

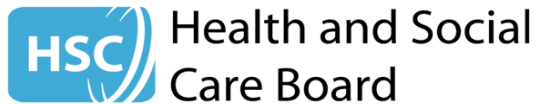
|          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                    |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
|          | <p>Members discussed presentations to be given by Directors to provide an introductory session to new Non-Executive Members.</p> <p>The Chief Executive referred to the confidential section and Mr Rice advised that he was finalising a suite of papers to be issued in advance. He agreed to circulate to members this evening and asked for any comments to be given by close of play on Thursday 18 February 2016.</p> <p><b>3.2 NICON Conference 2016 – change of dates</b></p> <p>The Chief Executive drew member's attention to the change of dates for the NICON Conference. The new dates are Tuesday 28 and Wednesday 29 June 2016 and this will take place in the La Mon Hotel, Belfast.</p> | <p><b><i>All – comments by 18 Feb 2016</i></b></p> |
| <b>4</b> | <p><b>MATTERS ARISING</b></p> <p>There were no matters arising.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                    |
| <b>5</b> | <p><b>STRATEGIC PLANNING</b></p> <p><b>5.1 Winter Pressures</b></p> <p>The Winter Pressures Action Plan and Directorate responses will be tabled at next week's SMT Meeting.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p><b><i>24 February 2016</i></b></p>              |
| <b>6</b> | <p><b>FINANCIAL PLAN 2015/16</b></p> <p><b>6.1 15/16 Financial Plans</b></p> <p>Mr McNally advised on 15/16 financial position. He advised that Month 10 figures were now available. Mr McNally drew members attention to the difficulties regarding the processing of requisitions and stressed the potential problems faced if teams are not incurring the anticipated spend.</p> <p><b>6.2 Financial Plan 2016/17</b></p> <p>Mr McNally advised that there had been no further update from the Trust's submission. Members asked that the list is circulated again for further consideration amongst SMT.</p>                                                                                         | <p><b><i>Mr McNally to re-circulate</i></b></p>    |

|   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                  |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| 7 | <p><b>PERFORMANCE UPDATE</b></p> <p><b>7.1 Performance Update</b><br/>A draft performance report for Trust Board was tabled. All to provide comments to A Magwood by 19 February 2016.</p> <p><b>7.2 Proposal to Pilot Mobile Call Recording in the GP Out of Hours Service</b><br/>Mrs Toner referred members to the paper on the proposal to Pilot Call Mobile Call Recording in GP OOH.</p> <p>The paper outlines the key issues and risks for the Trust to investigate remote call recording technologies that would allow the GP in OOH to provide triage services from their own home. Members discussed the potential of these services and noted the associated risks. Following agreement, this will proceed on a pilot basis and reviewed to ascertain if successful.</p> | <p><b><i>Approved – test basis</i></b></p>       |
| 8 | <p><b>INNOVATION/CONTINUOUS IMPROVEMENT</b></p> <p><b>8.1 Quality Improvement Framework Update</b><br/>Mrs Magwood referred to the QIF update and previously circulated papers which will be presented at Board Workshop. Members were asked to submit comments, if any, to Mrs Magwood by Thursday 18 February 2016.</p> <p><i>Mrs Magwood left the meeting</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                | <p><b><i>All Comments by 18 Feb 2016</i></b></p> |
| 9 | <p><b>GOVERNANCE ISSUES</b></p> <p><b>9.1 Conflicts of Interest Policy</b><br/><b>9.2 Gifts, Hospitality &amp; Sponsorship Policy</b><br/>Mr Donaghy drew member's attention to the Conflicts of Interest Policy and the Gifts, Hospitality &amp; Sponsorship Policy. He advised that these policies had previously formed one composite policy but following Departmental advise and guidance they have now been separated into 2 individual policies.</p> <p>Following approval at SMT, Mr Donaghy advised that the</p>                                                                                                                                                                                                                                                           |                                                  |

|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                 |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
|           | <p>policies will be submitted to the Policy Scrutiny Committee. Members considered and approved.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <b><i>Approved</i></b>                                                                                          |
| <b>10</b> | <p><b>INFECTION CONTROL UPDATE</b></p> <p><b>10.1 HCAI Update/Briefing</b><br/>Dr Wright updated members on the current HCAI situation within the Trust. He advised that there were no new cases since the previous report.</p> <p><b>10.2 HCAI Update – PFA Targets</b><br/>There was no separate report.</p> <p><b>10.3 Winter Flu Vaccination Action Plan 2015</b><br/>Mr Donaghy advised that further correspondence had been issued but no further vaccinations have taken place. Discussion took place regarding the need to 'stand down' staff at the vaccination clinics.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                 |
| <b>11</b> | <p><b>CAPITAL PRIORITIES/REVENUE BUSINESS CASES</b></p> <p><b>11.1 IPT's/Business Cases for approval</b></p> <ul style="list-style-type: none"> <li>- <b>SHSCT VDCP Transformation:- K Donaghy</b> <ul style="list-style-type: none"> <li>• <b>IP Telephony Upgrade South Tyrone and Towerhill Hospitals</b></li> <li>• <b>IP Telephony Upgrade Daisy Hill Hospital</b></li> <li>• <b>IP Telephony Upgrade Craigavon Hospital</b></li> <li>• <b>IP Telephony Upgrade St. Luke's Hospital</b></li> </ul> </li> </ul> <p>Members noted the 4 papers regarding telephony upgrades and following consideration agreed that this was the right course of action to take. Members referred to previous presentation given to SMT and subject to some minor wording changes, as will be agreed with Mr McNally, agreement was given as the framework for going forward and to support the revenue cases.</p> <p>Mr Donaghy, Mr McNally and Mrs Magwood to meet by close of play Thursday 18 February 2016 to agree on submissions.</p> <ul style="list-style-type: none"> <li>- <b>IPT – Non Obstetric Ultrasound</b></li> <li>- <b>IPT – Plain Film Reporting</b></li> </ul> | <p><b><i>Approved</i></b></p> <p><b><i>Mr Donaghy,<br/>Mr McNally &amp;<br/>Mrs Magwood<br/>to meet</i></b></p> |

|           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                        |
|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|
|           | <p>Mrs Gishkori referred members to the above IPT's and highlighted the rationale.</p> <p>Following consideration, members approved the direction of travel to proceed as outlined.</p> <p><b>11.2 Summary of Revenue Post Project Evaluations (PPEs) 2014/15</b></p> <p>Members noted the summary overview and Mrs Tally advised that the planning department had contacted the relevant department leads. Members were asked for any comments to be submitted.</p> | <b><i>Approved</i></b> |
| <b>12</b> | <p><b>WORKFORCE ISSUES</b></p> <p>There were no issues to discuss.</p>                                                                                                                                                                                                                                                                                                                                                                                               |                        |
| <b>13</b> | <p><b>COMMUNICATIONS &amp; PUBLIC AFFAIRS</b></p> <p>Mrs McKimm advised on the current topical issues.</p>                                                                                                                                                                                                                                                                                                                                                           |                        |
| <b>14</b> | <p><b>DHSSPS CIRCULARS/CORRESPONDENCE</b></p> <p>There were no specific items of correspondence to note.</p>                                                                                                                                                                                                                                                                                                                                                         |                        |
| <b>15</b> | <p><b>ANY OTHER BUSINESS</b></p> <p><b>15.1 PARIS Optimum Bias Case</b></p> <p>Mr Rice informed members that the Trust had received confirmation of funding from the Department for the Optimum Bias Case for PARIS. Members acknowledged this good news.</p>                                                                                                                                                                                                        |                        |
| <b>16</b> | <p><b>DATE OF NEXT MEETING</b></p> <p><b>Wednesday 24 February 2016</b></p>                                                                                                                                                                                                                                                                                                                                                                                          |                        |





*Performance Management and Service  
Improvement Directorate*

Trust Directors of Acute Services

*HSC Board Headquarters  
12-22 Linenhall Street  
Belfast  
BT2 8BS*

*Tel :*

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*Email:*

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Our Ref: HM670

Date: 27 April 2010

Dear Colleagues

## **REGIONAL UROLOGY REVIEW**

As you are aware, the Trust was represented on the Regional Urology Review which was completed in March 2009. The final report was presented to the Department in April 2009 and was endorsed by the Minister on 31 March 2010. I am aware an initial meeting of team East was held on 22 March and team North on the 1 April 2010 and team South is planned for the 13 May 2010.

Now that the Minister has endorsed the recommendations from the Review, it is imperative that the Trusts with lead responsibility for the development of the Business Case/Implementation Plan move quickly to develop the team model and agree the activity to be provided from the additional investment.

The Teams should base their implementation plan on each of the relevant Review recommendations; a full list of the recommendations is included in Appendix 1. I am aware that each of the teams has established project management arrangements to develop and agree the implementation plan for each team. It is also anticipated that these teams will agree the patient pathways, complete a baseline assessment of the current service, their current location and the activity available from the existing service model. The teams should aim to have completed the first draft of the Implementation Plan and submit this to the Board by Friday 11 June 2010.

It is planned that an overarching Implementation Project Board will be established comprising the Chair and Clinical Advisor from each of these project Teams, and key HSCB staff; to oversee the implementation of the Review. The first meeting of the Urology Project Implementation Board will be held on Thursday 1 July 2010 at 2.00pm in the Conference Room, Templeton House. The Project Team chair should send the team nominated representatives to [Ricardo.consiglio](mailto:Ricardo.consiglio@hsc.nhs.uk) by Friday 7 May 2010. I have asked Beth Malloy, Assistant Director, Scheduled Services, Performance Management and Service Improvement, to chair the Project Implementation Board.

The Review estimated the cost of implementing the recommendations to be £3.5m, of this £637k has already been allocated to Belfast Trust, and the remaining balance of £2.9m is

available. Please see Appendix 2 which has notionally allocated this budget to each of the teams, and it is on this basis the Teams should work collectively across Trusts to develop the Implementation Plans. The plan should also include a proposal for the use of the non-recurrent 'slippage' funding available from the teams share of the recurring £2.9m, this should include what additional in-house sessions will be provide to maintain the waiting times as at 31 March 2010 and to deal with any backlog of patients waiting for urological diagnostic investigations or outpatient review.

As per the details outlined in the Review, the initial assumption regarding the activity associated with each of the additional Consultant appointments is included in Appendix 3. To assist the teams in the further discussion, the figures outlined in the Urology Review have been updated and are attached in Appendix 4.

The Implementation plan, proposed patient pathways and the non-recurrent funding proposal should be sent to Beth Malloy Personal Information redacted by the USI by Friday 11 June 2010.

Yours sincerely

Personal Information redacted by the USI

**HUGH MULLEN**  
**Director of Performance Management and Service Improvement**

Enc

cc Trust Directors of Performance  
John Compton  
Paul Cummings  
Beth Malloy  
Michael Bloomfield  
Iain Deboys  
Lyn Donnelly  
Paul Cavanagh  
Paul Turley  
Bride Harkin

## Appendix 1

### 1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

#### Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative ‘M’ code) constitute a substantial proportion of a surgeon’s practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.
2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of “N” Code work and the associated resources to the Urology Team.
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

#### Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.
5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.
6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.
10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

## **Section 4 – Capacity, Demand and Activity**

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

## **Section 5 – Performance Measures**

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.
13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.
14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.
15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.
16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.
17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

## **Section 7 – Urological Cancers**

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.
19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.
20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

**Section 8 – Clinical Workforce Requirements**

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.
22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.
23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

**Section 9 – Service Configuration Model**

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.
25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.
26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

