85	34.15
Jul-2018	68	32
Aug-2018	65.22	34.78
Sep-2018	81.48	18.52
Oct-2018	45.71	54.29
Nov-2018	35.29	64.71
Dec-2018	26.09	73.91
Jan-2019	44.44	55.56
Feb-2019	53.85	46.15
Mar-2019	37.04	62.96

CUMULATIVE

% Under target	% Over target
54.85	45.15



Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

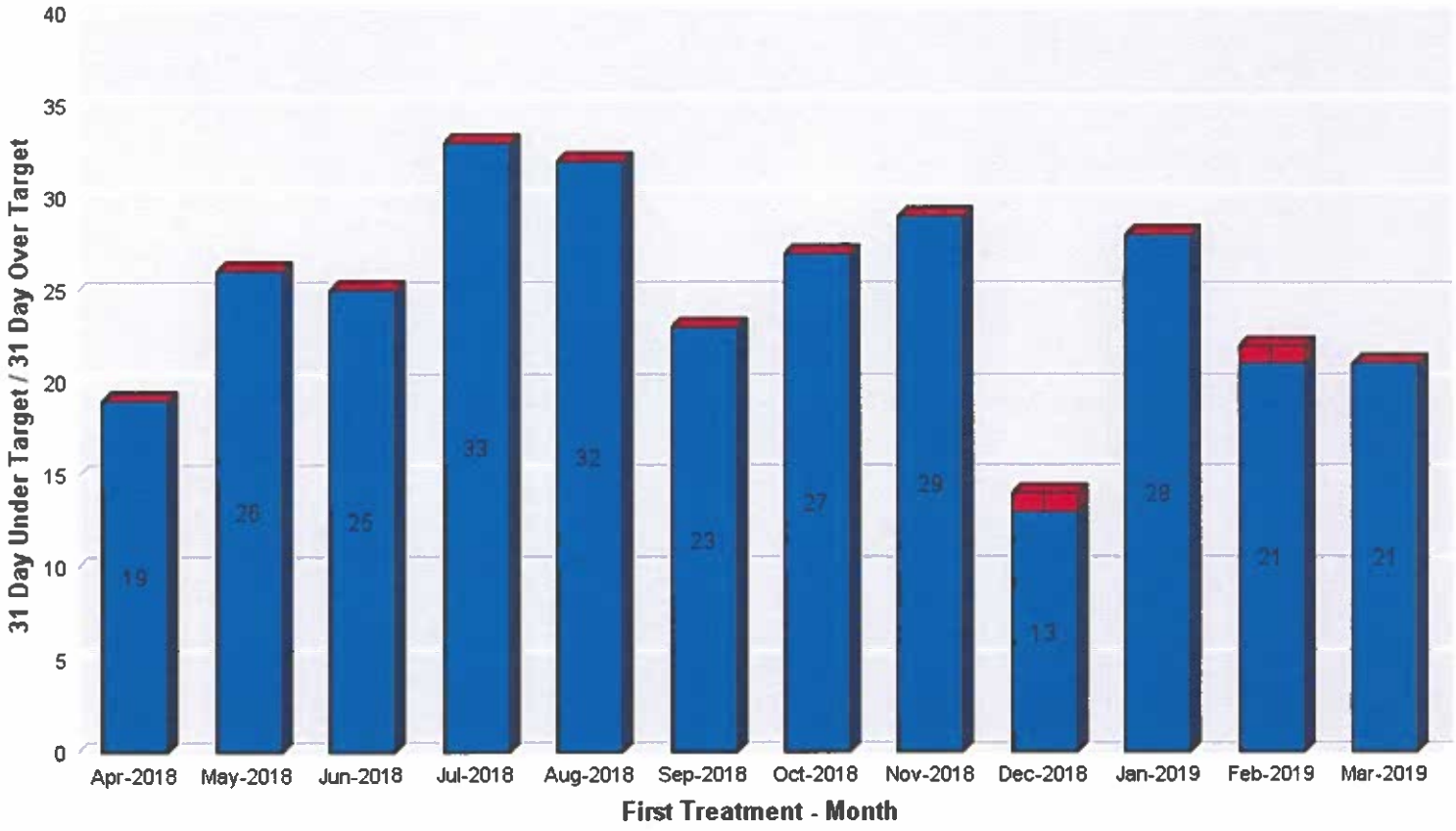
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2018	19	0	19
May-2018	26	0	26
Jun-2018	25	0	25
Jul-2018	33	0	33
Aug-2018	32	0	32
Sep-2018	23	0	23
Oct-2018	27	0	27
Nov-2018	29	0	29
Dec-2018	13	1	14
Jan-2019	28	0	28
Feb-2019	21	1	22
Mar-2019	21	0	21
Sum:	297	2	299



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2018 TO 31/03/2019

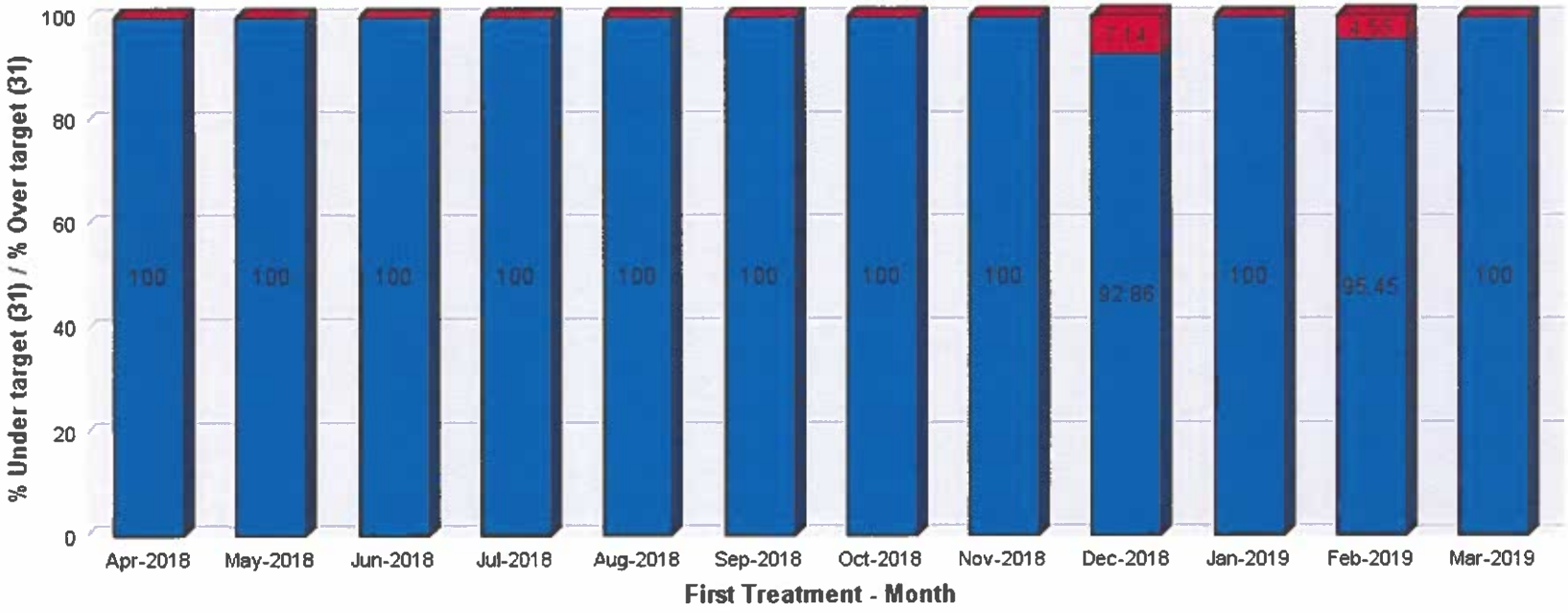
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2018	100	0
May-2018	100	0
Jun-2018	100	0
Jul-2018	100	0
Aug-2018	100	0
Sep-2018	100	0
Oct-2018	100	0
Nov-2018	100	0
Dec-2018	92.86	7.14
Jan-2019	100	0
Feb-2019	95.45	4.55
Mar-2019	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
99.33	0.67



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SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of decision to treat and at least 95% of patients urgently referred with a suspected cancer should begin their definitive treatment witin 62 days.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

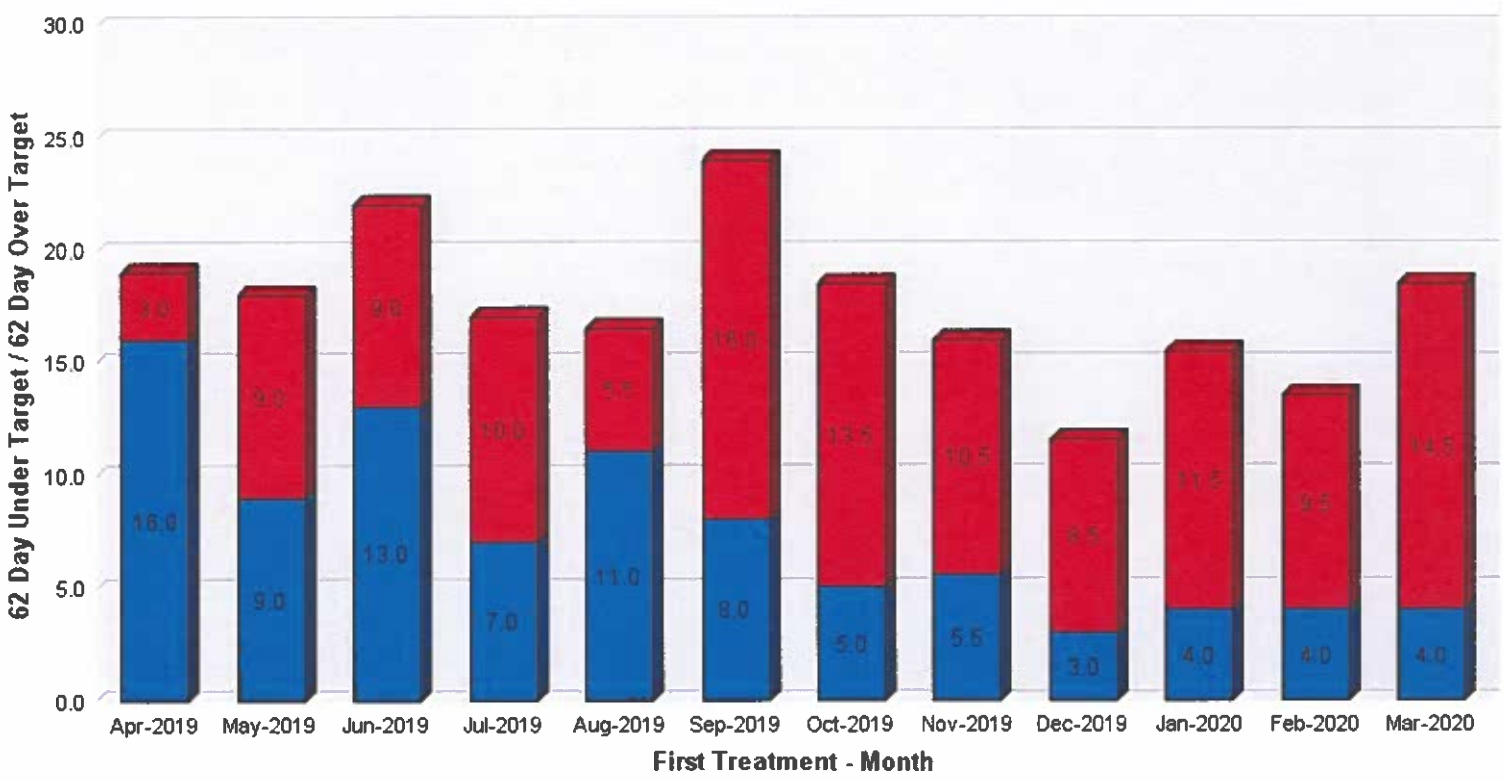
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2019 TO 31/03/2020

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2019	16.0	3.0	19
May-2019	9.0	9.0	18
Jun-2019	13.0	9.0	22
Jul-2019	7.0	10.0	17
Aug-2019	11.0	5.5	16.5
Sep-2019	8.0	16.0	24
Oct-2019	5.0	13.5	18.5
Nov-2019	5.5	10.5	16
Dec-2019	3.0	8.5	11.5
Jan-2020	4.0	11.5	15.5
Feb-2020	4.0	9.5	13.5
Mar-2020	4.0	14.5	18.5
Sum:	89.5	120.5	210