**Appendix 2****Estimated Team Costs for the Implementation of Adult Urology Review Recommendations.**

|                                                               | Team South | Team North | Team East | Total    | No   | Unit Cost | Total    |
|---------------------------------------------------------------|------------|------------|-----------|----------|------|-----------|----------|
| <b>Staffing Costs</b>                                         |            |            |           |          |      |           |          |
| Consultant Urologist – additional wte team allocation         | 2 wte      | 1 wte      | 3 wte     | 6        | 6    |           |          |
| Consultant Urologists wte                                     | £208,000   | £104,000   | £312,000  | £624,000 |      | £104,000  | £624,000 |
| Consultant Anaesthetist @ 0.6 wte per Con. Urologist          | £124,800   | £62,400    | £187,200  | £374,400 | 3.6  | £104,000  | £374,400 |
| Consultant Radiologist @ 0.3 wte per Con. Urologist           | £62,400    | £31,200    | £93,600   | £187,200 | 1.8  | £104,000  | £187,200 |
| Band 5 Radiographer @ 6 per wte Con Radiologist               | £100,782   | £50,391    | £151,173  | £302,346 | 10.8 | £27,995   | £302,346 |
| Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist           | £100,782   | £50,391    | £151,173  | £302,346 | 10.8 | £27,995   | £302,346 |
| Band 3 Nursing @ 0.46 wte per Con. Urologist                  | £17,870    | £8,935     | £26,805   | £53,610  | 2.7  | £19,856   | £53,611  |
| Band 7 Specialist Nursing *1                                  | £103,605   | £0         | £103,605  | £207,210 | 5    | £41,442   | £207,210 |
| Band 5 Nursing @ 0.64 wte (day surgery)                       | £5,972     | £2,986     | £8,958    | £17,916  | 0.64 | £27,995   | £17,917  |
| Band 4 Personal Secretary @ 0.5 wte per consultant urologists | £23,265    | £11,633    | £34,897   | £69,795  | 3    | £23,265   | £69,795  |

|                                                                  |                   |                 |                   |                   |      |         |                   |
|------------------------------------------------------------------|-------------------|-----------------|-------------------|-------------------|------|---------|-------------------|
| Band 3 Admin support to radiologists at 0.5 wte per Radiologist  | 6,618             | 3,309           | 9,927             | £19,854           | 1    | £19,856 | £19,856           |
| Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2 | £31,438           | £0              | £28,129           | £59,567           | 3    | £19,856 | £59,568           |
| Band 4 Medical Records support 0.5 per unit *3                   | £11,632           | £23,265         | £23,265           | £58,162           | 2.5  | £23,265 | £58,162           |
| Band 7 MLSO – Bio-medical Science *4                             |                   |                 | £41,442           | £41,442           | 1    | £41,442 | £41,442           |
| <b>Staffing Costs Sub Total</b>                                  | <b>£797,164</b>   | <b>£348,510</b> | <b>£1,172,174</b> | <b>£2,317,848</b> |      |         | <b>£2,317,853</b> |
| <b>Support Costs</b>                                             |                   |                 |                   |                   |      |         |                   |
| Surgical G&S @ £94,500 per Con. Urologist                        | 189,000           | 94,500          | 283,500           | £567,000          | X 6  | £94,500 | £567,000          |
| Theatre Goods/Disposables @ £50,000 per Con.Urologist            | 100,000           | 50,000          | 150,000           | £300,000          | X 6  | £50,000 | £300,000          |
| Radiology G&S per Con. Urologist                                 | 5,000             | 2,500           | 7,500             | £15,000           | X 6  | £2,500  | £15,000           |
| CSSD @ £32,000 per Con. Urologist                                | 64,000            | 32,000          | 96,000            | £192,000          | X 6  | £32,000 | £192,000          |
| Outpatients Clinics @ 2 per Con. Urologist                       | 40,000            | 20,000          | 60,000            | £120,000          | X 12 | £10,000 | £120,000          |
| <b>Support Costs Sub Total</b>                                   | <b>£398,000</b>   | <b>£199,000</b> | <b>£597,000</b>   | <b>£1,194,000</b> |      |         |                   |
| <b>Sub Total</b>                                                 | <b>£1,195,164</b> | <b>£547,510</b> | <b>£1,769,174</b> | <b>£3,511,848</b> |      |         | <b>£3,511,853</b> |
| <b>Less funding in 2008/09</b>                                   |                   |                 | <b>£637,076</b>   | <b>£637,076</b>   |      |         | <b>-£637,076</b>  |
| <b>FINAL TOTAL</b>                                               | <b>£1,195,164</b> | <b>£547,510</b> | <b>£1,132,098</b> | <b>£2,874,772</b> |      |         | <b>£2,874,777</b> |

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

\*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

|            | Existing Establishment | Number of consultants with a sub-specialty interest | Additional CNS |
|------------|------------------------|-----------------------------------------------------|----------------|
| Team South | 0                      | 2                                                   | 2              |
| Team North | 2                      | 2                                                   | 0.5            |
| Team East  | 2                      | 4                                                   | 2.5            |

\*2 – 0.5 allocated to each Team as per the Specialist Nurse

\*3 – 0.5 allocated to each Trust Unit within each Team

\*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board



## Appendix 3

The exact details of the additional activity associate with the additional Consultant appointments will require agreement with the Board Commissioning teams. As outlined in the Review, it is assumed that the additional activity will be as follows:

Ref: Review Page 40-41

Outpatients: 1176 – 1680 per Consultant

Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post

Outpatients 19,992 to 28,560

IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments

Outpatients 7,056 to 10,080

IP/DC FCEs – 6,000 to 7,500

Regional Total

Outpatients 27,048 to 38,640

IP/DC FCEs – 23,000 to 28,750

Please note:

This analysis does not take into account the improvements expected from the introduction and full implementation of the ICATS for urology, as outlined on page 19 of the Review. The additional activity from the CNS has still to be quantified. In addition, the quantification of the service improvements, to be gained from the implementation of the Review recommendations, still to be agreed with the each Trust (for each of the team) and the Board are not included.

**From:** Stinson, Emma M  
**Sent:** 23 April 2010 10:25  
**To:** Mackle, Eamon; Young, Michael; Brown, Robin; Trouton, Heather; Clarke, Paula; Carroll, Ronan; Walker, Helen; Cassells, Carol; 'beth.malloy@usl.nhs.uk'; 'joe.lusby@usl.nhs.uk';  
**Cc:** Renney, Cathy; McCorry, Monica; Akhtar, Mehmood; Murphy, Jane S; Radcliffe, Sharon; Lappin, Aideen; McNeice, Andrea; 'orla.morrow@usl.nhs.uk';  
**Subject:** Steering Group Meeting - 13th May 2010  
**Attachments:** Team South Agenda - 13 May 2010.doc; REGIONAL REVIEW RECOMMENDATIONS.doc; Team South Urology Steering Groups.doc; Review of Urology Services update april 10.doc

**Importance:** High

Dear Everyone

The first meeting of the Steering Group to manage the planning and implementation of the Regional Urology Review will take place on Thursday 13th May 2010 starting at 10.00 am in the Board Room, Trust HQ.

I have attached the following documents in preparation:

- Agenda
- Steering Group, Project Team and Clinical Assurance Group Membership
- Regional Review recommendations
- Southern Trust outline position regarding recommendations

Given that Mr Mark Fordham, the Urology Surgeon engaged to provide clinical leadership to this NI Review, will be with the Trust for the day, I have invited Mr O'Brien and Mr Akhtar to join the Steering Group meeting and subsequent meetings on the day

The Steering Group will commence at 10am and is likely to take most of the morning. The remainder of the day will be used for clinical discussions with Mr Fordham on specific issues in relation to the review and visiting urology facilities in CAH.

I would be grateful for an indication of your availability if my office is not already aware of this.

Regards

Gillian

Dr Gillian Rankin  
Interim Director of Acute Services

Emma Stinson  
PA to Dr Gillian Rankin, Interim Director of Acute Services Admin Floor Craigavon Area Hospital

Tel: [Redacted]  
Fax: [Redacted]

Email: [Redacted]

## **AGENDA**

**TEAM SOUTH UROLOGY STEERING GROUP MEETING ON 13 MAY 2010  
AT 10.00 PM IN CRAIGAVON HOSPITAL,**

- 1. WELCOME AND INTRODUCTIONS**
- 2. MINISTERS ENDORSEMENT OF ALL UROLOGY REVIEW  
RECOMMENDATIONS**
- 3. UPDATE ON PROJECT MANAGEMENT ARRANGEMENTS FOR  
TEAM SOUTH – MEMBERSHIP AND CHAIR**
- 4. UPDATE ON PROGRESS WITH RECOMMENDATIONS –  
IDENTIFICATION OF ANY KEY RISKS AND ACTIONS TO  
RESOLVE**
- 5. IDENTIFY KEY PATIENT PATHWAYS AND PROTOCOLS**
- 6. BUSINESS CASE FOR SERVICE EXPANSION**
- 7. AGREE NEXT STEPS AND TIMETABLE**
- 8. ANY OTHER BUSINESS**

## RELEVANT REVIEW RECOMMENDATIONS

### Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.
2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

### Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.
5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.
6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.
7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.
8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.
9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home.

#### **Section 4 – Capacity, Demand and Activity**

11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.

#### **Section 5 – Performance Measures**

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.
13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.
14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.
15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.
16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.
17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

## **Section 7 – Urological Cancers**

18. The NICA Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.
19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.
20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

## **Section 8 – Clinical Workforce Requirements**

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.
22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.
23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

## **Section 9 – Service Configuration Model**

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.
25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.
26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for

service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

| Teams      | Geographical Area/ Catchment Population                                                                                                                                                                                                                    | Consultant Staffing/Suggested Special Interest Areas**                                                                                                 | Arrangements for Elective and Non Elective Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Team North | Upper 2/3 <sup>rd</sup> of Northern* and Western integrate to form one Team/Network.<br><br>Catchment population circa 480,000                                                                                                                             | Six wte<br><br>All core Urology<br>Uro-oncology – 2<br>Stones/endourology – 2*<br>Functional/female Urology – 1<br>Andrology – 1                       | One on-call rota (1:6). One local MDT/MDM.***<br>Main acute elective and non elective inpatient unit in Altnagelvin<br>Approximately 7 elective beds in Causeway (Selected minor/intermediate cases)<br>Day surgery – Altnagelvin, Causeway, Tyrone County<br>Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley<br>May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster<br>*Mobile ESWL (Lithotripter) on Causeway site                                                    |
| Team South | Lower 1/3 <sup>rd</sup> Western (Fermanagh) and all of Southern integrate to form one Team/Network.<br><br>Catchment population circa 410,000                                                                                                              | Five wte<br><br>All core Urology<br>Uro-oncology – 2<br>Stones/endourology – 2*<br>Functional/female Urology – 1                                       | One on-call rota (1:5). One local MDT/MDM.***<br>Main acute elective and non elective inpatient unit in Craigavon<br>Day surgery – Craigavon, South Tyrone, Daisy Hill<br>Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh<br>May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen<br>*Static/fixed ESWL (lithotripter) on Craigavon site.                                                                                                                  |
| Team East  | SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim).<br><br>Catchment population circa 870,000<br>Complex cancer catchment 1.76m | Twelve Wte<br><br>All core Urology<br>Uro-oncology/cancer centre – 4<br>Stones/endourology – 3*<br>Functional/female Urology – 2<br>Reconstruction – 3 | One on-call rota (1:12) (may wish to consider 2 <sup>nd</sup> tier on-call). One local MDT/MDM plus regional/specialist MDM.***<br>Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster<br>Day surgery – BCH, Mater, Lagan Valley, Ards, Downe<br>Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe<br>Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne<br>*Mobile ESWL lithotripter on BCH site. |

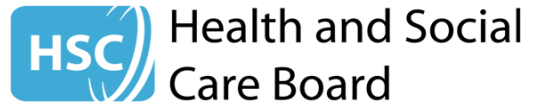
**Table 14 Elements and Arrangements in Three Team Model**

\*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.