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

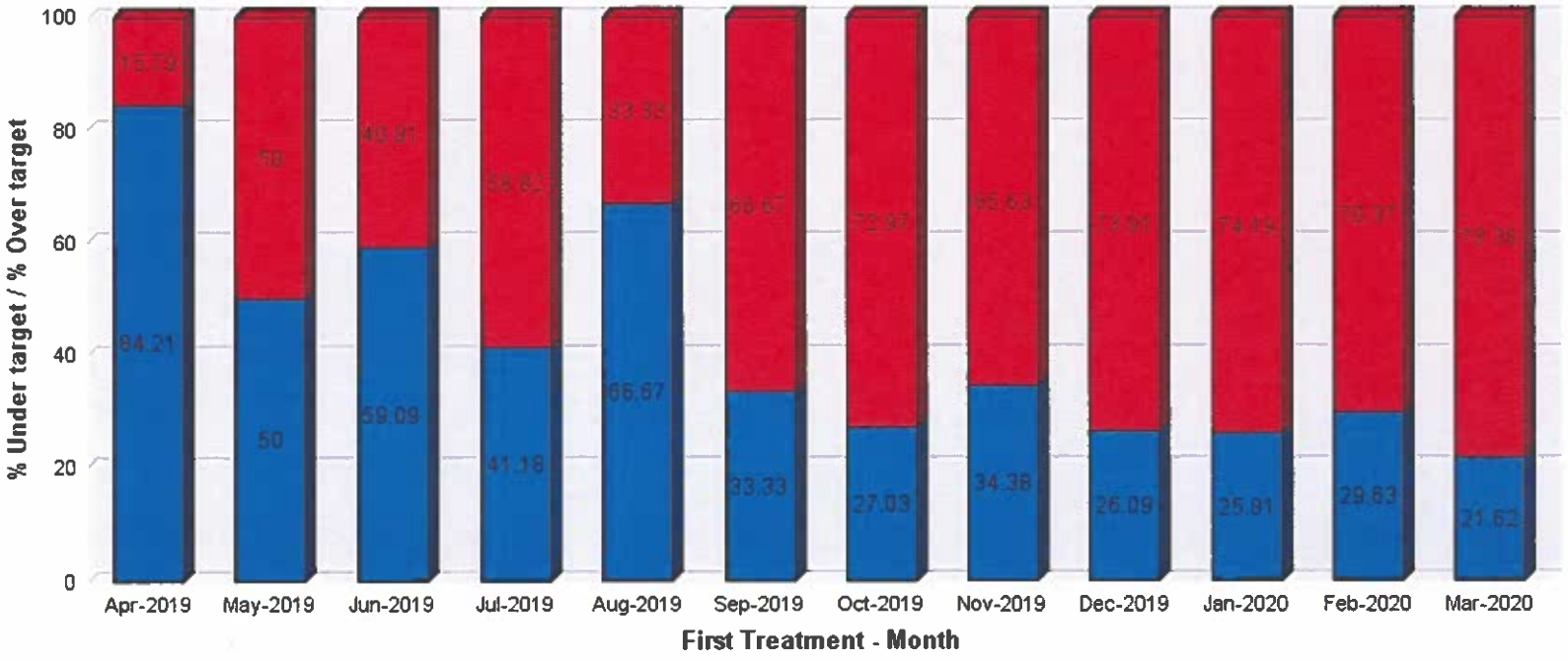
FROM 01/04/2019 TO 31/03/2020

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2019	84.21	15.79
May-2019	50	50
Jun-2019	59.09	40.91
Jul-2019	41.18	58.82
Aug-2019	66.67	33.33
Sep-2019	33.33	66.67
Oct-2019	27.03	72.97
Nov-2019	34.38	65.63
Dec-2019	26.09	73.91
Jan-2020	25.81	74.19
Feb-2020	29.63	70.37
Mar-2020	21.62	78.38

CUMULATIVE

% Under target	% Over target
42.62	57.38



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SOUTHERN HEALTH AND SOCIAL CARE TRUST

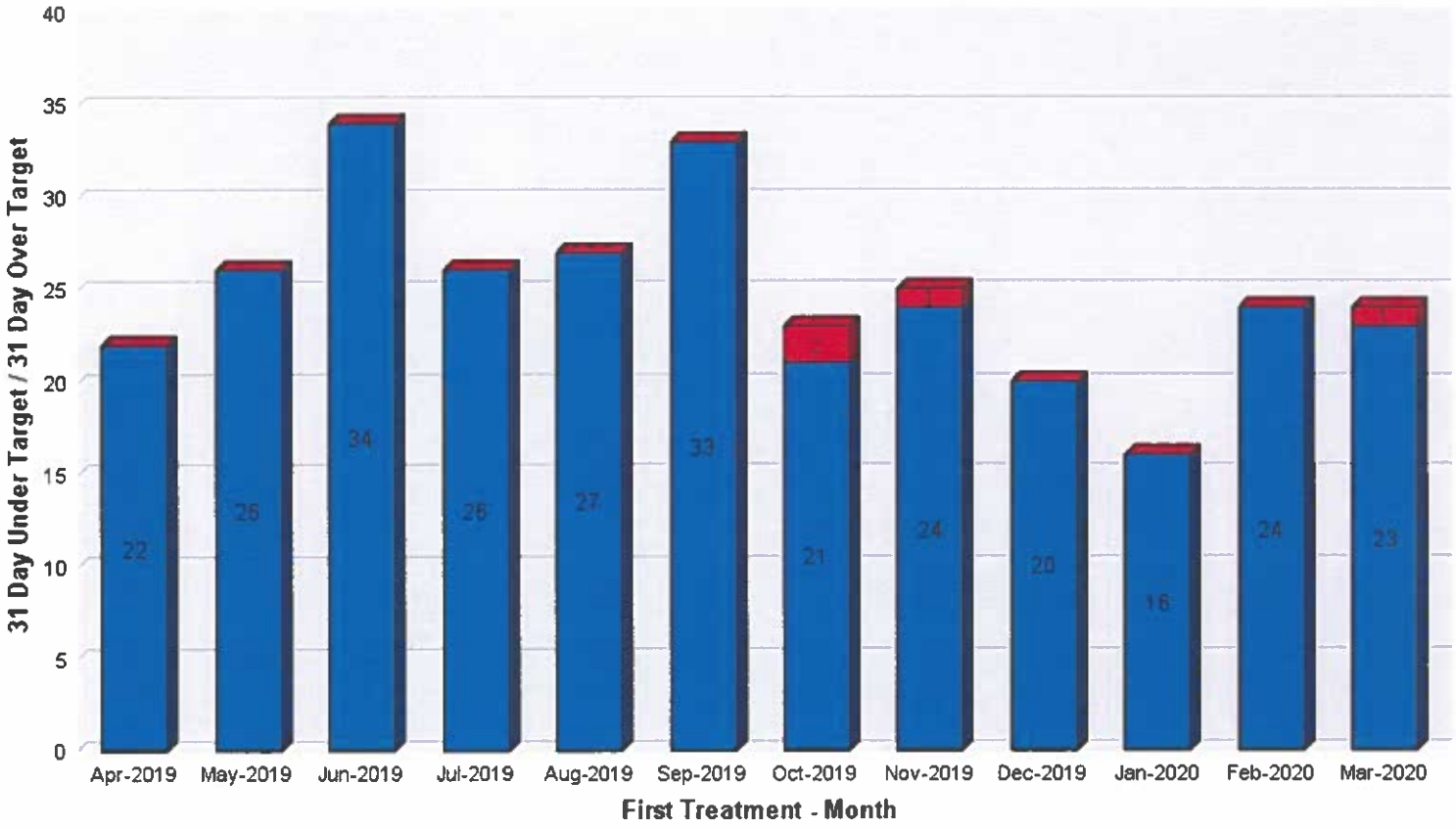
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2019 TO 31/03/2020

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2019	22	0	22
May-2019	26	0	26
Jun-2019	34	0	34
Jul-2019	26	0	26
Aug-2019	27	0	27
Sep-2019	33	0	33
Oct-2019	21	2	23
Nov-2019	24	1	25
Dec-2019	20	0	20
Jan-2020	16	0	16
Feb-2020	24	0	24
Mar-2020	23	1	24
Sum:	296	4	300



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2019 TO 31/03/2020

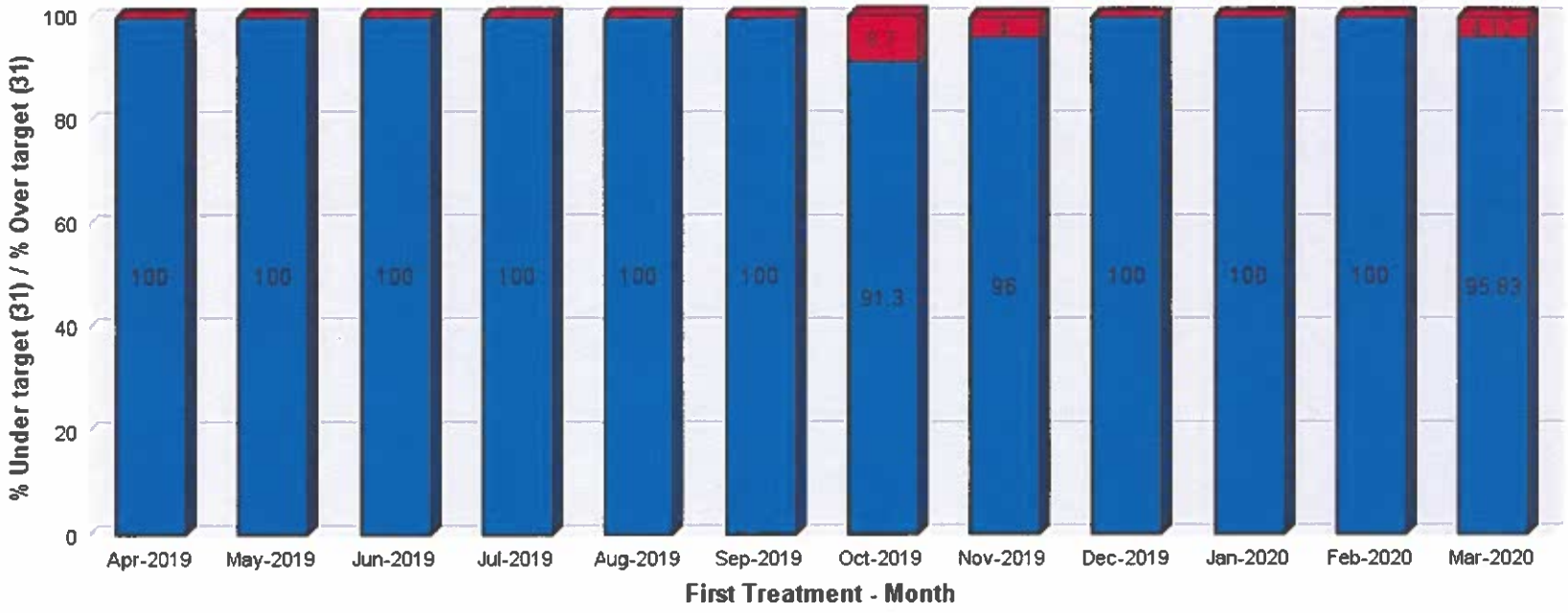
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2019	100	0
May-2019	100	0
Jun-2019	100	0
Jul-2019	100	0
Aug-2019	100	0
Sep-2019	100	0
Oct-2019	91.3	8.7
Nov-2019	96	4
Dec-2019	100	0
Jan-2020	100	0
Feb-2020	100	0
Mar-2020	95.83	4.17

CUMULATIVE

% Under target (31)	% Over target (31)
98.67	1.33



SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of decision to treat and at least 95% of patients urgently referred with a suspected cancer should begin their definitive treatment witin 62 days.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