\*\* Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

\*\*\* MDM reconfiguration has been approved by NICaN Group





## **REGIONAL REVIEW OF ADULT UROLOGY SERVICES**

**April 2010**

This document makes a total of 26 Recommendations, which are set out in Table 1 below.

| Recommendation                                                                                                                                                                                                                                                                                   | Update 15 April 2010                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial portion of a surgeon's practice (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team. | Only the Urologist's in the Southern Trust undertake these urological procedures.                                                                                                                     |
| 2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team                                                                                  | The Trust will keep this under review as Consultant Surgeons retire and make appropriate plans to transfer the "N" code work to urologists.                                                           |
| 3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance. (Section 2 – Introduction and Context, pg 5)                                                                                         | The Trust need to undertake this review and to take into account the service pathways from Primary Care to both Urology and Gynae services.<br><b>Action: Group to be set up to take this forward</b> |
| 4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.                                                                                                                                             | This process was reviewed by the Trust last Summer and is in place.                                                                                                                                   |

|                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.</p>                                                           | <p>The Trust has a number of representatives that sit and attend meetings for this Group and have been involved in the discussion in respect to the referral guidelines and pathways. The Trust commenced its formal Multi-disciplinary Team meetings on 1 April on Thursday afternoons were suspected and confirmed urological cancer pathways and referrals are discussed.</p> |
| <p>6. Deployment of New Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.</p>                                                                       | <p>The Trust will take this into account when preparing job descriptions and job plans.</p>                                                                                                                                                                                                                                                                                      |
| <p>7. Urologists, in collaboration with General Surgery and A&amp;E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).</p> | <p>The Trust have commenced work on this, for example patients presenting with Urinary Tract Retention. These have been shared with A&amp;E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways.</p>                                                            |
| <p>8. Urologists, in collaboration with A&amp;E colleagues, should develop and implement protocols/care pathways for those patients requiring direct</p>                                                                                                                                                | <p>The Trust have commenced work on this, for example</p>                                                                                                                                                                                                                                                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>patients presenting with Urinary Tract Retention. These have been shared with A&amp;E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways</p>                                                                                                                                                                                                                                    |
| <p>9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5).</p>                                                                                       | <p>This recommendation will be actioned as part of the implementation of the review and will include representatives from Urology, A&amp;E and General Surgeons from the those hospitals that do not have a Urology Unit.</p> <p><b>Action:- Meeting to be set up to include all as mentioned above to take this forward</b></p>                                                                                                                                                                     |
| <p>10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5).</p> | <p>This recommendation has commenced as from week beginning 5 April the protected Urology Thursday slot will look at each of the ICATS services. 8<sup>th</sup> April looked at Andrology and it was agreed that this service would be split in two and one part will deal with erectile dysfunction. Today the discussions were concentrating on benign prostatic disease. Notes from these meetings will be available and then discussions and recommendations from these will be implemented.</p> |

|                                                                                                                                                                                                                                               | <b>Action: these weekly meetings to continue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.                                                                                  | The Trust currently adhere to key elements of the Elective Reform Programme, for example, IEAP, pre-op assessment, monitor admission on day of surgery, etc and through weekly dashboard reports etc will be able to evidence. For example the Trust are also looking at methods of operation e.g. TURP to increase day surgery and recognise that some investment is required for equipment to meet these targets and other of the key elements are being taken into consideration for Urology. |
| 12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6). | This redesign is all part of the protected ‘Thursday’ meetings and are currently aiming through Thorndale unit to facilitate a single visit for suspected urological cancer patients. we are currently drawing up a timetable at what will be discussed at each of these meetings so as to assist in taking forward these recommendations                                                                                                                                                        |
| 13. Trusts should implement the key elements of the elective reform programmed with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.                                                     | This is currently on-going as per recommendation 11                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6).</p>                                                                                       | <p>This point will part of the implementation plan and still needs to be actioned with Consultants. Mr Mark Fordham is visiting the Trust on 13 May and can be included in discussions with the Urologists.</p>                                                                                                                                                                                     |
| <p>15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6).</p> | <p>This point will part of the implementation plan and still needs to be actioned with Consultants along with their colleagues in other Trusts</p>                                                                                                                                                                                                                                                  |
| <p>16. Trusts should review their outpatient review practice, design other methods/staff where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.</p>                                                                                                                                                                                     | <p>This has partially commenced in the Dr Rodgers, General Practitioner with Specialist Interest (GPWSI) attends Mr Young's weekly CAH outpatient clinic to see reviews. Also Shirley Tedford the Urology Nurse Co-ordinator has started to do chart, letter and results reviews on review patients and then discusses their outcome with the consultants and agrees the best pathway for them.</p> |
| <p>17. Trust must modernise and redesign outpatient clinic templates and admin/booking processes to ensure their capacity for new and review patients and to prevent backlogs occurring in the future.</p>                                                                                                                                                                                             | <p>The admin/booking processes are in place. As part of the whole review each Urologist will be met to</p>                                                                                                                                                                                                                                                                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                 | discuss their clinic templates and ensure that there is enough capacity for the new and review. This will also depend on the availability of Registrars/Junior Staff to assist at the clinics as there had been a deficit for a while. <b>Action: On-going</b> |
| 18. The NICA Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG. (Section 7 – Urological Cancers, pg 6).                                                                                                            | This is on-going with representatives of the Trust attending and actioning recommendations from the NICA group                                                                                                                                                 |
| 19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6). | There is ongoing discussions taking place regarding this recommendation                                                                                                                                                                                        |
| 20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6).                                                                     | There is ongoing discussions taking place regarding this recommendation                                                                                                                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6).</p>                                                                                                                                                                                                         | <p>A business case needs to be prepared for two additional Consultant Urologists for the Southern Trust to include their support and any equipment required in order that they will take into account specialist interests as per Recommendation 6. Work has commenced on team job plans and job descriptions will now have to be drawn up.</p> |
| <p>22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6).</p>                                                                                       | <p>Work has commenced on team job plans and job descriptions will now have to be drawn up.</p> <p>Discussions need to take place with Theatres to identify the additional operating sessions and take into account the other sites within the catchment area.</p>                                                                               |
| <p>23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6).</p> | <p>Job plans, job descriptions will have to be developed as part of the implementation plan.</p>                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <p>24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7).</p>                                                                                                                                                                                                                                                                                                                  | <p>Agreement that this is part of the implementation plan</p>                                                                               |
| <p>25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7).</p>                                                                                                                                                                            | <p>Not applicable to this Trust</p>                                                                                                         |
| <p>26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7).</p> | <p>Meeting being set up for beginning of May with the Western Trust to begin to work in partnership to discuss the implementation plan.</p> |

Team South Urology Steering Group/Project Board

|                     |                                                                       |
|---------------------|-----------------------------------------------------------------------|
| Dr Gillian Rankin   | Interim Director of Acute Services (Chair)                            |
| Dr Eamon Mackle     | Associate Medical Director – Surgery & Elective Care                  |
| Mr Michael Young    | Clinical Lead Urologist                                               |
| Mr Robin Brown      | Clinical Director – Surgery & Elective Care                           |
| Mrs Heather Trouton | Acting Assistant Director of Acute Services – Surgery & Elective Care |
| Mrs Paula Clarke    | Acting Assistant Director of Performance & Reform                     |
| Mr Ronan Carroll    | Assistant Director of Acute Services – Cancer & Clinical Services     |
| Mr Joe Lusby        | Deputy Chief Executive, Director of Acute Services, Western Trust     |
| GP Representative   | Western Trust                                                         |
| Mrs Helen Walker    | Assistant Director – Human Resources                                  |
| Mrs Carol Cassells  | Senior Financial Management Accountant - Acute Services               |
| Ms Beth Malloy      | Assistant Director Scheduled Services, PMSID, H&SCB                   |

Project Team

|                        |                                                                               |
|------------------------|-------------------------------------------------------------------------------|
| Mrs Heather Trouton    | Acting Assistant Director of Acute Services – Surgery & Elective Care (Chair) |
| Mrs Martina Corrigan   | Head of Urology & ENT                                                         |
| Sandra Waddell         | Head of Planning – Acute                                                      |
| Project Manager        | To be appointed                                                               |
| Heads of Service       | As needed                                                                     |
| Finance Representative |                                                                               |
| HR Representative      |                                                                               |

Clinical Assurance Group

Mr Young  
Mr O'Brien  
Mr Akhtar  
Mrs Martina Corrigan  
Mrs Shirley Tedford  
GP Representative

# Regional Review of Urology Services

## Team South Implementation Plan

| Document History  |                                |
|-------------------|--------------------------------|
| Document Name:    | Team South Implementation Plan |
| Status:           | Draft v0.2                     |
| Version and Date: | V0.2 23 Jun 10                 |
| Origin:           | Acute Planning SHSCT           |

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## 1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

*'Develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'*

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

## 2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

### **The Urology Team**

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The clinical sessions which are currently being undertaken by medical and specialist nursing staff are given as Appendix 1.

### **The ICATS Service**

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

### **Current Sessions**

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

**Table 1: Current Urology Sessions**

|                           | <b>Craigavon</b>           | <b>South Tyrone</b> | <b>Banbridge</b> | <b>Armagh</b> | <b>Total</b> |
|---------------------------|----------------------------|---------------------|------------------|---------------|--------------|
| <b>Consultant Led OPs</b> |                            |                     |                  |               |              |
| General                   | 2.75 per week <sup>1</sup> | 1 per month         | 2 per month      | 2 per month   | 4 per week   |
| Stone Treatment           | 1 weekly                   |                     |                  |               | 1 week       |

| <b>ICATS</b>                 | <b>Weekly</b> |
|------------------------------|---------------|
| Prostate Assessment          | 1.5           |
| Prostate Biopsy              | 1             |
| Prostate Histology           | 1.5           |
| LUTS                         | 3             |
| Haematuria                   | 2             |
| Andrology                    | 2.5           |
| General Urology/Uro Oncology | 2.5           |
|                              |               |
|                              | <b>14</b>     |

| <b>Main Theatres (CAH)</b> | <b>Weekly</b> |                 |
|----------------------------|---------------|-----------------|
|                            | 6             | 3 all day lists |

|                     | <b>Craigavon</b>        | <b>South Tyrone</b> |
|---------------------|-------------------------|---------------------|
| <b>Day Surgery</b>  |                         |                     |
| GA                  | 1 weekly <sup>2</sup>   | 1 monthly           |
| Flexible Cystoscopy | 1.5 weekly <sup>3</sup> |                     |
| Lithotripsy         | 2 weekly                |                     |

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month

2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover

3) 2 lists/1 list on alternate weeks

### **Current Activity**

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. The new outpatient attendances are therefore understated by approximately 240.

**Table 2: 2009/10 Actual Activity for the Urology Service**

|                |                        | <b>Core Activity</b> | <b>IHA</b> | <b>IS</b> | <b>Totals</b> |
|----------------|------------------------|----------------------|------------|-----------|---------------|
| <b>2009/10</b> | Cons Led New OP        | 610                  | 474        | 0         | <b>1084</b>   |
|                | ICATS/Nurse Led New OP | 1233                 | 30         |           | <b>1263</b>   |
|                | Total New OP           | 1843                 | 504        | 0         | <b>2347</b>   |
|                |                        |                      |            |           |               |
|                | Cons Led Review OP     | 2391                 | 70         | 0         | <b>2461</b>   |
|                | ICATS/Nurse Led Rev OP | 1594                 | 0          | 0         | <b>1594</b>   |
|                | Total Review           | 3985                 | 70         | 0         | <b>4055</b>   |
|                |                        |                      |            |           |               |
|                | Day Case               | 1502                 | 3          | 383       | <b>1888</b>   |
|                | Elective FCE           | 1199                 | 29         | 140       | <b>1368</b>   |
|                | Non Elective FCE       | 629                  | 0          | 0         | <b>629</b>    |

Activity by consultant for 2009/10 is provided in Table 3.

**Table 3: Activity by Consultant for 2009/10**

|                |                             | <b>Mr Young<sup>2</sup></b> | <b>Mr O'Brien</b> | <b>Mr Akhtar<sup>3</sup></b> | <b>All Core Activity</b> |
|----------------|-----------------------------|-----------------------------|-------------------|------------------------------|--------------------------|
| <b>2009/10</b> | New OP                      | 242                         | 174               | 193                          | <b>609</b>               |
|                | Review OP                   | 964                         | 903               | 327                          | <b>2194</b>              |
|                | Total OP                    | 1206                        | 1077              | 520                          | <b>2803</b>              |
|                |                             |                             |                   |                              |                          |
|                | Day Case                    | 696                         | 452               | 354                          | <b>1502</b>              |
|                | Elective FCE                | 380                         | 512               | 307                          | <b>1199</b>              |
|                | Non Elective FCE            | 233                         | 210               | 186                          | <b>629</b>               |
|                | FCEs + DCs                  | <b>1309</b>                 | <b>1174</b>       | <b>847</b>                   | <b>3330</b>              |
|                | Day Case Rates <sup>1</sup> | 65%                         | 47%               | 54%                          | 56%                      |

<sup>1</sup> INCLUDES flexible cystoscopies (M45) and DCs/FCEs with no primary procedure recorded.

<sup>2</sup> Mr Young's new outpatients are understated by an estimated 240, as Stone Treatment new attendances were recorded as reviews.

<sup>3</sup> Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

#### **Notes:**

1) Source is Business Objects

2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)



3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).

4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The total number of patients is 4,037. The Trust's plan to deal with this backlog has been included as Appendix 2.

### **Pre-operative Assessment**

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

### **Suspected Urological Cancers**

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The only outstanding issue is that of oncology input to the meeting. Confirmation of when this will be available is awaited from Belfast Trust and it is expected that a date for commencement will be available in the near future.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers

and radiotherapy for all cancers is provided by Belfast Trust. When oncology support is available for the MDM then referral will take place during the meetings. An interim arrangement is in place with referral taking place outside the meetings.

The Trust accepts that all radical pelvic operations will be undertaken at Belfast City Hospital. The Trust asks for clarification with regard to:

- o At what point in the pathway patients should be referred;
- o Arrangements for review of the patients.

### 3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position with further detail being provided in Appendix 3.

**Table 4: Regional Benchmarking**

|                                   |              | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|-----------------------------------|--------------|----------------|----------------|----------------|----------------|
| <b>New : Review Ratio</b>         | All Trusts   | 1.96           | 2.03           | 1.79           | 1.68           |
|                                   | <b>SHSCT</b> | <b>4.04</b>    | <b>3.27</b>    | <b>3.28</b>    | <b>2.09</b>    |
|                                   |              |                |                |                |                |
| <b>Day Case Rates</b>             | All Trusts   | 50.1           | 48.5           | 49.8           | 48.5           |
|                                   | <b>SHSCT</b> | <b>43.8</b>    | <b>45.5</b>    | <b>48.8</b>    | <b>40.0</b>    |
|                                   |              |                |                |                |                |
| <b>Average LOS (elective)</b>     | All Trusts   | 3.7            | 3.5            | 3.4            | 2.9            |
|                                   | <b>SHSCT</b> | <b>3.7</b>     | <b>4.3</b>     | <b>3.9</b>     | <b>2.7</b>     |
|                                   |              |                |                |                |                |
| <b>Average LOS (non elective)</b> | All Trusts   | 4.8            | 4.7            | 4.6            | 4.4            |
|                                   | <b>SHSCT</b> | <b>4.5</b>     | <b>4.8</b>     | <b>4.6</b>     | <b>4.7</b>     |

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1<sup>st</sup> January – 31<sup>st</sup> December 2009 for elective and non elective admissions.

**Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)**

| HRG v3.5                                                                                               | Spells | SHSCT LOS | Peer LOS |
|--------------------------------------------------------------------------------------------------------|--------|-----------|----------|
| L55 - Urinary Tract Findings <70 without complications & comorbidities                                 | 11     | 3.5       | 0.3      |
| L32 - Non-Malignant Prostate Disorders                                                                 | 16     | 3.6       | 2        |
| L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities                         | 670    | 0.3       | 0.1      |
| L14 - Bladder Major Open Procedures or Reconstruction                                                  | 4      | 11        | 6.7      |
| L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis                  | 3      | 4.3       | 0.5      |
| P21 - Renal Disease                                                                                    | 13     | 1.8       | 0.7      |
| L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities             | 21     | 4.4       | 3.1      |
| L52 - Renal General Disorders >69 or with complications & comorbidities                                | 9      | 5.9       | 3.7      |
| L69 - Urinary Tract Stone Disease                                                                      | 37     | 2.3       | 1.9      |
| L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities                 | 28     | 6.7       | 3.2      |
| L02 - Kidney Major Open Procedure >49 or with complications & comorbidities                            | 34     | 9.5       | 7.8      |
| L25 - Bladder Neck Open Procedures Male                                                                | 11     | 6.4       | 4.8      |
| L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities | 5      | 2         | 1.3      |
| L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities | 20     | 9.1       | 8.4      |
| L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities             | 78     | 5.3       | 4.2      |
| L17 - Bladder Major Endoscopic Procedure                                                               | 77     | 4.7       | 3.8      |
| L03 - Kidney Major Open Procedure <50 without complications & comorbidities                            | 9      | 5.7       | 4.8      |
| L13 - Ureter Intermediate Endoscopic Procedure                                                         | 91     | 2.3       | 1.6      |
| L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities                     | 61     | 4.2       | 3        |
| L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities         | 45     | 1.4       | 1.2      |
| L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities                 | 16     | 2.2       | 1.9      |

The British Association of Day Surgery (BADs) produces targets for short stay and day case surgery for the various surgical specialties. The Trust has compared its performance to the BADs targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete). The analysis is provided as Appendix 4.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

#### **4. Demand for Team South Urology Service**

The Trust has utilised the methodology recommended by the Board to calculate the demand for the service. It has been assumed that the population of Fermanagh will be similar to the Southern area. As inclusion of Fermanagh will increase the population catchment area for urology by 18%, an uplift of 18% has been applied. Table 6 overleaf shows the calculation of the estimated demand for the service. It should be noted that this does not factor in any future growth in demand. In addition capacity to deal with the current review backlog has not been included. It has been assumed that the Trust's proposal to manage the review backlog (Appendix 2) will be funded separately.

**Table 6: Projected Activity for Team South**

|                |                        | 2009/10 Actual Activity |     |     |              | SHSCT Activity to be Provided | Team South Capacity Required <sup>6</sup> |
|----------------|------------------------|-------------------------|-----|-----|--------------|-------------------------------|-------------------------------------------|
|                |                        | Core Activity           | IHA | IS  | Growth in WL |                               |                                           |
| <b>2009/10</b> | Cons Led New OP        | 610                     | 474 | 0   | 87           | 1171                          | 1382                                      |
|                | ICATS/Nurse Led New OP | 1233                    | 30  |     | 100          | 1363                          | 1608                                      |
|                | Total New OP           | 1843                    | 504 | 0   | 187          | 2534                          | <b>2990</b>                               |
|                |                        |                         |     |     |              |                               |                                           |
|                | Cons Led Review OP     | 2391                    | 70  | 0   |              | 2461                          | 2904                                      |
|                | ICATS/Nurse Led Rev OP | 1594                    | 0   | 0   |              | 1594                          | 1881                                      |
|                | Total Review           | 3985                    | 70  | 0   |              | 4055                          | <b>4785</b>                               |
|                |                        |                         |     |     |              |                               |                                           |
|                | Day Case               | 1502                    | 3   | 383 | 47           | 1935                          | <b>2283</b>                               |
|                | Elective FCE           | 1199                    | 29  | 140 | 28           | 1396                          | <b>1647</b>                               |
|                | Non Elective FCE       | 629                     | 0   | 0   |              | 629                           | <b>742</b>                                |

1) Source is Business Objects

2) Activity has been counted on specialty of clinic

3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog . As shown N:R = 1:2

4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).

5) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs

6) 18% added for Fermanagh, based on population size relative to SHSCT population

The projected demand from Table 6 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 7 below with the detail of the calculations provided as Appendix 5.

**Table 7: Weekly Sessions for New Service Model**

| <b>Weekly Sessions</b>                 |           |
|----------------------------------------|-----------|
| <b>Consultant Led OPs</b>              |           |
| General                                | 5         |
| Stone Treatment                        | 1         |
|                                        |           |
| <b>ICATS</b>                           |           |
| Prostate Assessment                    | 1.5       |
| Prostate Biopsy <sup>1</sup>           | 1         |
| Prostate Histology <sup>2</sup>        | 1         |
| LUTS                                   | 3         |
| Haematuria                             | 1         |
| Andrology/General Urology/Uro-oncology | 5         |
| Urodynamics                            | 1.5       |
|                                        | <b>14</b> |
|                                        |           |
| <b>Main Theatres</b>                   | 9         |
|                                        |           |
| <b>Day Surgery</b>                     |           |
| GA                                     | 3         |
| Flexible Cystoscopy                    | 3         |
| Lithotripsy                            | 2         |

1) Prostate Assessment and Biopsy will run side by side

2) Consultants will see their own patients, so whilst this has been noted as a single session, it is unlikely to be a single session in practice.

3) All sessions with the exception of ICATS andrology & general urology, will run over 48 weeks. ICATS andrology & general urology will run over 42 weeks.

4) Lithotripsy day case sessions have been calculated over 42 and 48 weeks. A second consultant with special interest in stone treatment will be required if sessions are to run over 48 weeks.

## 5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The ICATS service is currently being reviewed. Some changes which will improve the service provided to patients have already been agreed by clinical staff. These include:

- The prostate pathway has been reviewed (a draft revised pathway is included in Appendix 6). Patients requiring a biopsy will be given the opportunity to have this done on the same day as their initial assessment (where this is clinically appropriate).
- Patients triaged to the haematuria service will have flexible cystoscopy carried out on the same day as their initial assessment. In the current service model these patients have to come back to the hospital to have this done in the Day Surgery Unit.
- Urodynamics will move from the inpatient ward to the Thorndale Unit and sufficient staff will be trained to avoid backlogs of patients awaiting investigation.

The Andrology and General Urology elements of the ICATS service will be reviewed over the coming months.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals. Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time. The frequency of sessions has to be agreed with the Western Trust.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Banbridge Poly Clinic, Armagh Community Hospital and Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

Consultant and Nurse led sessions will be provided over 48 weeks. The detail of job plans is to be agreed with clinical staff but they will be based around the sessions identified in the previous section. Due to the availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.



Work is ongoing to develop patient flow and clinical pathways for the service. Draft pathways are included as Appendix 6. The on call urologist at Craigavon Area Hospital will be available to provide advice at any time to medical staff at the Erne or Daisy Hill Hospitals on the management or transfer of emergency cases.

## 6. Timetable for Implementation

| <b>Task</b>                                                | <b>Timescale</b> |
|------------------------------------------------------------|------------------|
| Submission of Team South Implementation Plan               | 23 June 10       |
| Approval to Proceed with Implementation from HSCB          | July 10          |
| Completion of Job Plans/Descriptions for Consultant Posts  | End July 10      |
| Completion of Job Plans/Descriptions for Specialist Nurses | End July 10      |
| Consultant Job Plans to Specialty Advisor                  | End July 10      |
| Advertisement of Consultant Posts                          | September 10     |
| Advertisement of Specialist Nurse Posts                    | September 10     |
| New Consultants and Specialist Nurses in post              | February 11      |

# ***APPENDICES***

## Appendix 1

**Clinicians Name – Mr Young**

**Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Consultant**

|                                                                                                                                                                                                                                           | <b>AM – 4 Hour Session</b>                                                                                                                                                                                                                                                                | <b>PM – 4 Hour Session</b>                                                                                                                                                    | <b>Other</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade<br>of clinicians at clinic<br>Number of slots per clinic?  | 1 outpatient clinic per month Banbridge (9 patients per Doctor)<br>1 outpatient clinic per month Armagh Clinic (9 patients per doctor)<br>CAH STC Clinic (12 – 2pm) STC Cover treatments and<br>Outpatient Clinic (between 9 & 24 patients)<br>Consultant, SPR and Nurses<br>Lithotripter | Day 4 Clinic Thorndale, CAH (between 2-3 patients)<br>No Equipment<br>Specialist Nurse<br><br>Ultrasound Dynamics (2 patients)<br>Urodynamic machine<br><br>Specialist Nurses |              |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade<br>of clinicians at clinic<br>Number of slots per clinic? | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br><br>DSU 1 per month CAH (4-5 patients)<br><br>See attached equipment list that is used in theatres                                                                                                                    | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br><br>See attached equipment list that is used in theatres                                                  |              |
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?                                                                                      | CAH<br>STC Treatments – (day Cases – 4 treatments) - Lithotripter<br>Administration<br>Main Theatre Backfill                                                                                                                                                                              |                                                                                                                                                                               |              |

|                                                                                                                                                                                                                                         |                                                                                                                                 |                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--|
| Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?                                                                                                                                                        | See attached equipment list that is used in theatres                                                                            |                                                                                  |  |
| <b>Thursday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? | CAH<br>X-Ray Conference<br>Grand Ward Round<br>Departmental Meeting                                                             | MDT                                                                              |  |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?   | CAH<br>Teaching<br>Administration<br>Lead Clinician<br>Theatre Backfill<br>See attached equipment list that is used in theatres | CAH<br>Outpatient Clinic<br>Cons + SPR<br>10 patients per doctor<br>No equipment |  |
| <b>Saturday</b>                                                                                                                                                                                                                         |                                                                                                                                 |                                                                                  |  |
| <b>Sunday</b>                                                                                                                                                                                                                           |                                                                                                                                 |                                                                                  |  |