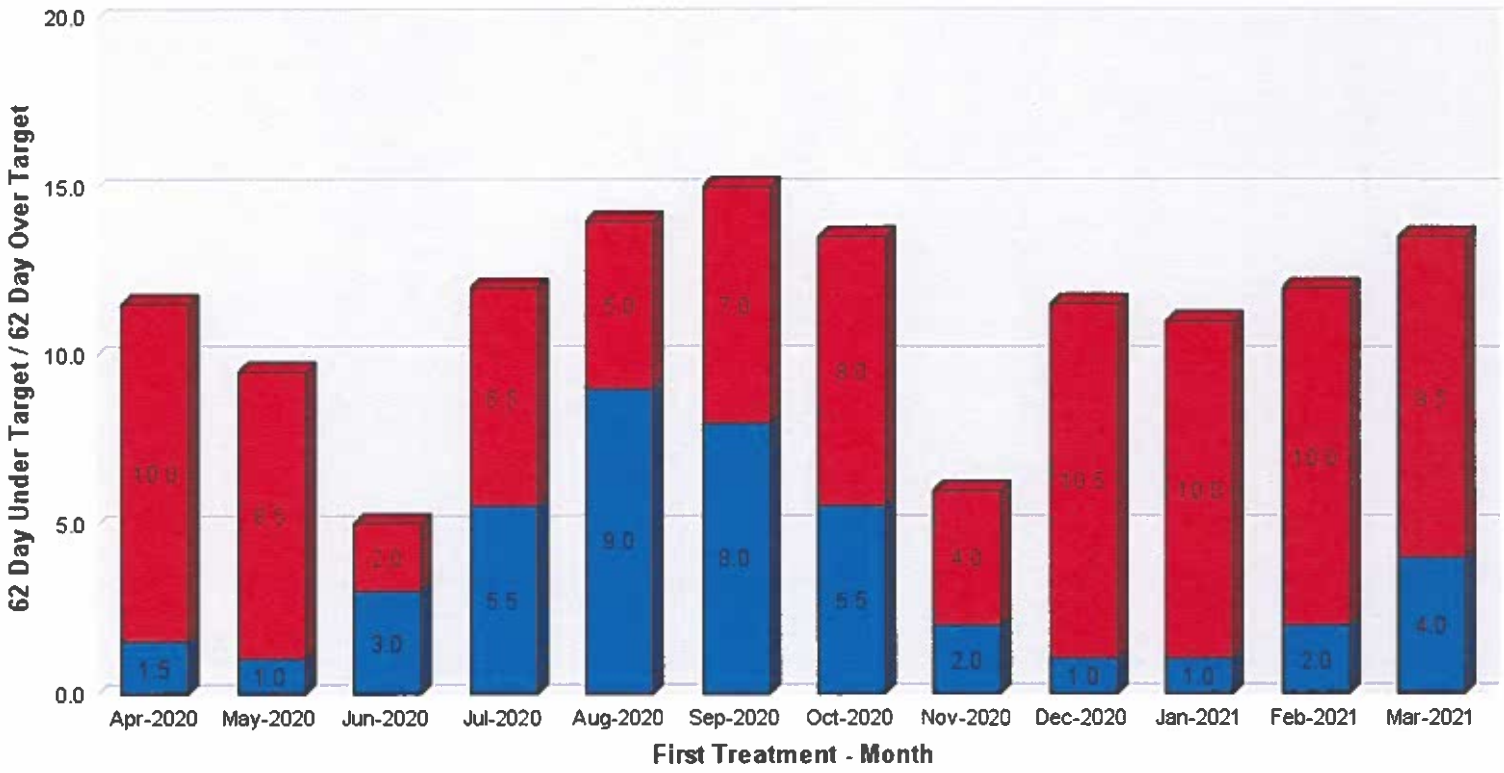
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2020 TO 31/03/2021

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2020	1.5	10.0	11.5
May-2020	1.0	8.5	9.5
Jun-2020	3.0	2.0	5
Jul-2020	5.5	6.5	12
Aug-2020	9.0	5.0	14
Sep-2020	8.0	7.0	15
Oct-2020	5.5	8.0	13.5
Nov-2020	2.0	4.0	6
Dec-2020	1.0	10.5	11.5
Jan-2021	1.0	10.0	11
Feb-2021	2.0	10.0	12
Mar-2021	4.0	9.5	13.5
Sum:	43.5	91.0	134.5

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



Produced By Directorate of Peformance and Reform, Informatics Division, Acute Information Team

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

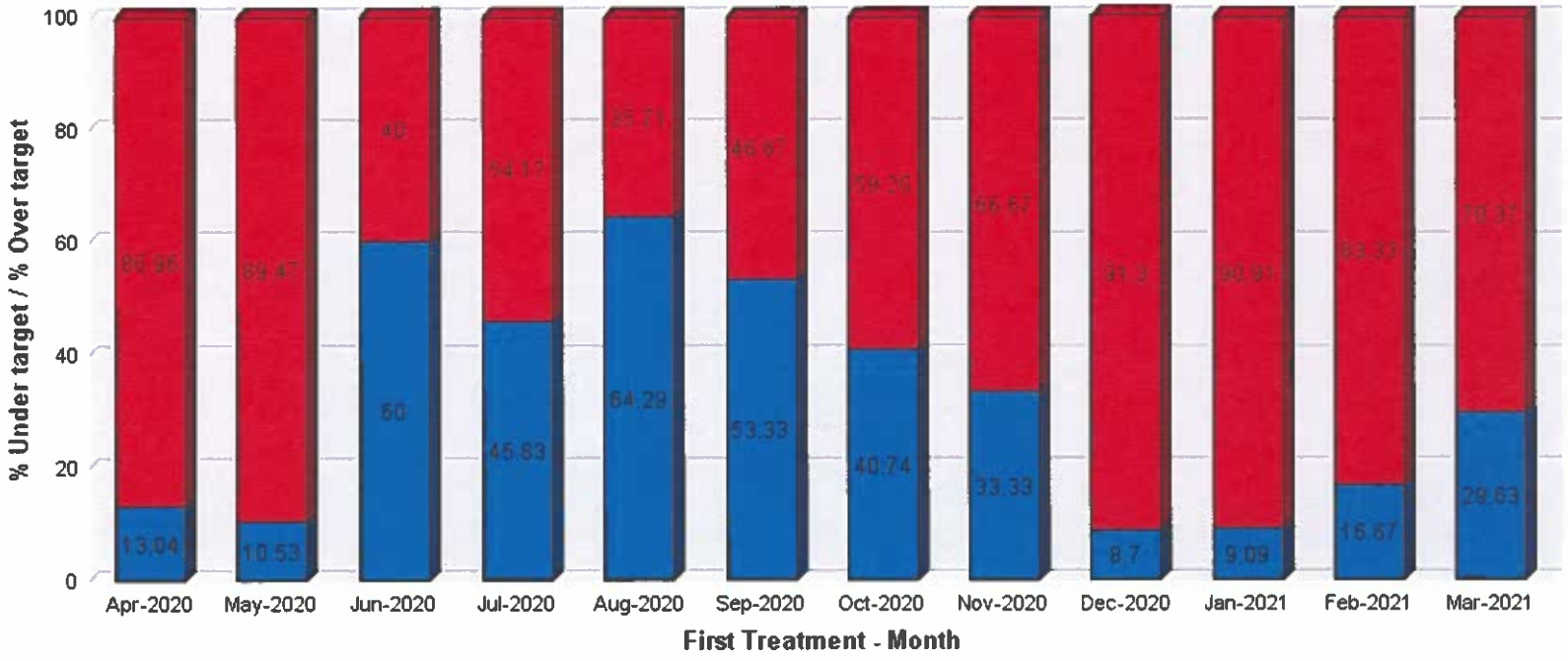
FROM 01/04/2020 TO 31/03/2021

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2020	13.04	86.96
May-2020	10.53	89.47
Jun-2020	60	40
Jul-2020	45.83	54.17
Aug-2020	64.29	35.71
Sep-2020	53.33	46.67
Oct-2020	40.74	59.26
Nov-2020	33.33	66.67
Dec-2020	8.7	91.3
Jan-2021	9.09	90.91
Feb-2021	16.67	83.33
Mar-2021	29.63	70.37

CUMULATIVE

% Under target	% Over target
32.34	67.66



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SOUTHERN HEALTH AND SOCIAL CARE TRUST

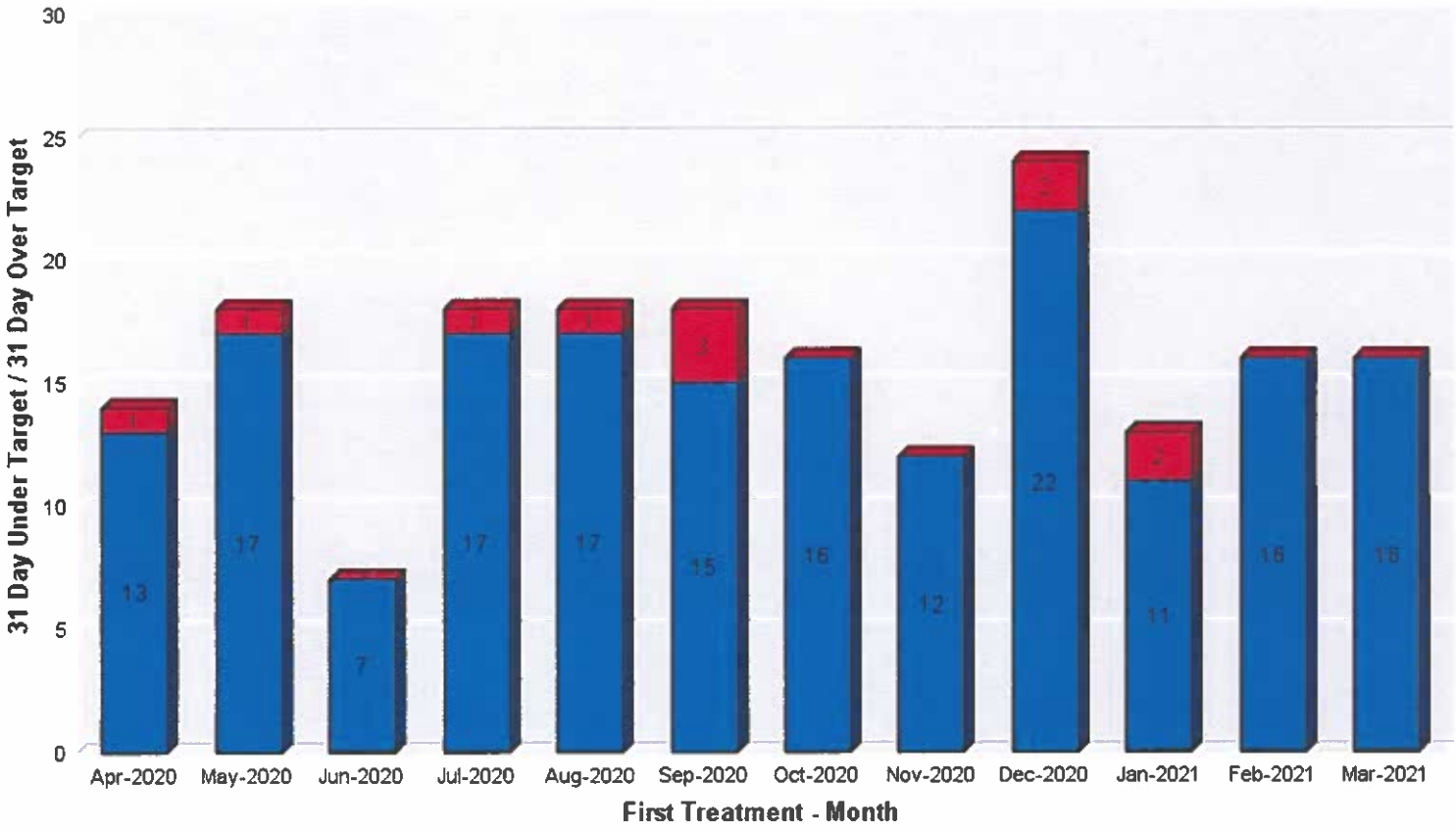
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2020 TO 31/03/2021

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2020	13	1	14
May-2020	17	1	18
Jun-2020	7	0	7
Jul-2020	17	1	18
Aug-2020	17	1	18
Sep-2020	15	3	18
Oct-2020	16	0	16
Nov-2020	12	0	12
Dec-2020	22	2	24
Jan-2021	11	2	13
Feb-2021	16	0	16
Mar-2021	16	0	16
Sum:	179	11	190



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2020 TO 31/03/2021

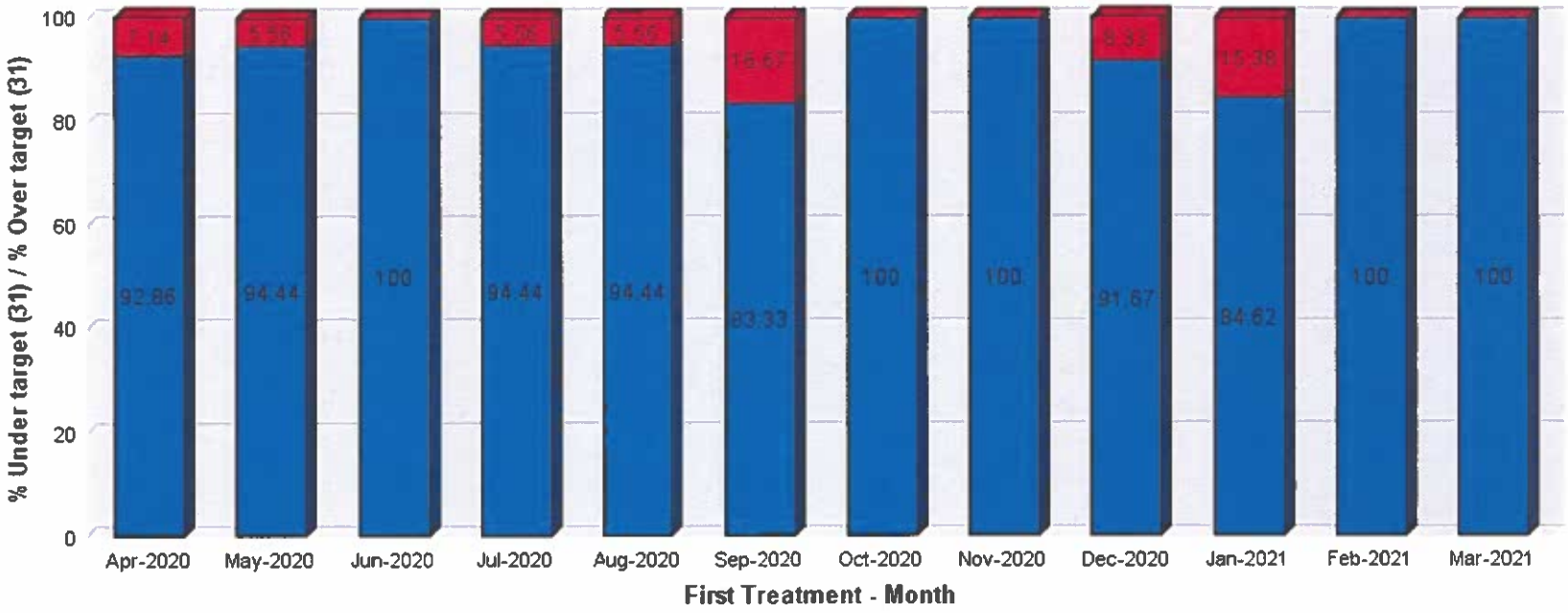
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2020	92.86	7.14
May-2020	94.44	5.56
Jun-2020	100	0
Jul-2020	94.44	5.56
Aug-2020	94.44	5.56
Sep-2020	83.33	16.67
Oct-2020	100	0
Nov-2020	100	0
Dec-2020	91.67	8.33
Jan-2021	84.62	15.38
Feb-2021	100	0
Mar-2021	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
94.21	5.79



SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

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SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

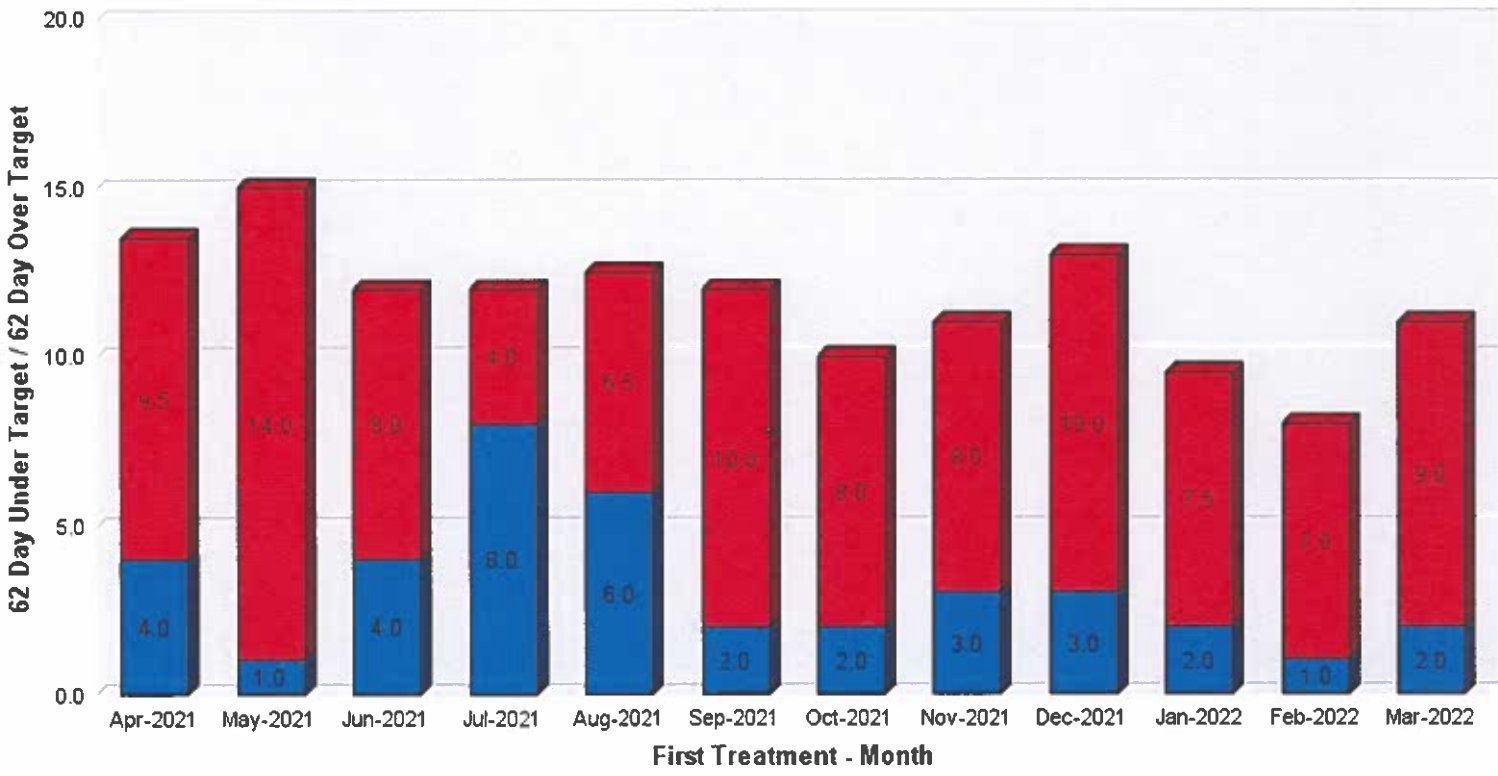
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2021 TO 31/03/2022

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2021	4.0	9.5	13.5
May-2021	1.0	14.0	15
Jun-2021	4.0	8.0	12
Jul-2021	8.0	4.0	12
Aug-2021	6.0	6.5	12.5
Sep-2021	2.0	10.0	12
Oct-2021	2.0	8.0	10
Nov-2021	3.0	8.0	11
Dec-2021	3.0	10.0	13
Jan-2022	2.0	7.5	9.5
Feb-2022	1.0	7.0	8
Mar-2022	2.0	9.0	11
Sum:	38.0	101.5	139.5

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

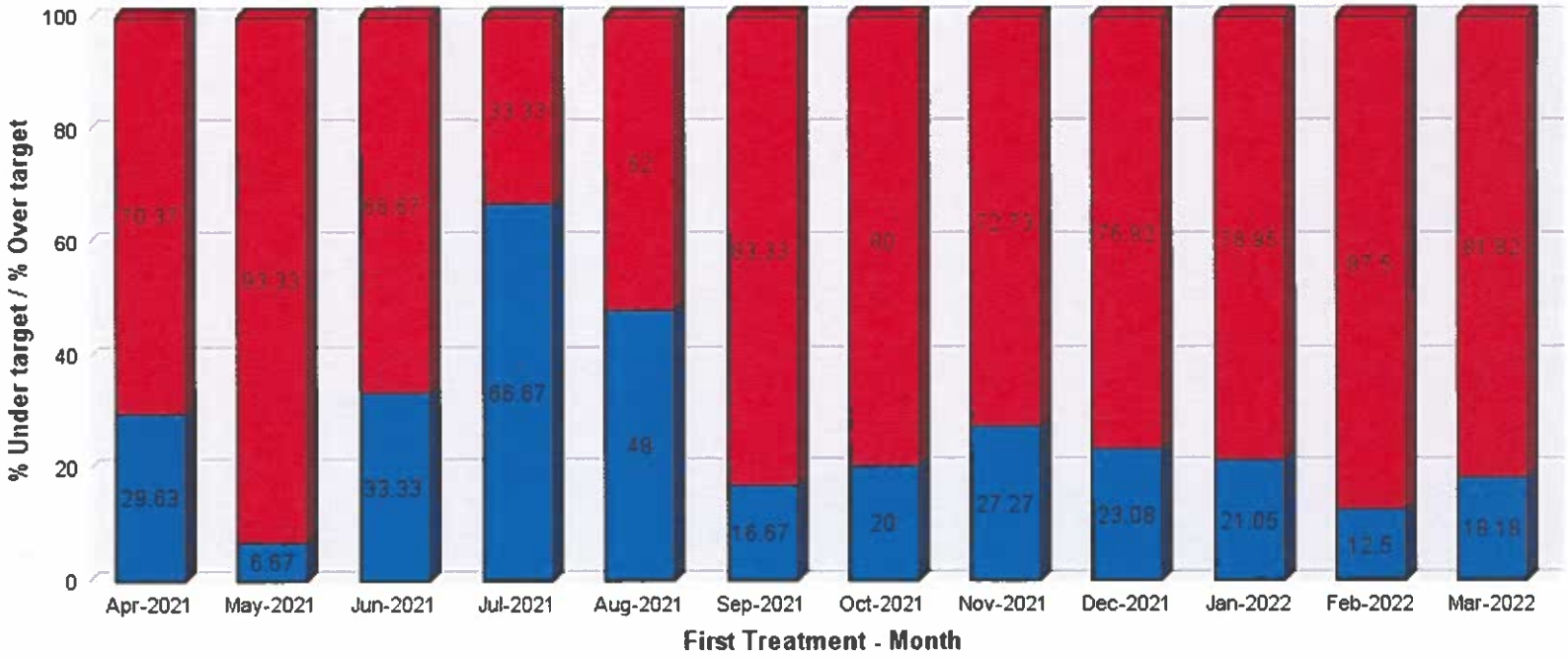
FROM 01/04/2021 TO 31/03/2022

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2021	29.63	70.37
May-2021	6.67	93.33
Jun-2021	33.33	66.67
Jul-2021	66.67	33.33
Aug-2021	48	52
Sep-2021	16.67	83.33
Oct-2021	20	80
Nov-2021	27.27	72.73
Dec-2021	23.08	76.92
Jan-2022	21.05	78.95
Feb-2022	12.5	87.5
Mar-2022	18.18	81.82

CUMULATIVE

% Under target	% Over target
27.24	72.76



Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

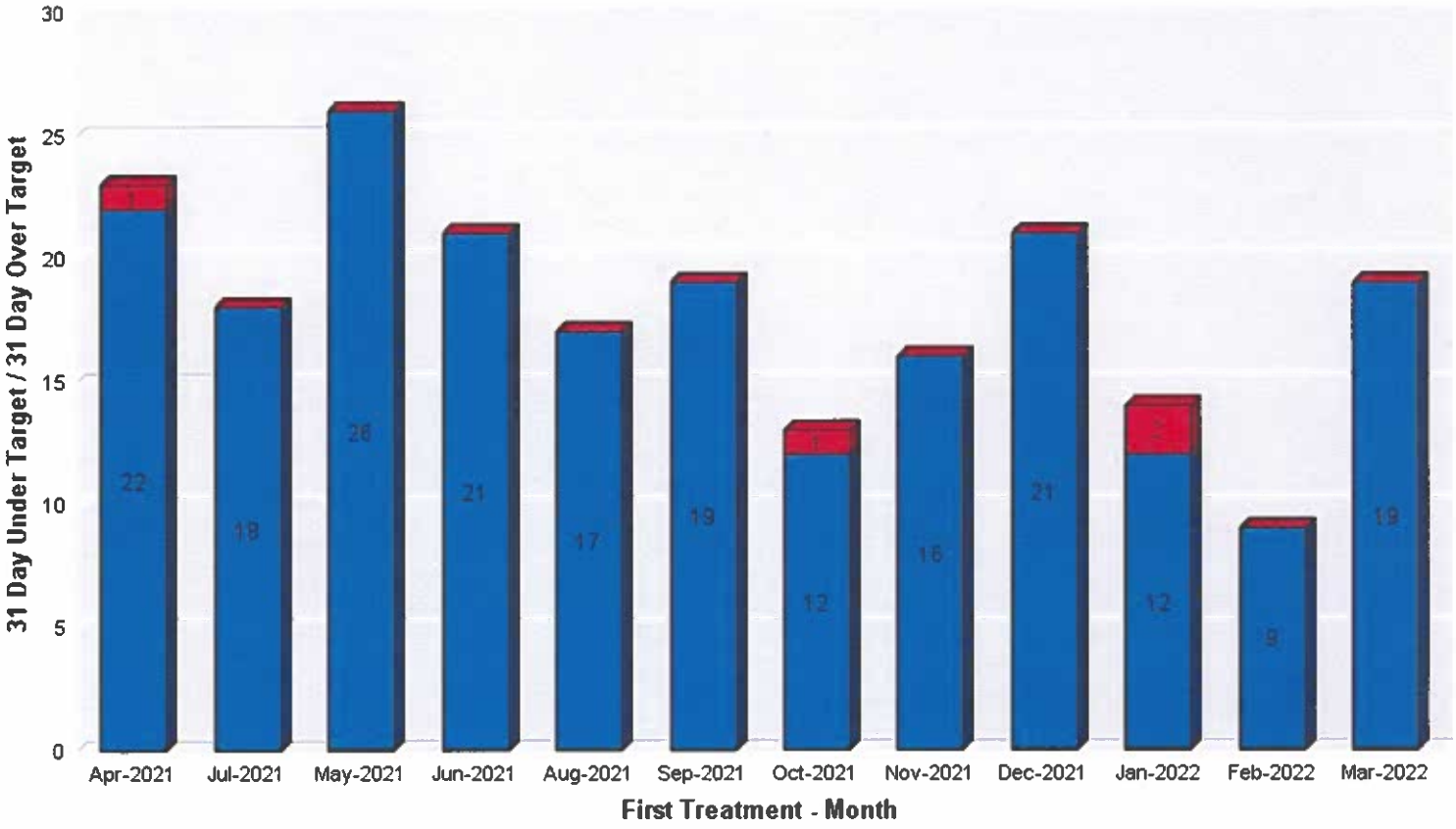
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2021 TO 31/03/2022

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2021	22	1	23
Jul-2021	18	0	18
May-2021	26	0	26
Jun-2021	21	0	21
Aug-2021	17	0	17
Sep-2021	19	0	19
Oct-2021	12	1	13
Nov-2021	16	0	16
Dec-2021	21	0	21
Jan-2022	12	2	14
Feb-2022	9	0	9
Mar-2022	19	0	19
Sum:	212	4	216



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2021 TO 31/03/2022

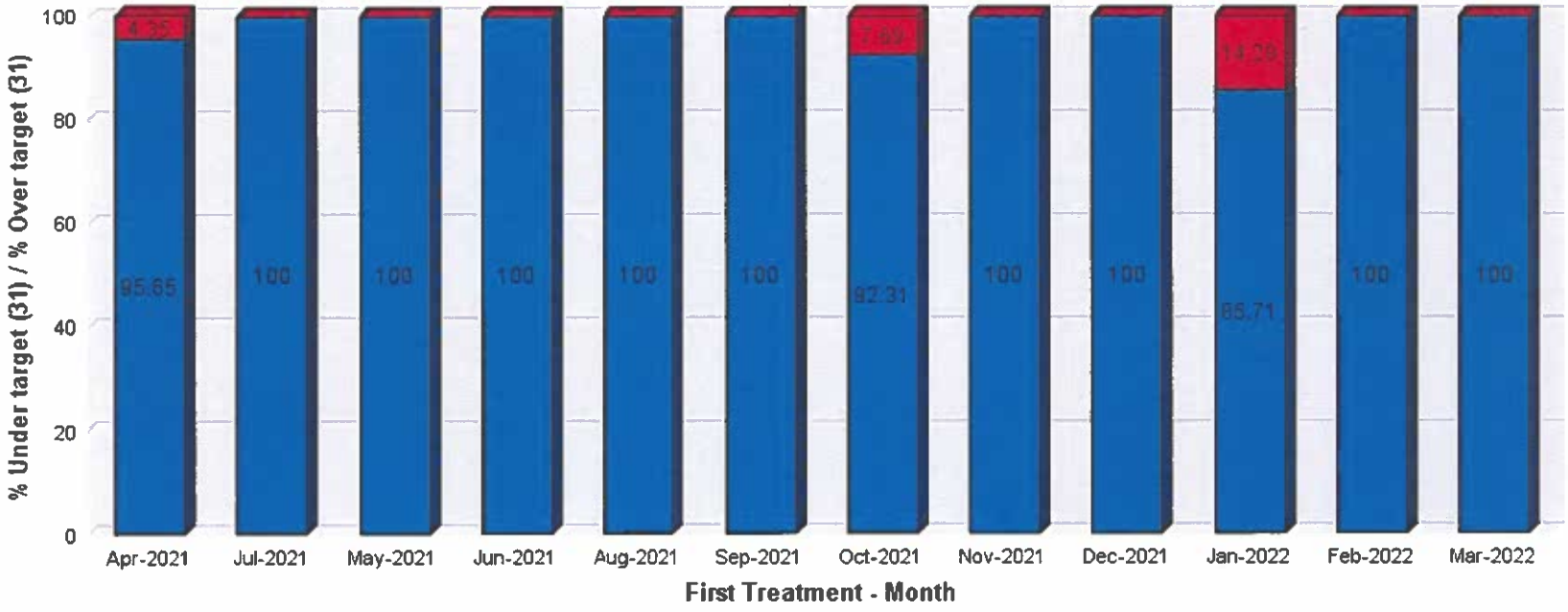
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2021	95.65	4.35
Jul-2021	100	0
May-2021	100	0
Jun-2021	100	0
Aug-2021	100	0
Sep-2021	100	0
Oct-2021	92.31	7.69
Nov-2021	100	0
Dec-2021	100	0
Jan-2022	85.71	14.29
Feb-2022	100	0
Mar-2022	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
98.15	1.85



Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

Urology Cancer MDT
Business Meeting, SHSCT

23rd January 2020, 4pm, Meeting Room 1, MEC, CAH

ATTENDEES: Mr Glackin (Chair), Mr O'Donoghue, Mr Haynes, Dr McClean, Dr Williams, Sr McCourt, Sr O'Neill, Mr Sharma (Urology ST), Ms McVeigh (MDT Coordinator), Mrs Haughey (Macmillan Cancer Service Improvement Lead) & Mrs Corrigan (Head of Service for Urology)

APOLOGIES: None

AGENDA

1. Review of Operational Policy: updated by Mr Glackin and Mrs Haughey, final draft to be circulated for comments.
2. Protocolled care for case discussion at MDT: appendix 1 agreed in order to faciltate a streamlined pathway and MDM.
3. Audit activity
    a. TURBT muscle in histology specimens: Action Dr McClean
    b. TRUS biopsy prostate: Action Sr O'Neill
    c. Prospective TP biopsy prostate: Action Sr O'Neill & Mr Sharma
    d. Readmission rates following Urological Cancer Surgery: Action Mr Glackin
    e. Keyworker Activity: Action Sr McCourt
4. Urology MDT patient leaflet: this item is in place and provided to all new urological cancer patients
5. Holistic Needs Assessment: Work ongoing at Trust level to improve this aspect of care. This is not deliverable within the present workforce allocation for urology.
6. Key workers: In place and available at all new patient clinics and consultant oncology review clinics
7. Renal Cancer and Prostate Cancer follow up protocols for development: Work yet to be started. This will commence once the Urology Cancer CNS team are released from other duties in the Thorndale unit.

8. AOB

   a. Urology red flag waiting times as of 14/01/2020

      i. Urology (Prostate) 101

      ii. Urology (Haematuria) 51

      iii. Urology (Other) 51

      iv. The current demand is in excess of capacity. Other services have had significant investment to address waiting times (Breast). Urology is in a much worse position than any other specialty.

NEXT MEETING July 2020, date TBC

Appendix 1 Protocolled care for Urology Cancer MDT SHSCT January 2020

Non muscle invasive bladder cancer

Utilising the categories described in NICE Guideline NG2:

New and recurrent low risk urothelial cancer cases are to be listed for noting at MDM. The responsible Consultant Urologist will arrange appropriate endoscopic surveillance and further management.

New intermediate risk urothelial cancer cases are to be listed for noting at MDM. The responsible Consultant Urologist will arrange a 6 week course of intravesical therapy, with either mitomycin C or epirubicin, to be followed by endoscopic surveillance and further management.

If intermediate-risk non-muscle-invasive bladder cancer recurs after a course of intravesical therapy, refer the person's care to a specialist urology multidisciplinary team.

All cases of high risk urothelial cancer are to be listed for discussion at MDM. Offer the choice of intravesical BCG (Bacille Calmette-Guérin) or radical cystectomy to people with high-risk non-muscle-invasive bladder cancer, and base the choice on a full discussion with the person, the clinical nurse specialist and a urologist who performs both intravesical BCG and radical cystectomy.

If induction BCG fails (because it is not tolerated, or bladder cancer persists or recurs after treatment with BCG), or if the patient wishes to consider primary radical cystectomy refer the person's care to the specialist urology multidisciplinary team at the Belfast Trust.

Muscle invasive bladder cancer

All cases must be listed for MDM and notified to the specialist urology multidisciplinary team at the Belfast Trust as soon as possible in order to expedite timely treatment (do not wait for staging investigation results before advising the specialist urology multidisciplinary team of the case). All cases will require discussion at the specialist urology multidisciplinary team meeting at the Belfast Trust.

Penile Cancer

Direct referral to the regional penile cancer service is the preferred option. In cases of clinical uncertainty initial assessment may be required by the designated local penile cancer lead (Mr Glackin, SHSCT) followed by referral to the regional penile cancer service in accordance with the NW Penile Cancer operational policy 2019-2020.

Testis Cancer

All cases of confirmed testis cancer are to be listed for discussion at MDM following completion of staging, histology and tumour markers, and for referral to the Testis Cancer specialist multidisciplinary team at the Belfast Trust.

Prostate Cancer

Clinicians should utilise the grid below to guide the choice of staging investigations. Following completion of staging all cases of confirmed prostate cancer must be listed for discussion of management options at MDM.

		PSA			
Gleason Grade	Grade group	<10	≥10, <20	≥20, <40	≥40
3+3=6	1	MRI	MRI	MRI, BS	BS, CT, MRI if no mets on BS / CT
3+4=7	2	MRI	MRI	MRI, BS	BS, CT, MRI if no mets on BS / CT
4+3=7	3	MRI	MRI, BS	MRI, BS	BS, CT, MRI if no mets on BS / CT
3+5=8 4+4=8 5+3=8	4	MRI, BS	MRI, BS	MRI, BS	BS, CT, MRI if no mets on BS / CT
4+5=9 5+4=9 5+5=10	5	MRI, BS	MRI, BS	MRI, BS, CT	BS, CT, MRI if no mets on BS / CT

2021/2022

Directorate	Division	HOS	Specialty	Activity Type	Category	Funding Allocation Period	Funding Source	Recording Methodology	Volume to be delivered (Patients/ Sessions)	Current Total Funding Allocated	Current Cost per Patient
ASD	ATICS & SEC	Wendy Clayton	Urology - Virtual Reviews	Out-Patients	Red Flag / Urgent	Q1		IHA	360	£19,440.00	£54
ASD	ATICS & SEC	Wendy Clayton	Urology - Face to Face Reviews	Out-Patients	Red Flag / Urgent	Q1		IHA	36	£5,400.00	£150
ASD	ATICS & SEC	Jane Scott	Admin Validation for Orthopaedics, Urology and ENT	Validation	Urgent	Q2 & Q3-4		IHA		£88,201.50	TBC
ASD	ATICS & SEC	Wendy Clayton/ Martina Corrigan	Urology - Review	Out-Patients	Urgent	Q2		IHA	274	£37,648.22	£137.03
ASD	ATICS & SEC	Wendy Clayton	Urology Mega Clinic (Pre Assessment)	OP	Urgent	Q3-4		IHA	100	£8,585.00	£86.85
ASD	ATICS & SEC	Wendy Clayton/Martina Corrigan	Regional Urology - Hermitage (Subject to Contract)	IP/DC	Urgent	Q3-4		IS	0	£700,000.00	£0.00
ASD	ATICS & SEC	Wendy Clayton	Urology - 352	OP		Q3-4		IS		£0.00	

2020/2021

Directorate	Division	HOS	Specialty	Activity Type	Funding Allocation Period	Recording Methodology	Volume to be delivered (Patients/ Sessions)	Current Total Funding Allocated	Current Cost per Patient	Actual Reported Activity at 07.05.21 (Cumulative to Date)
ASD	SEC	Wendy Clayton	Urology Virtual Backlog Clinics	ROP	Q2-4	IHA	0	£0.00	£53.00	117

2019/2020

								2019/20 Allocation and Volume As at 23rd March 2020			
Directorate	Division	HOS	Specialty	Activity Type	Category	Funding Source	Recording Methodology	Volume to be delivered (Patients/ Sessions)	Current Total Funding Allocated	Current Cost per Patient	Comments/Notes
ASD	SEC	Martina Corrigan	[redacted]	NOP	RF	C&S	IHA	111	£17,649.00	£159.00	
ASD	SEC	Martina Corrigan	Urology stone treatment new urgent	NOP	Urgent	C&S	IHA	0	£0.00	£159.00	
ASD	SEC	Martina Corrigan	[redacted]	DC	Urgent	C&S	IHA	3	£1,896.00	£632.00	
ASD	SEC	Martina Corrigan	[redacted]	ROP	RF	C&S	IHA	111	£14,097.00	£127.00	
ASD	SEC	Martina Corrigan	[redacted]	ROP	Urgent	C&S	IHA	162	£3,969.00	£39.00	
ASD	SEC	Martina Corrigan	Urology Virtual - Review Backlog Urgent	ROP	Urgent	C&S	IHA	0	£0.00	£39.00	
ASD	SEC	Martina Corrigan	[redacted]	NOP	RF/Urgent	C&S	IHA	50	£7,950.00	£159.00	

2018/2019

Specialty	Recording Methodology	Funding	Type	Projected No Provided for Year End March 19 as at End of February by OSL.	Actual Activity from returns - As at 13/05/19 (Unless stated in comments column)	Actual Activity Projected by OSLs to March 19 as at 18/04/19	% Variance from Predicted at the end of February	Unit Cost £	Projected Cost £
Urology Haematuria	IHA	C&S	NOP	48	48	48	0	£159.00	£7,632.00
Urology Haematuria	IHA	C&S	ROP	68	71	62	-6	£127.00	£9,017.00