**Clinicians Name – Mr Aidan O'Brien Consultant Urologist**

**Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate - Consultant**

|                                                                                                                                                                                                                                          | AM – 4 Hour Session                                                                                                                                                                                                                                                                                      | PM – 4 Hour Session                                                                                                      | Other                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?    | 1out patient clinic per month<br>Banbridge (9 patients per Doctor)<br>1 outpatient clinic per month<br>Armagh (9 patients per doctor)<br>Alternative weeks when not in outreach<br>Day 4 (2 patients) or Urodynamics studies (2 patients) Thorndale CAH<br>Urodynamic equipment<br>Consultant & 2 nurses | Day 4 (2 patients) or<br>Urodynamics studies (2 patients) Thorndale CAH<br>Urodynamic equipment<br>Cons + 2 Nurses       | Ward Rounds<br>Administration |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?   | Day Surgery x 2 monthly sessions<br>CAH<br>4 patients<br>Alternative Tuesday's<br>Thorndale Unit<br>Review of Cases                                                                                                                                                                                      | Outpatient Clinic<br>CAH<br>CONS + Register<br>10 Slots per Clinician                                                    | Ward Rounds<br>Administration |
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br><br>See attached equipment list that is used in theatres                                                                                                                                                                             | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br>See attached equipment list that is used in theatres | Ward Rounds<br>Administration |

|                                                                                                                                                                                                                                            |                                                                                                                                                  |                                                                                                                                                           |                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>Thursday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade<br>of clinicians at clinic<br>Number of slots per clinic? | CAH<br>X – Ray Meeting - 8.30am<br>Grand Ward Round - 10am<br>Departmental Meeting -12noon                                                       | CAH<br>MDM - 2.15pm                                                                                                                                       | Administration |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade<br>of clinicians at clinic<br>Number of slots per clinic?   | Day Review or<br>NHS Patients or<br>Private Patients or<br>Backfill Theatre Inpatient<br>See attached equipment list that is<br>used in theatres | Thorndale<br>Urodynamic Studies<br>X 2 patients<br>Consultant and 2 nurses<br>Urodynamic equipment<br>Day 4 Reviews<br>Consultant and specialist<br>nurse | Ward Round     |
| <b>Saturday</b>                                                                                                                                                                                                                            | Wards / Theatre / Administration                                                                                                                 |                                                                                                                                                           |                |
| <b>Sunday</b>                                                                                                                                                                                                                              | Emergencies only                                                                                                                                 |                                                                                                                                                           |                |

**Clinicians Name – Mr Akhtar**

**Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Consultant**

|                                                                                                                                                                                                                                          | <b>AM – 4 Hour Session</b>                                                                                                                             | <b>PM – 4 Hour Session</b>                                                                                 | <b>Other</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|--------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?    | CAH<br>Ward Round & patient Administration                                                                                                             | CAH<br>Outpatient Clinic<br>12 patients<br>Consultant only<br>No equipment                                 |              |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?   | South Tyrone Hospital<br>2 sessions per month<br>Day Surgery/Flexis<br>4 patients/10 patients<br>No Equipment<br><br>Alternative Tuesdays<br>SPA – CAH | South Tyrone Hospital<br>1 Session per month<br>Outpatient Clinic<br>9 Patients per doctor<br>No Equipment |              |
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? |                                                                                                                                                        | CAH<br>SPA Activities]                                                                                     |              |

|                                                                                                                                                                                                                                            |                                                                                                                                 |                                                                                                                                 |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|
| <b>Thursday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic? | CAH<br>Xray Meeting<br>Grand Ward Round<br>Departmental Meeting                                                                 | CAH<br>MDT – Acting Lead clinician                                                                                              |  |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic?   | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br><br>See attached equipment list that is<br>used in theatres | Main Theatre CAH<br>Inpatients<br>(numbers will depend on cases)<br><br>See attached equipment list that<br>is used in theatres |  |
| <b>Saturday</b>                                                                                                                                                                                                                            |                                                                                                                                 |                                                                                                                                 |  |
| <b>Sunday</b>                                                                                                                                                                                                                              |                                                                                                                                 |                                                                                                                                 |  |



**Clinicians Name – Dr Rogers GPSI**

**Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: GPwSI**

|                                                                                                                                                                                                                                             | <b>AM – 4 Hour Session</b>                                                        | <b>PM – 4 Hour Session</b>                                                        | <b>Other</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic?    | OFF                                                                               | OFF                                                                               |              |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic?   | Thorndale CAH<br>Andrology Clinic<br><br>Outpatients 8-9 pt's<br><br>No Equipment | Thorndale CAH<br>Andrology Clinic<br><br>Outpatients 5-6 pt's<br><br>No Equipment |              |
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic? | Administration Session                                                            | Thorndale, CAH<br>General Urology clinic<br><br>10 patients<br><br>Ultrasound     |              |

|                                                                                                                                                                                                                                            |                                                                                                             |                                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|--|
| <b>Thursday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic? | Thorndale, CAH<br>Alternative weeks<br>Andrology / Prostate Diagnostic<br><br>10 patients<br><br>Ultrasound | Administration Session                                                        |  |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic?   | Thorndale, CAH<br>Stable Prostrate Cancer Clinic<br><br>5pt's<br><br>No Equipment                           | OPD CAH<br>Mr Young backlog Review<br>Clinic<br>7patients<br><br>No Equipment |  |
| <b>Saturday</b>                                                                                                                                                                                                                            |                                                                                                             |                                                                               |  |
| <b>Sunday</b>                                                                                                                                                                                                                              |                                                                                                             |                                                                               |  |

**Clinicians Name – Mr Jerome Marley – Nurse Lecturer**

**Consultant or Staff Grade or Clinical Nurse Specialist or GPSI or other – Please indicate: Specialist Nurse**

|                                                                                                                                                                                                                                          | <b>AM – 4 Hour Session</b>                                                               | <b>PM – 4 Hour Session</b> | <b>Other</b> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------|--------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?    |                                                                                          |                            |              |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?   | Thorndale<br>Joint Andrology Clinic with DR Rogers<br>Patients 9<br>No Equipment         |                            |              |
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? | CAH<br>Stone Treatment Centre<br><br>Lithotripsy Operator<br><br>4 Patients Lithotripter |                            |              |
| <b>Thursday</b>                                                                                                                                                                                                                          |                                                                                          |                            |              |

|                                                                                                                                                                                                                                          |  |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
| Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic?                  |  |  |  |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of<br>clinicians at clinic<br>Number of slots per clinic? |  |  |  |
| <b>Saturday</b>                                                                                                                                                                                                                          |  |  |  |
| <b>Sunday</b>                                                                                                                                                                                                                            |  |  |  |

**Clinicians Name – Clinical Nurse Specialists Jenny McMahon & Kate O’Neil –**

As these services have evolved it has proved most effective to have flexibility across the timetable, therefore sessions can be covered by either nurse, example of this below. Kate works a 5day week – (K), Jenny works a 4 day week (J)

**All services below are provided on an out-patient basis within the Thorndale Unit at Craigavon Hospital.**

Thorndale Staff (in addition to nurse specialists) The staff nurses provide support to all clinics within the Thorndale Unit, for example prostate biopsy & decontamination, haematuria assessment & venepuncture for all GPwSI clinics

S/N Kate McCreesh 23hrs

S/N Dolores Campbell 23hrs

S/N Mairead Leonard 34hrs (17hrs Urodynamics) N/A Marie Briggs 30hrs assist with all clinics

|                                                                                                                                                                                                                                        | <b>AM – 4 Hour Session</b>                                                                                                                                                       | <b>PM – 4 Hour Session</b>                                                                                                          | <b>Other</b>                                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?  | (J) Lower urinary tract symptom (LUTS) review clinic 8 patients<br>(K) Prostate assessment clinic 4patients<br>Ultrasound/ Flow meter & bladder scanner                          | (J) LUTS new clinic 4 patients<br>(K) Prostate histology 4-6 patients<br>(S/N) Ward histology 8 patients<br>Ultrasound / Flow meter | (J/K) mon pm – Ad hoc Consultant clinic for e.g. staging results, urgent referrals                                                                                                                                        |
| <b>Tuesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? | (J&K) Prostate biopsy 5 patients – L/A and decontamination required<br>Andrology service – (J&K) support from nurse specialist in absence of lecturer practitioner<br>Ultrasound | Andrology service – (K) support GPwSI                                                                                               | Tues pm – Admin (J)<br><br>All admin. Sessions include for eg. Virtual histology clinic for negative biopsy preparation for diagnostic services & cancer support for patients & ward management duties for Thorndale unit |

|                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                           |                                                                    |                                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <b>Wednesday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic? | (K) Prostrate biopsy 4 patients alternate weeks<br>L/A and decontamination required<br>(S/N) Haematuria clinic 4 patients<br>(K) Ad hoc Consultant clinic for eg. Staging results urgent referrals<br>(S/N) ward Histology 6 patients 1-2 clinics per month<br>Ultrasound | Urology clinic – (K) support GPwSI                                 | Jenny off Wednesday                                                                           |
| <b>Thursday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?  | (J) Prostate assessment clinic 4 patients (red flag) alternate weeks /andrology service – 4 patients alternate weeks<br>Urology review clinic 4 patients support GPwSI<br>Ultrasound                                                                                      | MDM<br>Both nurse specialist attend                                | (K) Admin Thursday am                                                                         |
| <b>Friday</b><br>Where is the location?<br>What service is provided?<br>Theatre – IP or DC or LA<br>Diagnostic Session<br>What equipment is used?<br>Outpatient – Number/grade of clinicians at clinic<br>Number of slots per clinic?    | (J) LUTS new clinic 4 patients<br>(K) Cancer review clinic 4 patients<br>Ultrasound                                                                                                                                                                                       | (S/N) Flexible Cystoscopy list (as part of the Haematuria Service) | Admin session for nurse specialists/ cover for flexible cystoscopy if staff nurse unavailable |

**Equipment that Consultant Urologist's use in Craigavon Area Hospital Main Theatre**

Maquet operating table with appropriate attachments for abdominal x raying and for positioning patients in lithotomy position.

Holmium 100watt laser and consumables eg. Laser fibres 200, 350 and 500, cleaving tools for each fibre and cutting tool for same. Laser safety glasses.

Image intensifier, light weight lead coats and thyroid collars.

Swiss lithoclast Master.

Ultracision

Camera stacking system with recording and insufflator.

Omnitract or a Book Walter retractor

Instrumentation

Flexible cystoscopy

Flexible ureteroscopes

Rigid ureterorenoscopes, sizes 6fg and 8/9 fg

Rigid cystscopes size 21fg 23.5 fg 17 fg

Resectoscopes size 26fg continous.

Bipolar resectoscopes

Stent removing forceps

Bladder biopsy forceps, rigid and flexible

Ureteric grasping forceps and bladder grasping forceps

Internal ureterotomy trays

Mauyer Mayer stone crusher

PCNL trays

0 degree telescopes

Laprascopic instruments for hand assisted nephrectomy

Numerous consumables eg stents, guidewires, urethral catheters, baskets for removing stones, dilators, giving sets, ellicks evacuator.



## Appendix 2

### Proposal to Manage Urology Review Backlog

Process to manage the substantial volume of patients involved in Urology -  
Total = 4037 (2008- 31 May 2010)

- Identify patients who may be at risk and require an urgent review
- Identify patients who require a consultant reassessment in an agreed timeframe
- Cleanse list – ensure that there are no duplicate open requests for same issue.

The Specialty Nurses have agreed to coordinate the process by reviewing patient centre letters and results and collate into the following categories:-

**Category 1:** Urgent appointment required  
Automatically arrange an urgent review appointment

**Category 2:** Decision required on review management  
Lead nurse will meet with consultant to determine a plan for each patient, i.e. either agree review required in a specified time frame or agree an alternative plan.

**Category 3:** ?Discharge based on clinical results available  
Lead nurse to get permission from consultant to discharge and send letter to GP and patient

**Category 4:** PAS errors/duplication  
Lead nurse to get permission from consultant to discharge from PAS

To date there has been a reduction in the waiting list by 6%.

## Appendix 3

### Regional Benchmarking

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland for:

- New to review ratios;
- Day Case rates;
- Average length of stay for elective and non elective procedures.

#### **New : Review Ratio**

1/04/06 - 28/02/10

|            | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|------------|----------------|----------------|----------------|----------------|
| All Trusts | 1.96           | 2.03           | 1.79           | 1.68           |

|                       | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|-----------------------|----------------|----------------|----------------|----------------|
| Belfast Trust         | 1.63           | 2.09           | 1.77           | 1.72           |
| Northern Trust        | 1.97           | 1.67           | 1.31           | 1.75           |
| South Eastern Trust   | 1.15           | 1.1            | 1.15           | 1.25           |
| <b>Southern Trust</b> | <b>4.04</b>    | <b>3.27</b>    | <b>3.28</b>    | <b>2.09</b>    |
| Western Trust         | 2.65           | 2.32           | 2.49           | 1.73           |

**Note – the** review backlog will have skewed the figures for 2009/10 (perhaps for all Trusts)

**Day Case Rates by Trust**

April 06 - Feb 10

(Excludes Prim Op M45 and Not coded procedures) (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

|            |                     | 2006/07     | 2007/08     | 2008/09     | 2009/10     |
|------------|---------------------|-------------|-------------|-------------|-------------|
| All Trusts | Day Cases           | 3793        | 3733        | 4255        | 3492        |
|            | Elective Admissions | 3780        | 3963        | 4293        | 3710        |
|            | DCs+ElecAdm         | 7,573       | 7,696       | 8,548       | 7,202       |
|            | <b>Daycase Rate</b> | <b>50.1</b> | <b>48.5</b> | <b>49.8</b> | <b>48.5</b> |

|                     |                     | 2006/07      | 2007/08      | 2008/09      | 2009/10      |
|---------------------|---------------------|--------------|--------------|--------------|--------------|
| Belfast Trust       | Daycases            | 1737         | 1584         | 1896         | 1615         |
|                     | Elective Admissions | 1938         | 2092         | 2015         | 1873         |
|                     | Total               | <b>3,675</b> | <b>3,676</b> | <b>3,911</b> | <b>3,488</b> |
|                     | <b>DC Rates</b>     | 47.3         | 43.1         | 48.5         | 46.3         |
| Northern Trust      | Daycases            | 211          | 209          | 241          | 372          |
|                     | Elective Admissions | 465          | 430          | 582          | 448          |
|                     | Total               | <b>676</b>   | <b>639</b>   | <b>823</b>   | <b>820</b>   |
|                     | <b>DC Rates</b>     | 31.2         | 32.7         | 29.3         | 45.4         |
| South Eastern Trust | Daycases            | 930          | 912          | 940          | 751          |
|                     | Elective Admissions | 257          | 325          | 369          | 328          |
|                     | Total               | <b>1,187</b> | <b>1,237</b> | <b>1,309</b> | <b>1,079</b> |
|                     | <b>DC Rates</b>     | 78.3         | 73.7         | 71.8         | 69.6         |
| Southern Trust      | Daycases            | 579          | 576          | 770          | 433          |
|                     | Elective Admissions | 742          | 691          | 807          | 650          |
|                     | Total               | <b>1,321</b> | <b>1,267</b> | <b>1,577</b> | <b>1,083</b> |
|                     | <b>DC Rates</b>     | 43.8         | 45.5         | 48.8         | 40.0         |
| Western Trust       | Daycases            | 336          | 452          | 408          | 321          |
|                     | Elective Admissions | 378          | 425          | 520          | 411          |
|                     | Total               | <b>714</b>   | <b>877</b>   | <b>928</b>   | <b>732</b>   |
|                     | <b>DC Rates</b>     | 47.1         | 51.5         | 44.0         | 43.9         |

**Urology - Average LOS (Episode based)**

April 06 - Feb 10

**Elective**

|            | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|------------|----------------|----------------|----------------|----------------|
| All Trusts | 3.7            | 3.5            | 3.4            | 2.9            |

|                            | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|----------------------------|----------------|----------------|----------------|----------------|
| <b>Belfast Trust</b>       | 3.9            | 3.5            | 3.5            | 3.3            |
| <b>Northern Trust</b>      | 2.3            | 2.9            | 2.4            | 1.9            |
| <b>South Eastern Trust</b> | 3.8            | 4.0            | 3.4            | 3.2            |
| <b>Southern Trust</b>      | 3.7            | 4.3            | 3.9            | 2.7            |
| <b>Western Trust</b>       | 3.6            | 2.9            | 3.2            | 2.9            |

**Non Elective**

|            | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|------------|----------------|----------------|----------------|----------------|
| All Trusts | 4.8            | 4.7            | 4.6            | 4.4            |

|                            | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|----------------------------|----------------|----------------|----------------|----------------|
| <b>Belfast Trust</b>       | 5.5            | 4.9            | 5.4            | 5.0            |
| <b>Northern Trust</b>      | 4.3            | 5.4            | 4.9            | 3.7            |
| <b>South Eastern Trust</b> | 3.9            | 4.4            | 3.5            | 3.8            |
| <b>Southern Trust</b>      | 4.5            | 4.8            | 4.6            | 4.7            |
| <b>Western Trust</b>       | 3.9            | 3.8            | 4.1            | 3.4            |

## Appendix 4

### **British Association of Day Surgery (BADs)**

The British Association of Day Surgery (BADs) produces targets for short stay and day case surgery for the various surgical specialties. The tables overleaf compare the Trust's performance with the BADs targets for urology. The following notes apply:

- The first table relates to Trust activity for 2009/10. At 2<sup>nd</sup> June 2010 175 elective finished consultant episodes (FCEs) and 182 day cases were not coded;
- Elective FCEs and day cases have been included (no non elective activity);
- Only activity undertaken by the 3 consultant urologists has been included in the analysis.

**British Association of Day Surgery (BADs) Basket of Procedures for Urology  
2009/10 SHSCT Data**

|    |                                                               |                                      | BADs RECOMMENDATION |                |                 | SHSCT PERFORMANCE |                |                 |
|----|---------------------------------------------------------------|--------------------------------------|---------------------|----------------|-----------------|-------------------|----------------|-----------------|
|    |                                                               |                                      | DAY CASE %          | 23 HOUR STAY % | UNDER 72 HOUR % | DAY CASE %        | 23 HOUR STAY % | UNDER 72 HOUR % |
| 1  | Ureteroscopic extraction of calculus of ureter                | M27.1, M27.2, M27.3                  | 50                  | 50             |                 | 0%                | 53%            |                 |
| 2  | Endoscopic insertion of prosthesis into ureter                | M29.2, M29.5                         | 90                  | 10             |                 | 0%                | 38%            |                 |
| 3  | Removal of prosthesis from ureter                             | M29.3                                | 100                 |                |                 | 38%               |                |                 |
| 4  | Endoscopic retrograde pyelography                             | M30.1                                | 90                  | 10             |                 | 5%                | 84%            |                 |
| 5  | Other endoscopic procedures on ureter                         | M27, M28, M29.1, M29.4, M29.8, M29.9 | 90                  | 10             |                 | 13%               | 46%            |                 |
| 6  | Cystostomy and insertion of suprapubic tube into bladder      | M38.2                                | 90                  | 10             |                 | 0%                | 10%            |                 |
| 7  | Endoscopic resection/ destruction of lesion of bladder        | M42                                  | 20                  | 50             | 30              | 3%                | 32%            | 23%             |
| 8  | Endoscopic extraction of calculus of bladder                  | M44.1, M44.2                         | 50                  | 50             |                 | 0%                | 10%            |                 |
| 9  | Diagnostic endoscopic examination of bladder (inc any biopsy) | M45                                  | 90                  | 10             |                 | 87%               | 8%             |                 |
| 10 | Operations to manage female incontinence                      | M53.3, M53.6, M53.8                  | 80                  | 10             | 10              | 0%                | 0%             | 100%            |
| 11 | Dilation of outlet of female bladder                          | M58.2                                |                     | 90             | 10              | 100%              |                |                 |
| 12 | Endoscopic incision of outlet of male bladder                 | M66.2                                | 50                  | 50             |                 | 14%               | 71%            |                 |
| 13 | Endoscopic examination of urethra +/- biopsy                  | M77                                  |                     | 100            |                 | 100%              |                |                 |
| 14 | Endoscopic resection of prostate (TUR)                        | M65.1, M65.2, M65.3, M65.8           | 15                  | 45             | 40              | 0%                | 0%             | 20%             |

|    | DESCRIPTION                                                  | OPCS Codes                             | BADS RECOMMENDATION |                |                 | SHSCT PERFORMANCE |                |                 |
|----|--------------------------------------------------------------|----------------------------------------|---------------------|----------------|-----------------|-------------------|----------------|-----------------|
|    |                                                              |                                        | DAY CASE %          | 23 HOUR STAY % | UNDER 72 HOUR % | DAY CASE %        | 23 HOUR STAY % | UNDER 72 HOUR % |
| 15 | Resection of prostate by laser                               | M65.4, M65.3+Y08.3, M65.3+Y08.4        | 90                  | 10             |                 | 0%                | 33%            |                 |
| 16 | Prostate destruction by other means                          | M67.1,M67.2, M67.5, M67.6              | 90                  | 10             |                 |                   |                |                 |
| 17 | Operations on urethral orifice                               | M81                                    | 90                  | 10             |                 | 33%               | 50%            |                 |
| 18 | Orchidectomy                                                 | N05, N06.1, N06.2, N06.3, N06.8, N06.9 | 90                  | 10             |                 | 44%               | 56%            |                 |
| 19 | Excision of lesion of testis                                 | N06.4, N07                             | 90                  | 10             |                 |                   |                |                 |
| 20 | Orchidopexy - bilateral                                      | N08                                    | 60                  | 35             | 5               |                   |                |                 |
| 21 | Orchidopexy                                                  | N09                                    | 75                  | 20             | 5               | 60%               | 40%            |                 |
| 22 | Correction of hydrocoele                                     | N11                                    | 90                  | 10             |                 | 80%               | 10%            |                 |
| 23 | Excision of epididymal lesion                                | N15                                    | 90                  | 10             |                 | 90%               | 0%             |                 |
| 24 | Operation (s) on varicocoele                                 | N19                                    | 90                  | 10             |                 | 60%               | 40%            |                 |
| 25 | Excision of lesion of penis                                  | N27                                    | 50                  | 50             |                 | 100%              |                |                 |
| 26 | Frenuloplasty of penis                                       | N28.4                                  | 90                  | 10             |                 | 100%              |                |                 |
| 27 | Operations on foreskin - circumcision, division of adhesions | N30                                    | 90                  | 10             |                 | 71%               | 14%            |                 |
| 28 | Optical urethrotomy                                          | M76.3                                  | 90                  | 10             |                 | 7%                | 56%            |                 |
| 29 | Laparoscopic nephrectomy                                     | M02.1,M02.5,M02.8, M02.9 (+Y75.2)      | 5                   | 75             | 25              | 0%                | 11%            | 0%              |
| 30 | Laparoscopic pyeloplasty                                     | M05.1+Y75.2                            | 10                  | 80             | 10              |                   |                |                 |
| 31 | Laparoscopic radical prostatectomy                           | M61.1,M61.2,M61.9 (+Y75.2)             |                     | 5              | 90              |                   | 0%             | 0%              |

**British Association of Day Surgery (BADS) Basket of Procedures for Urology**  
**2008/09 SHSCT Data**

|    | DESCRIPTION                                                   | OPCS Codes                                   | BADS RECOMMENDATION |                |           | SHSCT PERFORMANCE |                |           |
|----|---------------------------------------------------------------|----------------------------------------------|---------------------|----------------|-----------|-------------------|----------------|-----------|
|    |                                                               |                                              | DAY CASE %          | 23 HOUR STAY % | 72 HOUR % | DAY CASE %        | 23 HOUR STAY % | 72 HOUR % |
| 1  | Ureteroscopic extraction of calculus of ureter                | M27.1, M27.2, M27.3                          | 50                  | 50             |           | 11%               | 11%            |           |
| 2  | Endoscopic insertion of prosthesis into ureter                | M29.2, M29.5                                 | 90                  | 10             |           | 0%                | 0%             |           |
| 3  | Removal of prosthesis from ureter                             | M29.3                                        | 100                 |                |           | 47%               |                |           |
| 4  | Endoscopic retrograde pyelography                             | M30.1                                        | 90                  | 10             |           | 5%                | 37%            |           |
| 5  | Other endoscopic procedures on ureter                         | M27.4-M27.8, M28, M29.1, M29.4, M29.8, M29.9 | 90                  | 10             |           | 12%               | 24%            |           |
| 6  | Cystostomy and insertion of suprapubic tube into bladder      | M38.2                                        | 90                  | 10             |           | 8%                | 8%             |           |
| 7  | Endoscopic resection/ destruction of lesion of bladder        | M42                                          | 20                  | 50             | 30        | 3%                | 10%            | 35%       |
| 8  | Endoscopic extraction of calculus of bladder                  | M44.1, M44.2                                 | 50                  | 50             |           | 13%               | 30%            |           |
| 9  | Diagnostic endoscopic examination of bladder (inc any biopsy) | M45                                          | 90                  | 10             |           | 91%               | 4%             |           |
| 10 | Operations to manage female incontinence                      | M53.3, M53.6, M53.8                          | 80                  | 10             | 10        | 100%              |                |           |
| 11 | Dilation of outlet of female bladder                          | M58.2                                        |                     | 90             | 10        |                   |                |           |
| 12 | Endoscopic incision of outlet of male bladder                 | M66.2                                        | 50                  | 50             |           | 0%                | 33%            |           |
| 13 | Endoscopic examination of urethra +/- biopsy                  | M77                                          |                     | 100            |           | 100%              |                |           |
| 14 | Endoscopic resection of prostate (TUR)                        | M65.1, M65.2, M65.3, M65.8                   | 15                  | 45             | 40        | 2%                | 28%            | 5%        |
| 15 | Resection of prostate by laser                                | M65.4, M65.3+Y08.3, M65.3+Y08.4              | 90                  | 10             |           |                   |                |           |
| 16 | Prostate destruction by other means                           | M67.1, M67.2, M67.5, M67.6                   | 90                  | 10             |           |                   |                |           |
| 17 | Operations on urethral orifice                                | M81                                          | 90                  | 10             |           | 86%               | 14%            |           |