2017/2018

Specialty	Financial Period	Activity Type	Funding Source	Recording Methodology	Number of Sessions	Volume per Session	Number of Months	Total Sessions	Total Patients	Comments	Finance Costing
~~Urology Chart Review~~	Q1	Validation	HSCB	IHA	4	10	3	12	120	~~26/4/17 Volumes processed for 3 months activity.~~ - SEE COMMENT IN ROW 19	~~£ 6,650.00~~
Urology Chart Review (Consultant-Led)	Q1	Validation	HSCB	IHA	4	10	2	8	80	24/5/17: WC advised that only 8 sessions required. Remaining 4 sessions not required. Funding to be transferred to provide an additional 5 scopes -	£ 4,400.00
Urology	Q2	ROP	HSCB	IHA	1.33	10	3	4	40		£ 5,060.00
Urology Chart Review (Consultant-Led)	Q2	Validation	HSCB	IHA	2	10	3	6	60		£ 7,620.00
~~Urology Chart Review - Nurse-Led~~	Q2	Validation	HSCB	IHA	~~3.66~~	10	3	6	60	24/8/17: NOT UTILISED PER WC - UNUSED ALLOCATION TO BE USED TO OFF SET OVERSPEND IN ENDOSCOPY IN Q1.	~~£ 1,260.00~~

2016/2017

SPECIALTY	2016/17 IHA ALLOCATED VOLUME - Q1&2 AND Q3&4		Monthly Expected IHA Volume	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity to date	Cumulative Expected Activity to date	Variance	Variance %	VOLUME REMAINING
UROLOGY	19	ELECTIVE INPATIENT	2	0	0	0	0	7	3	2	0	0	0	0	0	12	19	-7	-37%	7
TOTAL	38	ELECTIVE INPATIENT	3	0	1	2	5	0	5	4	0	0	1	2	0	33	38	-5	-13%	5

SPECIALTY	2016/17 IHA ALLOCATED VOLUME - Q1&2 AND Q3&4		Monthly Expected IHA Volume	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity to date	Cumulative Expected Activity to date	Variance	Variance %	VOLUME REMAINING
UROLOGY	1	ELECTIVE DAY CASE	0	0	0	0	0	4	1	0	2	0	0	0	0	7	1	6	600%	-6
TOTAL	66	ELECTIVE DAY CASE	6	0	0	13	15	14	19	5	2	0	0	0	1	69	66	3	5%	-3

SPECIALTY	2016/17 IHA ALLOCATED VOLUME - Q1&2 AND Q3&4		Monthly Expected IHA Volume	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity to date	Cumulative Expected Activity to date	Variance	Variance %	VOLUME REMAINING
UROLOGY	0	NEW OUTPATIENT	0	0	0	0	0	0	0	0	0	0	0	20	108	128	0	128	#DIV/0!	-128
TOTAL	1468	NEW OUTPATIENT	122	0	132	527	283	225	244	18	29	17	17	199	1193	2612	1468	1144	78%	-1144

SPECIALTY	2016/17 IHA ALLOCATED VOLUME - Q1&2 AND Q3&4		Monthly Expected IHA Volume	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity to date	Cumulative Expected Activity to date	Variance	Variance %	VOLUME REMAINING
UROLOGY	34	REVIEW OUTPATIENT	8	0	0	0	0	76	34	0	0	0	4	7	31	152	34	18	82%	-79
TOTAL	2421	REVIEW OUTPATIENT	202	0	40	276	301	628	380	0	328	116	103	235	993	2900	2421	179	7%	-279

SOUTHERN TRUST – ED and ELECTIVE CARE DIRECTORS' MEETING – ACTIONS / ISSUES REGISTER –1 MAY 2015

Issue	Action (Deadline)
Unscheduled Care ***4-hour and 12-hour Performance*** • Board (Michael Bloomfield) congratulated the Trust on its 4-hour and 12-hour performance which had both improved during 2014/15 compared with the previous year. ***Patient Flow Priorities*** • Board (Michael Bloomfield) advised that its SMT will shortly be considering a paper based on the priorities recommended by the Regional ED Taskforce and the associated costed plans developed by each Trust. Initially SMT will be considering three of the priorities for approval of funding with further work required on the remaining priorities. • Trust (Debbie Burns) acknowledged that these were the regionally agreed priorities however, advised that in general the Southern Trust already manages these issues appropriately and that it has an IPT prepared for a number of other areas it considers necessary to further improve unscheduled care patient flow. • It was acknowledged that full implementation of 7-day working will on its own not deliver sustainable 95% performance of the 4-hour standard and that a focus on service improvement was still very much required to achieve this. The Board confirmed that this process should run in parallel and not detract from other necessary Trust/LCG discussions.	
2015/16 Elective Performance Process • Board (Michael Bloomfield) advised that, as it stands, there is no funding available for Trusts to undertake additional activity during 2015/16 other than in diagnostics. In view of the gap between demand and funded capacity, an increase in the number of patients waiting longer than the Ministerial maximum waiting time standards is therefore inevitable. Given this position, the Board (Michael Bloomfield) stressed that an increased focus by Trusts on delivery of commissioned volumes of core activity and strict chronological management was essential. • In order to ensure a focus on delivery of core, the Board will be asking the Trust for weekly improvement plans across a number of specialties. The improvement plans should set out the planned weekly runrate which demonstrates incremental improvement on the Q4 runrate or the previously submitted improvement plan. Improvement plans (using HSCB weekly template) should be submitted for the following specialties:	**Action: Trust to submit weekly Q1/Q2 improvement plans for requested specialties (template attached).** **Timescale: By Friday 15 May** **Update:** • Plan received for Dermatology. • Plans not submitted for T&O and

Issue	Action (Deadline)

Specialty Longest Wait at 31.3.15	2014/15 Core	Comments
Dermatology (NOP) 38 weeks	-25%	Trust to submit a weekly runrate improvement plan setting out the best position that can be delivered.
T & O (NOP) 40 weeks	-15% (cons led) +6% (ICATS)	Trust to submit a weekly runrate improvement plan setting out the best position that can be delivered.
Urology (NOP) 46 weeks	-11%	Trust to submit a weekly runrate improvement plan setting out the best position that can be delivered.
Urology (IPDC) 84 weeks	-14%	Trust to submit a weekly runrate improvement plan setting out the best position that can be delivered.

- The Board will also monitor longest waits with the expectation of incremental improvement, both in the improvement plan specialties and in the further specialties listed below.
- Trust (Debbie Burns) stated that it would not be in a position to reduce the longest waiting patients in a number of specialties where it is delivering SBA. Trust stated that the focus will be on urgent patients resulting in extended waits for routine patients. Trust reported that this had been raised with the Board's Chief Executive and Director of Commissioning at a separate meeting with the Trust.

Specialty	Longest Wait at 31.3.15
Cardiology (NOP)	32 weeks
Endocrinology (NOP)	40 weeks
ENT (NOP)	25 weeks
General Medicine including gastro (NOP)	23 weeks
General Surgery (NOP)	26 weeks
Neurology (NOP)	33 weeks
Pain Management (NOP)	24 weeks
Rheumatology (NOP)	42 weeks
Thoracic Medicine (NOP)	24 weeks
General Surgery (IPDC)	49 weeks
Pain Management (IPDC)	42 weeks
T & O (IPDC)	61 weeks

Urology. Update provided in email from Trust on 26 May.

Issue	Action (Deadline)
• For all other specialties it is expected that the Trust will deliver core capacity and appropriately manage the waiting list. If progress is found to be in line with the improvement plans then the Director level meeting will only be held where issues require escalation.	
June Monitoring Bid • Board (Michael Bloomfield) advised that the Department has asked the Board to submit a bid for the June monitoring round. • The likelihood of funds being available is currently unclear however, it has been agreed that both the Trust and Board need to give some consideration as to how any potential funding could be used. • Trusts should not approach the Independent Sector at this stage. It is the Board's intention to gather a small group to look at the potential utilisation of the Independent Sector should funding become available. Each Trust will be asked for a nomination(s) in order that this meeting can be arranged.	**Action: Trust to give proportionate consideration to the following points and respond to Board (Sara Long).** • **Priority specialties for additionality;** • **Potential WLI capacity;** • **Current IS solutions/contracts;** • **Admin infrastructure** **Timescale: By Friday 8 May** **Complete**
Diagnostics • Trust (Lynn Lappin) advised that its costed plan will be submitted to the Board today including maximum waiting times as calculated by the Trust. • Trust (Debbie Burns) explained that the contract for the mobile MRI scanner requires 4 weeks' notice and given that the funding for MRI set out in the Board's letter had only been sufficient for April, the Trust has cancelled the contract for June. Trust (Debbie Burns) advised that it could not expose the Trust to the financial risk for a second month. • Board (Michael Bloomfield) indicated to the Trust that it should be able to agree some flexibility to the contract with the IS provider until the Board has an opportunity to review all of the costed plans. In addition, the Trust has the option of redirecting some of the £1.2m allocation for diagnostics to MRI (c£51K per month) if it considers that the priority.	

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

FRIDAY 24 JUNE 2016

11.00am – 1.00pm

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

AGENDA

1. Welcome and introductions

2. Overview of 2016/17 performance meetings

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

- Elective care (Esther)

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

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

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

- Unscheduled care (Esther)

4-hour/12 hour position

- Cancer services (Esther)

14 –day breast/31/62 day position

- Mental health and learning disability services (Lesley) –

Reference brief from Bryce McMurray (attached)

- HCAI (Richard)

4. Children's services

- Unallocated cases (Lesley) _

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

5. Service delivery risks

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

6. Reform and modernisation

- Unscheduled Care (Aldrina)

7. AOB

Performance meeting – Agenda item 3 (mental Health)

Performance – Mental Health & Disability – June 2016

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

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

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

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

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

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

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

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

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

6. Patient Discharge - Learning Disability – AMBER / Mental Health GREEN
There continues to be a consistently small number of delayed discharges from acute mental health and learning disability impatient services. While progress for individuals is made, a new population continues to emerge.

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

Agenda item 4 (childrens)

Reference Unallocated cases report attached

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

Agenda Item 5

Service pressures/issues –

The Southern Trust's key challenges in 2016/17

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

1a .Medical Workforce – Recruitment Difficulties

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

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

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

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

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

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

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

1b. Nursing Workforce – Recruitment Difficulties

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

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

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

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

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

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

1c. Other Workforce Challenges

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

2. GP Out of Hours

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

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

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

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

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

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

3.Elective Care/ Access:

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

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

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

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

4. Unscheduled Care Demand

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

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

Key challenges include:

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

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

DHH Strategic Oversight Group

Summary of Key Points (June 2016)

Context:

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

Medical staffing levels:

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

Recruitment difficulties:

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

Locum expenditure:

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

College standards for cover during OOHs period

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

Unscheduled Care Briefing – Southern Area 2015/16

Key Points:

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

DHH

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

CAH

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

Previous actions to address pressures / mitigate risk:

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

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

Unscheduled Care Reform:

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

In summary:

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

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

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

GP OOH – Contacts April 2014 – March 2016

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

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

GP OOH Vacant Shift Report January – May 2016

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

Flexible Workforce – Overtime, Bank, Agency & Locum

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

Staff Levels WTE (HRMS/HRPTS) and Costs (£)	HRMS WTE		HRPTS WTE			Variance Staff WTE March 2012 and Current Month	Monthly Average Flexible Workforce Costs						2015/16 Costs to date as % of YTD Total Salary Bill
	Baseline Position				2015/16 to date as at 28 February 2016		2011/12	2012/13	2013/14	2014/15	2015/16	2011/12 Baseline & 2015/16 YTD Variance	
	Mar-12	Mar-13	Mar-14	Mar-15									
Staff Levels WTE (HRMS/HRPTS)	7,712.59	7,908.82	7,830.25	8,040.02	8,332.82	620.23							
Overtime Cost (£)	£2,378,447	£2,742,442	£2,405,219	£2,418,263	£2,658,221		£198,204	£228,537	£200,435	£201,522	£241,656	£43,453	0.81%
Bank Cost (£)	£7,988,757	£9,427,543	£10,316,793	£8,880,496	£8,524,348		£665,730	£785,629	£859,733	£740,041	£774,941	£109,211	2.59%
Agency Cost (£) (including M&D Agency Costs)	£4,951,745	£9,232,951	£8,244,487	£7,805,354	£10,383,243		£412,645	£769,413	£687,041	£650,446	£943,931	£531,286	3.16%
Locum Cost (£) (M&D Locum Staff employed by SHSCT)	£395,736	£428,785	£444,839	£664,870	£797,737		£32,978	£35,732	£37,070	£55,406	£72,522	£39,544	0.24%
Total Costs	£15,714,686	£21,831,721	£21,411,338	£19,768,983	£22,363,549		£1,309,667	£1,819,310	£1,784,278	£1,647,416	£2,033,060	£723,493	6.81%

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

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

Medical Workforce – Specific Detail

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

Consultant Dermatologists

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

Consultants & Specialty Doctors in Emergency Medicine

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

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

Consultant Radiologists

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

Psychology

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

GP Out of Hours

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

Geriatric Medicine

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

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

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

AGENDA

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

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

- Delivery of core

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

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

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

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

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

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

- Q1/2 Allocations (£700,000)
-

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

- Diagnostics

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

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

- Endoscopy

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

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

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

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

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

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

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

- Unscheduled care

  - Resilience plan update from Trust

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

- Cancer services

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

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

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

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

- Mental health and learning disability services

9 weeks to access Adult Mental Health Services

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

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

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

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

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

- *Diverting agreed referrals to an independent sector provider (note contract procured and awarded to Praxis – although currently in formal performance management procedures to address underperformance)*
- *Additional clinics – small in number and having only a minimal impact*