|    |                                                              |                                        | BADS RECOMMENDATION |                |           | SHSCT PERFORMANCE |                |           |
|----|--------------------------------------------------------------|----------------------------------------|---------------------|----------------|-----------|-------------------|----------------|-----------|
|    | DESCRIPTION                                                  | OPCS Codes                             | DAY CASE %          | 23 HOUR STAY % | 72 HOUR % | DAY CASE %        | 23 HOUR STAY % | 72 HOUR % |
| 18 | Orchidectomy                                                 | N05, N06.1, N06.2, N06.3, N06.8, N06.9 | 90                  | 10             |           | 14%               | 27%            |           |
| 19 | Excision of lesion of testis                                 | N06.4, N07                             | 90                  | 10             |           | 100               |                |           |
| 20 | Orchidopexy - bilateral                                      | N08                                    | 60                  | 35             | 5         | 100               |                |           |
| 21 | Orchidopexy                                                  | N09                                    | 75                  | 20             | 5         |                   |                |           |
| 22 | Correction of hydrocoele                                     | N11                                    | 90                  | 10             |           | 60%               | 28%            |           |
| 23 | Excision of epididymal lesion                                | N15                                    | 90                  | 10             |           | 75%               | 13%            |           |
| 24 | Operation (s) on varicocoele                                 | N19                                    | 90                  | 10             |           | 78%               | 11%            |           |
| 25 | Excision of lesion of penis                                  | N27                                    | 50                  | 50             |           | 80%               |                |           |
| 26 | Frenuloplasty of penis                                       | N28.4                                  | 90                  | 10             |           | 60%               | 40             |           |
| 27 | Operations on foreskin - circumcision, division of adhesions | N30                                    | 90                  | 10             |           | 66%               | 22%            |           |
| 28 | Optical urethrotomy                                          | M76.3                                  | 90                  | 10             |           | 22%               | 25%            |           |
| 29 | Laparoscopic nephrectomy                                     | M02.1,M02.5,M02.8,M02.9 (+Y75.2)       | 5                   | 75             | 25        | 0%                | 14%            | 0%        |
| 30 | Laparoscopic pyeloplasty                                     | M05.1+Y75.2                            | 10                  | 80             | 10        |                   |                |           |
| 31 | Laparoscopic radical prostatectomy                           | M61.1,M61.2,M61.9 (+Y75.2)             |                     | 5              | 90        |                   |                |           |

Total increase in daycases in 2008/09 if BADS recommended daycase rates achieved = 215

Updated following meeting on 17 Jun 10 to sign off planning assumptions

## Appendix 5

### Projected Activity & Sessions v0.1 23 June 10

Table 1 below gives the Board's calculation of the capacity gap, and using the Board's methodology, the projected activity for 'Team South'.

|                |                        | 2009/10 Actual Activity |     |     |                 | SHSCT<br>Activity to<br>be Provided | SBA  | SHSCT<br>Capacity<br>Gap | Team<br>South<br>Capacity<br>Required <sup>6</sup> |
|----------------|------------------------|-------------------------|-----|-----|-----------------|-------------------------------------|------|--------------------------|----------------------------------------------------|
|                |                        | Core Activity           | IHA | IS  | Growth<br>in WL |                                     |      |                          |                                                    |
| <b>2009/10</b> | Cons Led New OP        | 610                     | 474 | 0   | 87              | 1171                                | 1014 | 157                      | 1382                                               |
|                | ICATS/Nurse Led New OP | 1233                    | 30  |     | 100             | 1363                                | 990  | 373                      | 1608                                               |
|                | Total New OP           | 1843                    | 504 | 0   | 187             | 2534                                | 2004 | 530                      | <b>2990</b>                                        |
|                |                        |                         |     |     |                 |                                     |      |                          |                                                    |
|                | Cons Led Review OP     | 2391                    | 70  | 0   |                 | 2461                                | 3290 | -829                     | 2904                                               |
|                | ICATS/Nurse Led Rev OP | 1594                    | 0   | 0   |                 | 1594                                | 990  | 604                      | 1881                                               |
|                | Total Review           | 3985                    | 70  | 0   |                 | 4055                                | 4280 | -225                     | <b>4785</b>                                        |
|                |                        |                         |     |     |                 |                                     |      |                          |                                                    |
|                | Day Case               | 1502                    | 3   | 383 | 47              | 1935                                | 1239 | 696                      | <b>2283</b>                                        |
|                | Elective FCE           | 1199                    | 29  | 140 | 28              | 1396                                | 780  | 616                      | <b>1647</b>                                        |
|                | Non Elective FCE       | 629                     | 0   | 0   |                 | 629                                 | 816  | -187                     | <b>742</b>                                         |

1) Source is Business Objects

2) Activity has been counted on specialty of clinic

3) Review activity is actual activity and N:R ratio will be skewed because of the significant review backlog (4037 in June 2010). As shown N:R = 1:2

4) OP WL between end Mar 09 & end Mar 10 had increased by 187 (Information Dept).

5) 18% added for Fermanagh, based on population size relative to SHSCT population

6) SBA for ICATS is 1980 (no split between new and reviews so have just divided equally)

Updated following meeting on 17 Jun 10 to sign off planning assumptions

### **Outpatients**

To enable the numbers of clinic sessions to be calculated, Table 2 splits the numbers of new outpatient attendances by clinic, based on the 2009/10 attendances.

**Table 2: New Outpatient Attendances**

| <b>Clinic</b>                    | <b>Core</b> | <b>IHA</b> | <b>Total</b> | <b>%</b> | <b>Growth</b> | <b>SHSCT<br/>Total</b> | <b>Team<br/>South <sup>3</sup></b> |
|----------------------------------|-------------|------------|--------------|----------|---------------|------------------------|------------------------------------|
| Prostate TRUSA (&B)              | 248         |            | 248          | 10.6%    | 20            | 268                    | 316                                |
| LUTS                             | 323         |            | 323          | 13.8%    | 26            | 349                    | 412                                |
| Andrology/Dr Rodgers gen urology | 476         | 30         | 506          | 21.6%    | 40            | 546                    | 645                                |
| Haematuria                       | 186         |            | 186          | 7.9%     | 15            | 201                    | 237                                |
| Consultants clinics              | 374         | 474        | 848          | 36.1%    | 68            | 916                    | 1080                               |
| Urodynamics (consultants)        | 236         |            | 236          | 10.1%    | 19            | 255                    | 301                                |
|                                  | 1843        | 504        | <b>2347</b>  | 100.0%   | 187           | 2534                   | <b>2990</b>                        |

Stone Treatment new outpatients are being recorded as reviews and are therefore not included in the figures. This means that new outpatients at consultant clinics are under stated by approximately 240 attendances.

**Sessions are based on 48 weeks unless otherwise stated.****Prostate Pathway (Revised)**

**1<sup>st</sup> appointment** – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do digital rectal examination (DRE), take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 69% of patients will require biopsy (218)

316 patients @ 5 per session = 63 sessions per annum = 1.3 assessment sessions per week.

218 cases for biopsy @ 5 per session = 44 sessions per annum. 1 biopsy session per week should therefore suffice (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

**2<sup>nd</sup> appointment** will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. It is estimated that 40% of patients who have had biopsy will have positive pathology (using 40% this would be 88 patients. Adding on 10% for those patients with benign pathology who will need to come in for their results gives a figure of 97 patients needing a second appointment. This equates to 2 patients each week (over 48 weeks). These patients are now being seen by a registrar but the consultants want to build time into the new service model to see the patients themselves.

**3<sup>rd</sup> appointment** will be discussion of treatment with the estimated 88 patients per annum. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2<sup>nd</sup> and 3<sup>rd</sup> prostate appointments,
- Check urodynamic results/patients

Updated following meeting on 17 Jun 10 to sign off planning assumptions

## LUTS

412 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 330 reviews.

412 new patients @ 4 per session = 103 sessions

330 reviews @ 8 per session = 42 sessions

103 + 42 = 145 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

## Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to Day Surgery Unit to have flexi carried out by a Registrar (**Friday flexi sessions**).

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

237 new patients @ 5 per session = 48 sessions = **1 per week** (over 48 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

## Andrology/General Urology ICATS

This service will be reviewed over the next 6 months.

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

645 @ 3 new per session = 215 sessions = **5 per week** (over 42 weeks)

## Consultant Clinics

Urodynamics patients are included in the consultant clinics (301 new). If these are separated out this leaves 1080 new patients at consultant clinics.

Junior doctors will not be available to support all outpatient sessions. Therefore it has been assumed that on average 1.6 doctors will attend a clinic with 10 patients each, therefore on average 16 at a clinic. Consultants believe that 5 new and 11 reviews is the appropriate number at a clinic for this staffing level. This will give a new to review ratio of 1:2.2.

Updated following meeting on 17 Jun 10 to sign off planning assumptions

1080 patients @ 5 news per clinic = 216 sessions = 4.5 per week. 5 sessions (over 48 weeks) will be built in to the service model (to allow some flexibility because of the limited junior doctor support).

### Stone Treatment

240 attendances @ 6 news = 40 sessions. 1 session per week will be required.

The new:review rate is approximately 1:1.2. A further session will be required for reviews.

### Urodynamics (Revised Model)

Currently carried out on the ward with results reviewed by consultants. These will be moved to Thorndale/Ambulatory Care Unit to be carried out by a Specialist Nurse. Consultants wish to assess the results in their proposed Thorndale session.

301 cases at 5 per all day session = 60 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

### Day Cases

#### **Flexible Cystoscopy**

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving 1042. Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Updated following meeting on 17 Jun 10 to sign off planning assumptions

## **Lithotripsy**

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will require a second consultant with special interest in stone treatment) and 2 per week if delivered over 42 weeks.

## **Other Day Cases**

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.1 lists (over 48 weeks). As not all cases will be done within the dedicated day case lists, 3 weekly lists will suffice.

## **Inpatients**

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly

Updated following meeting on 17 Jun 10 to sign off planning assumptions

and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).



# ***APPENDIX 6***

## ***Draft Patient Flow and Clinical Pathways***

**Pathways for Non-Elective Admissions  
to either Daisy Hill or Erne Hospitals that do not have an acute Urology Unit**

Patient presents at Accident and Emergency in either Daisy Hill or Erne Hospitals

**Testicular Torsion**

Suspected cases of Testicular Torsion should be dealt with by the surgical team

**Testicular Infection**

Suspected cases of Testicular Infection should be dealt with by the surgical team at the presenting hospital

The patient should have an ultrasound carried out to exclude Testicular Tumour

Patient should then be referred to the Urological Team at Craigavon Area Hospital

**Renal Colic**

The patient needs to be assessed by the Surgical Team at the presenting hospital

Investigations such as non-contrast CT, IVP/Ultrasound should be undertaken to confirm diagnosis

This combined with the patient's renal function and sepsis status will govern the acuteness of the referral pathway.

**Haematuria**

Patients admitted with Haematuria/Clot retention that are requiring admission are to be assessed for need of catheter insertion.

Initial investigations of ultrasound and IVP should be undertaken followed by contacting the Craigavon Area Hospital for further advice on referral pathway as there may be a need for transfer or subsequent consultation

**Infection – Recurrent Urinary Tract Infection/pyelonephritis**

The patient needs to be assessed by the Surgical Team at the presenting hospital.