- *Ongoing audit of DNA rates with systemic and practitioner level initiatives to reduce DNA rates and increase capacity lost.*

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

Psychological Therapies – 13 week Target

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

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

4. *Serious Adverse Incidents – Outstanding Review Reports*

Update for HSCB Board Directors Meeting (Margaret Marsall

Outstanding SAI Reports (Slide 21 of HSCB presentation)

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

Present Position

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

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

Improvement Plan

Increased focus on strengthening our response to Adverse Incidents

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

Key areas of work

- *Incident screening and apportioning of investigation resources*

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

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

Regional Work streams

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

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

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

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

5. Update on TDP

(Aldrina as per letter to DS attached)

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

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

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

7. Reform and modernisation

(Aldrina – update on pathway reform)

8. AOB

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

TUESDAY 30 MAY 2017

2.00pm – 4.00pm

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

DRAFT AGENDA – WITH TRUST PREP NOTES (INTERNAL USE)

1. **Welcome and introductions**

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

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

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

IS and Elective additionality

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

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

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

Biggest growth areas

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

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

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

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

SBA / Core performance

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

SBA year end full report available

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March 2017 Month Er

Diagnostics

Waits over 26 weeks

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

Endoscopy

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

SBA - Endoscopy

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

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

AHP –

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

Unscheduled Care –

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

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

Cancer Services –

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

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

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

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

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

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

Breast

Refer to HSCB regional discussion and current actions

See dashboard below

Mental Health and Learning Disability Services –

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

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

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

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

6. Reform and Modernisation

- Daisy Hill Hospital emergency services

7. Service Delivery Risks

Note – consider alerting risk around Radiology – plain film backlog

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

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

9. AOB

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

Week Ending	Total Breast Symptomatic Referrals received	2ww Referrals Received	New Patient Slots Availabile (per rota)	Patients Seen	Patients Sent to Other Trust	Patients refusing offer of transfer to other Trusts	Lost Slots	Reasons for Lost Slots	2ww %	2WW Patients on target	2ww Patients breaching target	Total 2ww Patients Seen	2ww Volumes on Waiting List with Date	2ww Volumes on Waiting List without Date	Total 2WW Volumes	2ww Longest Waiter at point of booking (in days)	Volumes on Routine Waiting List	Longest Routine Waiter (weeks waiting)	TOTAL Breast OP Waiting List Volumes
5/05/2017	61	39	32	32	0	0	52	17 - BH 10 - reductions 25 - 4th clinic	***30.0%***	9	21	30	44	176	220	35	1264	55	1484
3/05/2017	92	66	47	53	50	0	41	16 - temp reductions x 3 clinics 25 - 4th evening clinic	***17.3%***	9	43	52	35	205	240	35	1434	56	1674
0/05/2017	78	55	32	32	0	0	52	17 - BH 10 - reductions 25 - 4th clinic	***10.9%***	3	25	28	53	215	268	42	1243	56	1511

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 Month No: 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)				2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				March 2018		March 2017	CUMULATIVE ACTIVITY (INTERNALLY RE-DIRECTED RESOURCES) 2016-17
KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	2015/16 SBA Position (for comparison) %	2015/16 SBA Position (for comparison) Variance	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	
100 In-Patient	1529	General Surgery (including Haematuna) IP	127	75	68	92	74	91	104	113	100	56	60	73	106	1032	1529	-497	-33%	-19%	-295	91 weeks	0
		Variance		-52	-59	-35	-53	-36	-73	-14	-27	-71	-67	-54	-21								
		Variance %		-41%	-37%	-28%	-42%	-28%	-18%	-11%	-21%	-56%	-53%	-43%	-17%								
100 Day Case	4301	General Surgery (including Haematuna) DC	358	326	277	316	262	251	348	301	289	178	223	217	312	3300	4301	-1001	-23%	-13%	-565	83 weeks	0
		Variance		-32	-81	-42	-96	-107	-10	-57	-69	-180	-135	-141	-46								
		Variance %		-9%	-23%	-12%	-27%	-30%	-3%	-16%	-19%	-50%	-38%	-39%	-13%								
100 TOTAL	5830	GENERAL SURGERY IPDC COMBINED	486	401	365	408	336	342	452	414	389	234	283	290	418	4332	5830	-1498	-26%	-15%	-861		0
		Variance		-85	-121	-78	-150	-144	-34	-72	-97	-252	-203	-196	-68								
		Variance %		-17%	-25%	-16%	-31%	-30%	-7%	-15%	-20%	-52%	-42%	-40%	-14%								
100C In-Patient	299	Breast Surgery IP	25	16	16	30	8	17	20	17	19	17	16	14	25	215	299	-84	-28%	-21%	-64	29 weeks	0
		Variance		-9	-9	5	-17	-8	-5	-8	-6	-8	-9	-11	0								
		Variance %		-36%	-36%	20%	-68%	-32%	-20%	-32%	-24%	-32%	-36%	-44%	0%								
100C Day Case	101	Breast Surgery DC	8	11	4	11	15	18	19	16	21	13	14	18	8	181	101	80	79%	71%	72	33 weeks	0
		Variance		3	-4	3	7	10	11	8	13	5	6	10	0								
		Variance %		31%	-52%	31%	88%	114%	138%	90%	160%	54%	86%	90%	-5%								
100C TOTAL	400	BSUR IPDC COMBINED	33	27	20	41	23	35	39	33	40	30	30	32	33	378	400	-24	-6%	2%	8		0
		Variance		-6	-13	8	-10	2	6	0	7	-3	-3	-2	0								
		Variance %		-18%	-40%	23%	-46%	5%	17%	-1%	20%	-10%	-10%	-6%	-1%								
101 In-Patient	1056	Urology IP	88	71	66	69	68	77	70	86	57	47	48	54	75	787	1056	-269	-25%	63%	362	165 weeks	0
		Variance		-17	-22	-19	-20	-11	-18	-2	-31	-41	-40	-34	-13								
		Variance %		-19%	-25%	-22%	-23%	-13%	-20%	-2%	-35%	-52%	-45%	-39%	-15%								
101 Day Case	3142	Urology DC (Excludes OPP New & Review)	262	284	264	306	243	290	323	288	338	262	333	296	295	3534	3142	392	12%	-14%	-623	152 weeks	0
		Variance		22	2	44	-19	28	61	26	76	0	71	34	33								
		Variance %		12%	1%	17%	-7%	11%	23%	10%	29%	0%	27%	13%	13%								
101 TOTAL	4198	UROLOGY IPDC COMBINED	350	355	330	375	311	367	393	354	395	309	381	350	370	4321	4198	123	3%	-5%	-261		0
		Variance		15	-20	25	-39	17	43	4	45	-41	31	0	20								
		Variance %		4%	-6%	7%	-11%	5%	12%	1%	13%	-13%	9%	0%	6%								
110 In-Patient	965	Orthopaedics IP	80	52	78	85	33	53	82	83	74	4	64	71	75	742	965	-223	-23%	-9%	-91	111 weeks	0
		Variance		-28	-2	5	-47	-27	-18	3	-6	-76	-16	-9	-5								
		Variance %		-35%	-2%	6%	-59%	-27%	-22%	3%	-8%	-95%	-20%	-11%	-6%								
110 Day Case	754	Orthopaedics DC	63	66	60	76	50	65	61	52	54	30	56	41	69	700	754	-54	-7%	12%	93	104 weeks	1
		Variance		3	-3	13	-13	2	-2	-11	-9	-33	-7	-22	6								
		Variance %		5%	-5%	21%	-20%	3%	-3%	-17%	-14%	-52%	-11%	-35%	10%								
110 Total	1719	ORTHOPAEDICS IPDC COMBINED	143	118	139	161	83	124	123	123	128	34	122	112	145	1442	1719	-277	-16%	0%	2		1
		Variance		-25	-4	18	-60	-19	-20	-20	-15	-109	-21	-31	2								
		Variance %		-18%	-3%	12%	-42%	-13%	-14%	-14%	-7%	-76%	-15%	-22%	1%								
120 In-Patient	1460	EAR, NOSE & THROAT IP	122	45	61	48	51	68	82	63	60	32	38	56	64	674	1460	-786	-54%	-47%	-593	44 weeks	0
		Variance		-77	-61	-74	-71	-54	-40	-59	-62	-90	-84	-66	-58								
		Variance %		-63%	-50%	-61%	-58%	-44%	-33%	-48%	-51%	-74%	-69%	-54%	-47%								
120 Day Case	1390	EAR, NOSE & THROAT DC	116	131	169	158	109	122	178	168	130	127	127	139	179	1778	1390	388	28%	28%	390	39 weeks	0
		Variance		15	53	42	-7	6	62	52	14	11	11	23	63								
		Variance %		13%	46%	36%	-6%	5%	54%	45%	14%	10%	10%	20%	54%								
120 Total	2850	EAR, NOSE & THROAT IPDC COMBINED	238	176	226	206	160	240	260	231	192	159	165	195	234	2450	2850	-400	-14%	-11%	-203		0
		Variance		-62	-12	-32	-72	2	22	-7	-46	-79	-73	-43	-4								
		Variance %		-26%	-5%	-13%	-31%	1%	9%	-3%	-19%	-33%	-31%	-18%	-1%								
191 Day Case	550	Pain Management DC	46	40	52	44	25	31	25	61	54	56	73	61	47	579	550	29	5%	14%	78	126 weeks	63
		Variance		-6	6	-2	-21	-15	-21	15	8	10	27	15	1								
		Variance %		-13%	13%	-5%	-46%	-32%	-45%	32%	18%	22%	59%	32%	2%								
300 In-Patient	117	General Medicine IP	10	8	3	11	7	6	8	4	9	5	6	8	11	89	117	-28	-24%	-36%	-42	10 weeks	0
		Variance		-2	-7	1	-3	-4	-2	-6	-1	-5	-4	-2	1								
		Variance %		-18%	-69%	13%	-28%	-36%	-18%	-59%	-6%	-49%	-40%	-18%	13%								
300 Day Case	1738	General Medicine DC	145	98	87	91	93	104	174	116	138	140	116	91	134	1360	1738	-378	-22%	-50%	-862		0
		Variance		-47	-58	-54	-52	-41	29	-29	-7	-5	-29	-54	-11								
		Variance %		-32%	-33%	-37%	-36%	-28%	20%	-20%	-5%	-3%	-20%	-37%	-7%								
300 Total	1855	GENERAL MEDICINE IPDC COMBINED	155	79	100	102	100	110	182	120	145	145	124	100	145	1449	1855	-406	-22%	-49%	-904		0
		Variance		-79	-55	-53	-55	-45	27	-35	-10	-10	-31	-55	-10								
		Variance %		-51%	-36%	-34%	-35%	-29%	18%	-22%	-6%	-6%	-20%	-35%	-6%								
301 In-Patient	17	Gastroenterology (Non-Scopes) IP	1	2	1	3	0	0	1	1	0	1	3	3	1	16	17	-1	-6%	12%	2		0
		Variance		1	0	2	-1	-1	0	0	-1	0	2	2	0								
		Variance %		41%	-29%	112%	-100%	-100%	-29%	-29%	-100%	-29%	112%	112%	-29%								
301 Day Case	188	Gastroenterology (Non-Scopes) DC	16	93	95	84	81	100	66	118	91	78	66	89	85	1026	188	838	446%	482%	906	23 weeks	0
		Variance		77	79	68	65	84	50	102	75	62	50	73	69								
		Variance %		494%	506%	436%	417%	539%	321%	653%	481%	398%	321%	340%	443%								
301 Total	205	GASTROENTEROLOGY (NON-SCOPES) IPDC COMBINED	17	95	96	87	81	100	67	119	91	79	69	72	86	1042	205	837	408%	443%	908		0
		Variance		78	79	70	64	83	50	102	74	62	52	55	69								
		Variance %		456%	462%	409%	374%	486%	292%	597%	433%	362%	304%	321%	403%								
303 In-Patient	100	Haematology (incl. Cancer Haem.) IP	8	4	4	4	11	9	3	7	9	1	2	2	5	57	100	-43	-43%	-52%	-52	17 weeks	0
		Variance		-4	-4	-4	3	1	-5	-1	-3	-7	-6	-6	-3								
		Variance %		-52%	-52%	-52%	32%	8%	-61%	-16%	-40%	-89%	-76%	-76%	-40%								
303 Day Case	1050	Haematology (incl. Cancer Haem.) DC	88	119	129	146	123	160	150	145	147	138	149	113	140	1659	1050	609	58%	40%	417		0
		Variance		32	42	58	35	72	62	57	58	51	62	26	53								
		Variance %		36%	47%	67%	41%	82%	71%	65%	65%	58%	70%	29%	60%								

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 Month No: 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)				2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				March 2016		March 2017	CUMULATIVE ACTIVITY
KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	2015/16 SBA Position (for comparison) %	2015/16 SBA Position (for comparison) Variance	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	(INTERNALLY RE-DIRECTED RESOURCES) 2016-17
303 Total	1150	HAEMATOLOGY (INCL. CANCER HAEM.) IPDC COMBINED	96	123	133	150	134	169	153	152	152	139	151	115	145	1718	1150	568	49%	32%	388		0
		Variance		27	37	54	38	73	57	56	56	43	55	19	49								
		Variance %		28%	39%	57%	40%	76%	60%	58%	58%	45%	58%	20%	51%								
330 In-Patient	115	Dermatology IP	10	0	0	0	0	0	1	0	0	0	0	0	0	1	115	-114	-99%	-100%	-115	29 weeks	0
		Variance		-10	-10	-10	-10	-10	-9	-10	-10	-10	-10	-10	-10								
		Variance %		-100%	-100%	-100%	-100%	-100%	-90%	-100%	-100%	-100%	-100%	-100%	-100%								
330 Day Case	981	Dermatology DC	82	140	115	146	77	117	134	141	143	102	114	111	127	1467	981	486	50%	53%	523		30
		Variance		58	33	64	-5	35	52	59	61	20	32	29	45								
		Variance %		71%	41%	78%	-6%	43%	64%	72%	75%	25%	39%	36%	55%								
330 Total	1096	DERMATOLOGY IPDC COMBINED	91	140	115	146	77	117	135	141	143	102	114	111	127	1468	1096	372	34%	37%	408		30
		Variance		49	24	55	14	29	44	50	52	11	23	20	36								
		Variance %		53%	26%	60%	18%	28%	48%	54%	57%	12%	25%	22%	39%								
340 In-Patient	10	Thoracic Medicine IP	1	2	3	2	0	3	1	4	1	0	2	0	2	20	10	10	100%	70%	7		0
		Variance		1	2	1	-1	2	0	3	0	-1	1	-1	1								
		Variance %		140%	200%	140%	-100%	200%	20%	300%	20%	-100%	140%	-100%	140%								
340 Day Case	490	Thoracic Medicine DC	41	40	38	44	44	47	41	42	40	30	38	37	39	481	490	-9	-2%	13%	63	3 weeks	0
		Variance		-1	-3	3	3	6	0	1	-1	-11	-3	-4	-2								
		Variance %		-2%	-7%	8%	8%	15%	0%	3%	-2%	-27%	-8%	-9%	-5%								
340 Total	500	THORACIC MEDICINE IPDC COMBINED	42	42	41	46	44	50	42	46	41	30	40	37	41	501	500	1	0%	14%	70		0
		Variance		0	-1	4	2	8	0	4	-1	-12	-2	-5	-1								
		Variance %		2%	-2%	10%	5%	20%	2%	10%	-2%	-28%	-5%	-12%	-2%								
361 In-Patient	34	Nephrology IP	3	1	1	1	0	4	3	2	1	1	0	1	0	15	34	-19	-56%	-65%	-22	<13 weeks	0
		Variance		-2	-2	-2	-3	1	0	-1	-2	-2	-3	-2	-3								
		Variance %		-65%	-65%	-65%	-100%	41%	8%	-29%	-65%	-65%	-100%	-65%	-100%								
361 Day Case	70	Nephrology DC	6	14	8	5	11	11	19	23	14	12	22	20	17	184	70	114	163%	349%	244		0
		Variance		8	2	-1	5	5	13	17	8	6	16	14	11								
		Variance %		140%	37%	-14%	83%	83%	226%	294%	140%	100%	277%	250%	183%								
361 Total	104	NEPHROLOGY IPDC COMBINED	9	15	9	6	11	15	22	25	15	13	22	20	17	199	104	95	91%	213%	232		0
		Variance		6	0	-3	2	6	13	16	6	4	12	10	8								
		Variance %		73%	4%	-31%	27%	73%	154%	198%	73%	50%	154%	225%	98%								
400 Day Case	390	NEUROLOGY DC	33	46	31	42	32	42	38	41	48	34	53	41	69	515	390	125	32%	26%	103	9 weeks	0
		Variance		14	-2	10	-1	10	6	9	14	2	21	9	37								
		Variance %		42%	-5%	32%	-2%	28%	17%	28%	42%	6%	62%	28%	116%								
410 In-Patient	10	RHEUMATOLOGY IP	1	0	1	0	0	0	1	2	0	0	0	0	0	4	10	-6	-60%	-80%	-8	16 weeks	0
		Variance		-1	0	-1	-1	-1	0	1	-1	-1	-1	-1	-1								
		Variance %		-100%	20%	-100%	-100%	-100%	20%	140%	-100%	-100%	-100%	-100%	-100%								
410 Day Case	2899	RHEUMATOLOGY DC	242	310	245	275	218	275	325	289	291	231	277	258	305	3299	2899	400	14%	9%	255		12
		Variance		68	3	33	-24	33	83	47	49	-11	35	16	63								
		Variance %		28%	1%	14%	-10%	14%	35%	20%	20%	-4%	15%	7%	26%								
410 Total	2909	RHEUMATOLOGY IPDC COMBINED	242	310	246	275	218	275	325	291	291	231	277	258	305	3303	2909	394	14%	8%	247		12
		Variance		68	4	33	-24	33	83	49	49	-11	35	16	63								
		Variance %		28%	1%	13%	-10%	13%	34%	20%	20%	-4%	14%	6%	26%								
420 In-Patient	80	Paediatric Medicine IP	7	2	6	10	7	7	6	7	7	7	6	7	10	86	80	6	8%	-8%	-8	NIA	0
		Variance		-5	-1	3	0	0	-1	0	0	0	1	0	3								
		Variance %		-70%	-20%	50%	0%	0%	-10%	0%	0%	0%	20%	0%	50%								
420 Day Case	40	Paediatric Medicine DC	3	0	0	0	0	0	2	0	1	0	2	3	2	8	40	-32	-80%	-58%	-23		0
		Variance		-3	-3	-3	-3	-3	-1	-3	-2	-3	-1	0	-1								
		Variance %		-100%	-100%	-100%	-100%	-100%	-100%	-100%	-70%	-100%	-40%	-12%	-40%								
420 Total	120	PAEDIATRIC MEDICINE IPDC COMBINED	10	2	6	10	7	7	8	7	8	7	10	10	12	94	120	-26	-22%	-24%	-29		0
		Variance		-8	-4	0	-3	-3	-2	-3	-2	-3	0	0	2								
		Variance %		-80%	-40%	0%	-30%	-30%	-20%	-30%	-20%	-30%	0%	0%	20%								
502 In-Patient	1281	Gynaecology IP	107	70	81	86	73	79	103	78	74	69	59	64	71	911	1281	-370	-29%	-20%	-250	33 weeks	0
		Variance		-37	-26	-21	-34	-28	-4	-29	-33	-38	-49	-39	-36								
		Variance %		-34%	-24%	-19%	-32%	-26%	-4%	-27%	-31%	-36%	-45%	-38%	-33%								
502 Day Case	1411	Gynaecology DC	118	148	118	106	116	133	127	125	133	101	105	115	129	1456	1411	45	3%	11%	154	25 weeks	0
		Variance		30	0	-12	-2	15	9	7	15	-17	-13	-3	11								
		Variance %		25%	0%	-10%	-1%	12%	8%	6%	13%	-14%	-11%	-3%	10%								
502 Total	2692	GYNAECOLOGY IPDC COMBINED	224	218	199	192	189	212	230	203	207	170	164	183	200	2367	2692	-326	-12%	-4%	-38		0
		Variance		-6	-25	-32	-35	-12	6	-21	-17	-54	-60	-41	-24								
		Variance %		-3%	-11%	-14%	-16%	-5%	3%	-10%	-8%	-24%	-27%	-18%	-11%								
620 Day Case	1746	COMMUNITY DENTISTRY DC	146	130	122	129	116	124	116	116	127	104	129	122	127	1466	1746	-280	-16%	-17%	-295	23 weeks	0
		Variance		-16	-24	-17	-30	-22	-30	-30	-19	-42	-17	-24	-19								
		Variance %		-11%	-16%	-11%	-20%	-15%	-19%	-19%	-13%	-29%	-11%	-16%	-13%								
130 Day Case	699	OPHTHALMOLOGY (VISITING SERVICE)	58	33	23	23	48	52	22	19	20	15	19	22	23	317	699	-382	-55%	-30%	-143	51 weeks	NIA
		Variance		-25	-35	-35	-10	-6	-36	-39	-38	-43	-39	-36	-35								
		Variance %		-43%	-61%	-61%	-18%	-10%	-62%	-67%	-66%	-74%	-67%	-62%	-61%								
IP	7073	INPATIENT TOTAL	589	348	432	441	338	420	465	446	407	235	310	362	446	4649	7073	-2424	-34%	-19%	-1288	166 weeks	104
		Variance		-241	-157	-148	-251	-169	-124	-144	-182	-354	-279	-227	-143								
		Variance %		-41%	-27%	-25%	-43%	-29%	-21%	-25%	-31%	-60%	-47%	-39%	-24%								
DC	21900	DAYCASE TOTAL	1825	2009	1873	2002	1658	1880	2188	2063	2077	1651	1917	1782	2044	23288	21900	1388	6%	4%	970		
		Variance		184	48	177	-167	168	343	238	252	-174	92	-43	270								
		Variance %		10%	3%	10%	-9%	9%	19%	13%	14%	-10%	5%	-2%	15%								

IN-PATIENT AND DAY CASE SERVICE BUDGET AGREEMENT

Month: March 2017 Month No: 12

Note: Cells highlighted denote additional activity in-month (figure in brackets) funded by Internally Re-directed Resources (IRR)				2016/2017 MONTHLY SBA PERFORMANCE - INPATIENTS & DAYCASES												2016/2017 CUMULATIVE SBA PERFORMANCE				March 2016		March 2017	CUMULATIVE ACTIVITY (INTERNALLY RE-DIRECTED RESOURCES) 2016-17
KORNER CODE	2016/17 SBA VOLUME - TBC	SPECIALTY	Monthly Expected SBA	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Cumulative Activity	Cumulative Expected SBA	Variance	Variance %	2015/16 SBA Position (for comparison) %	Variance	MONTH-END ACCESS (ACTUAL) LONGEST WAITER	
Total	28973	INPATIENT & DAYCASE TOTAL	2414	2357	2305	2443	1996	2413	2653	2508	2484	1886	2227	2144	2541	27937	28973	-1036	-4%	-1%	-298		
		Variance		-57	-109	29	-418	-1	239	94	70	-528	-187	-270	127								
		Variance %		-2%	-5%	1%	-17%	0%	9%	4%	3%	-22%	-8%	-11%	5%								

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

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

HSCB/TRUST SERVICE ISSUES AND PERFORMANCE MEETING

SOUTHERN TRUST

WEDNESDAY 23 MAY 2018

10.00am – 12.00pm

5th Floor Meeting Room, HSCB, Linenhall Street

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

AGENDA

HSCB ATTENDEES:

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

1. Welcome and introductions

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

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

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

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

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

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

2. Service Delivery Issues

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

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

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

- Elective care

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

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

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

- Unscheduled care

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

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

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

- Cancer services

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

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

- Mental health services

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

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

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

- HCAI

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

4. 2018/19 Performance Improvement Trajectories

SMT paper attached detailing areas by exception (Appendix 2)

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

Out-Patients

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

In-Patients/Day Cases

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

Other areas to be inserted / in compilation by Performance

5. SSI surveillance related issues

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

C-section – no known issues

Orthopaedic Brief – see below

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

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

Orthopaedic Surgical Site Infection Patient Safety Dashboard Q4 2017

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

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

Infection Key:

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

C/Section Surgical Site Infection Patient Safety Dashboard March 2018

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

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

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

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

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

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

Performance in National Audits – SSNAP (Brid Farrell presentation)

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

Key challenges related to

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

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

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

CAH SSNAP – Level D (No change)

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

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

DHH SSNAP – Level C (Improved from D)

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

6. Trust Issues:

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

7. AOB

Appendix 1 – year end report

20180521_YearEnda
tMarch2018_AccessT

Appendix 2 - performance improvement trajectory

OP/IP & DC

20180515_1819
PIT_UPDATED_SHSC

Appendix 4

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

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

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

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

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

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

ENT

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

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

2018/19 PERFORMANCE IMPROVEMENT TRAJECTORY

Delivery of Core - New Outpatients

Trust: Southern

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

Date Submitted (HSCB): 20 April 2018

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

Month: 1 (April 2018)

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

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

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

RAG status:

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

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

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

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

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

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

Received from SHSCT on 16/05/22. Annotated by the Urology Services Inquiry.

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

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

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

IN-PATIENTS AND DAY CASES

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

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

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

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

ALLIED HEALTH PROFESSIONALS

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

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

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

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

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

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

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

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

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

AGENDA

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

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

- Delivery of core

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

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

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

In-Patients/Day Cases:

** Cancellations of elective activity associated with unscheduled care pressures*

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

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

- Q1/2 Allocations (£700,000)
-

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

- Diagnostics

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

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

- Endoscopy

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

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

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