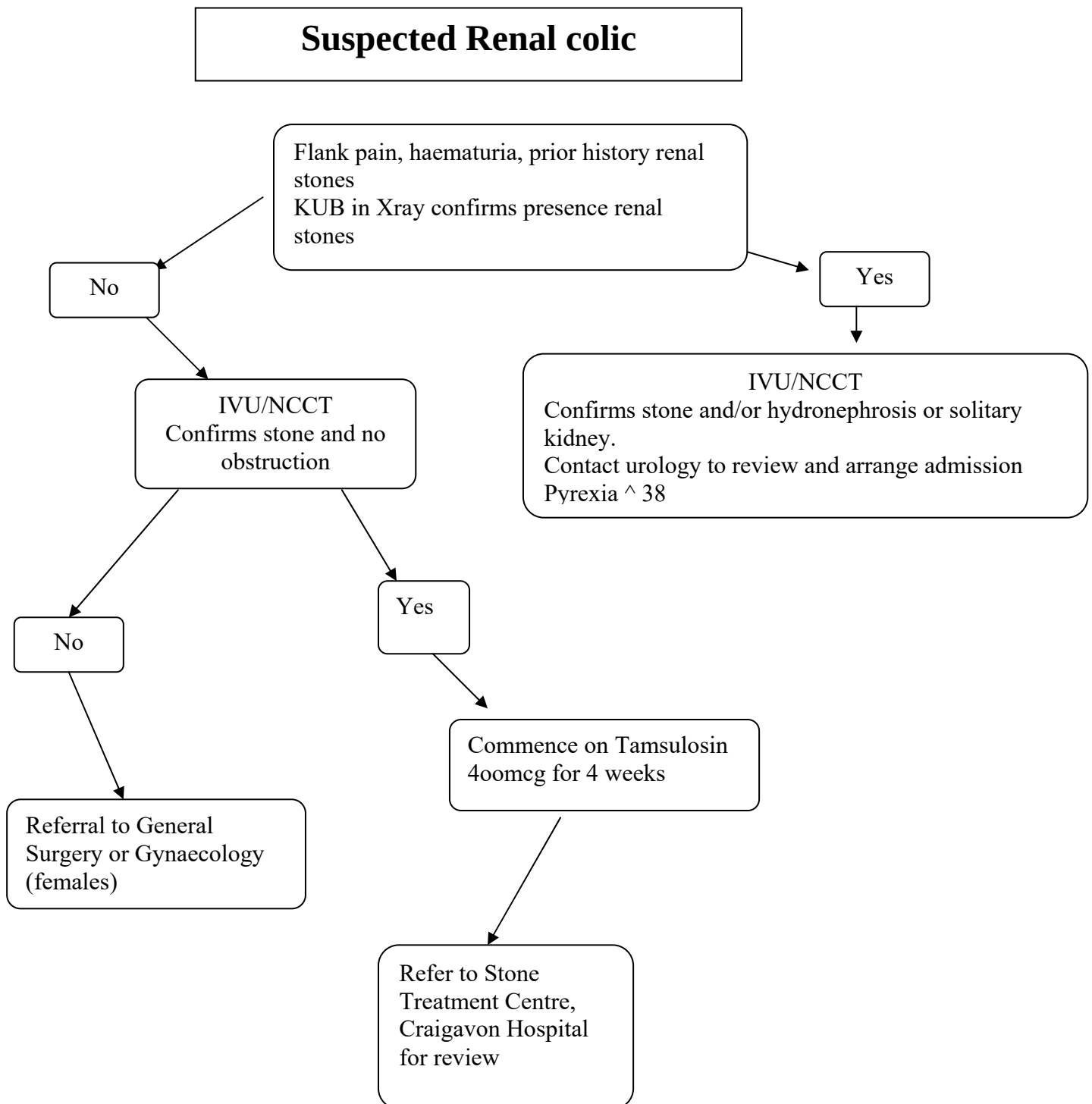
*Catheter Insertion*

Current guidelines and a protocol are being drawn-up for insertion of Catheter by the Urological Team at Craigavon Area Hospital and this will be available on all sites

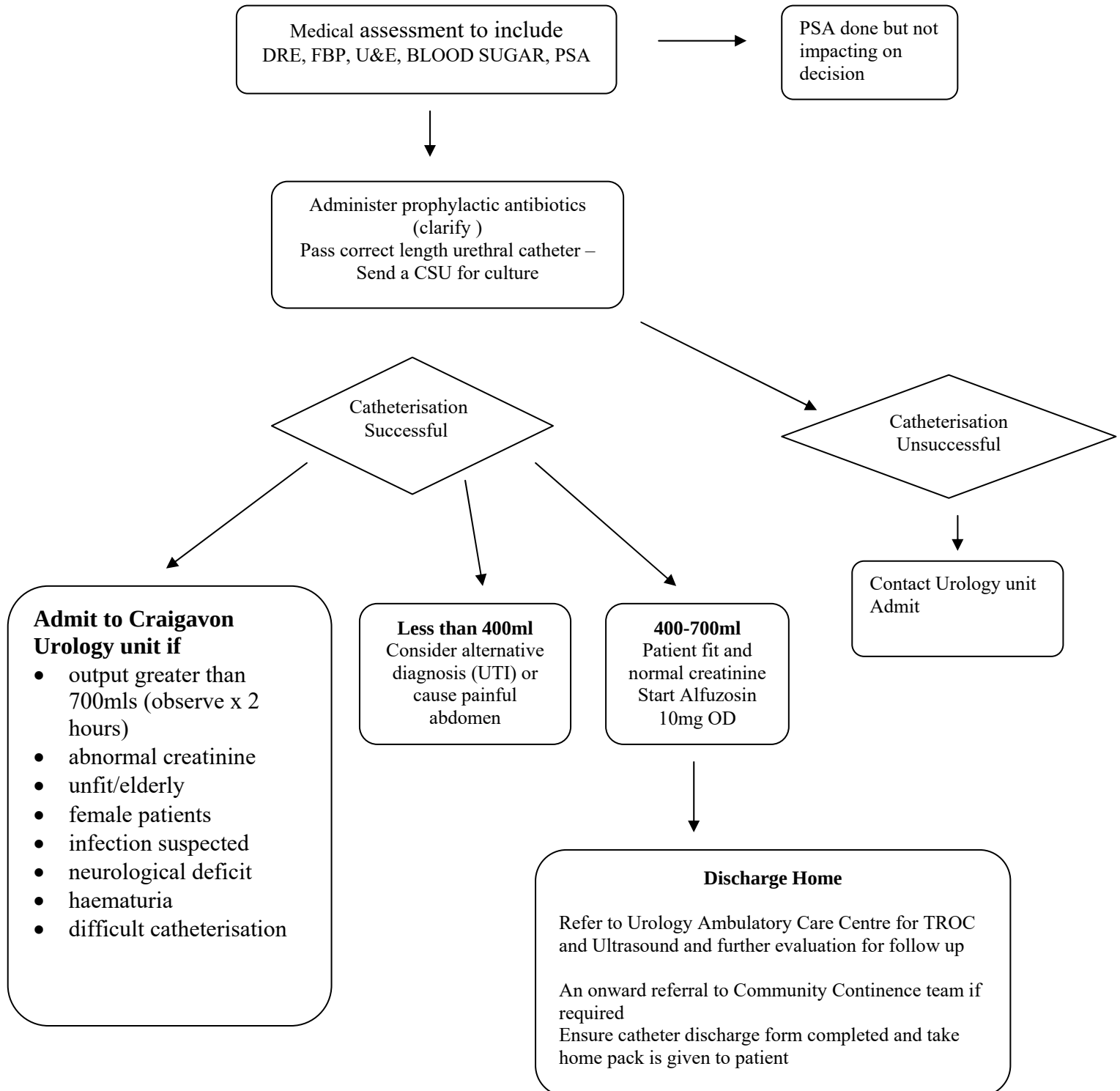
**Note: Any entity defined as a Urological Emergency can be referred/discussed with the Urological team at any time for advice/guidance on how best to manage/transfer**

If advice is required on any of the above the Urology On call doctor should be contacted via Craigavon Area Hospital Switchboard

**028 3833 4444**



## Making diagnosis of Urinary Retention in the A&E department



## Recurrent Urinary Tract Infections

### Step 1 – Nurse Led Service

Urine cultures- frequency to be determined by Consultant Nurse to obtain and monitor results and liaise with Consultant regarding any change to pathway including frequency of sample.

Oral antibiotic regime prescribed and altered by Consultant Urologist as per culture with input when necessary from Bacteriology

### Step 2 – Intravenous Antibiotic Regime

Nurse led Service  
Day case attendance

IV/SC Therapy  
Co-ordinator  
community

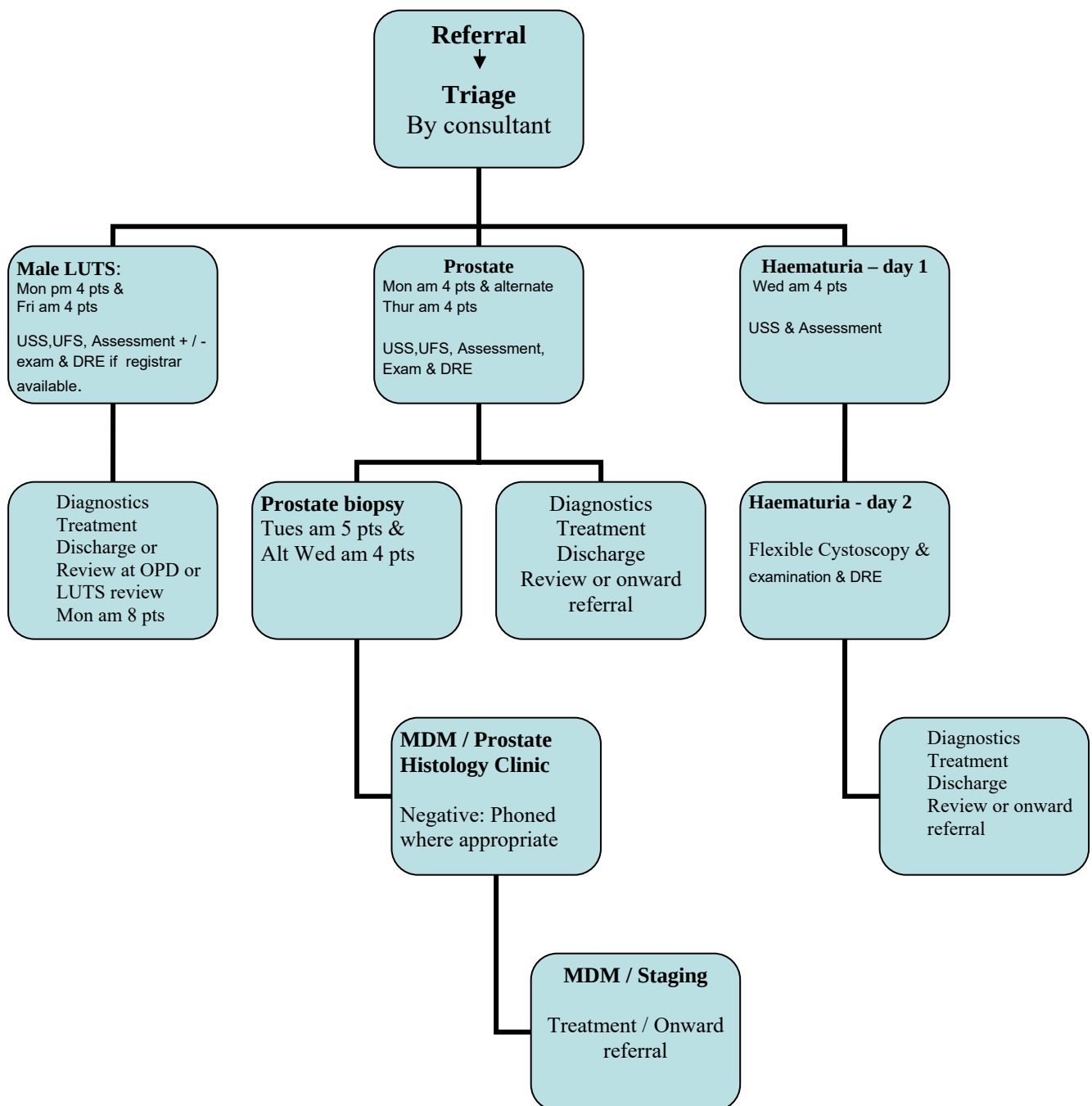
Inpatient  
Culture sensitivity  
Symptomatic  
Venous access easily  
obtained

### Step 3 – Intravenous Fluids and Antibiotic Regime

Nurse Led Service  
Day case attendance Monday – Friday  
Consultant to prescribe Intravenous Antibiotic regime as per Culture and with input when from Bacteriology

Inpatient  
Symptomatic  
Culture Sensitivity  
Venous access  
compromised

## CRAIGAVON UROLOGY ICATS PATHWAY

**Notes:**

USS – ultrasound urinary tracts

UFS – urine flow study

Assessment: Clinical history, urinalysis, Bloods, Urine tests, Symptom history etc

Aim to provide haematuria service in one stop session (resource dependent)

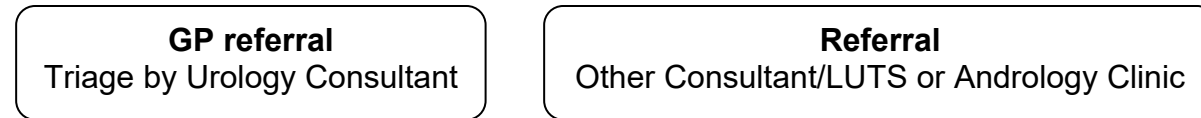
Aim to offer prostate biopsy on day 1 for suitable patients (resource dependent)

Daisy Hill Hospital provide a direct access haematuria service (4 patients weekly)

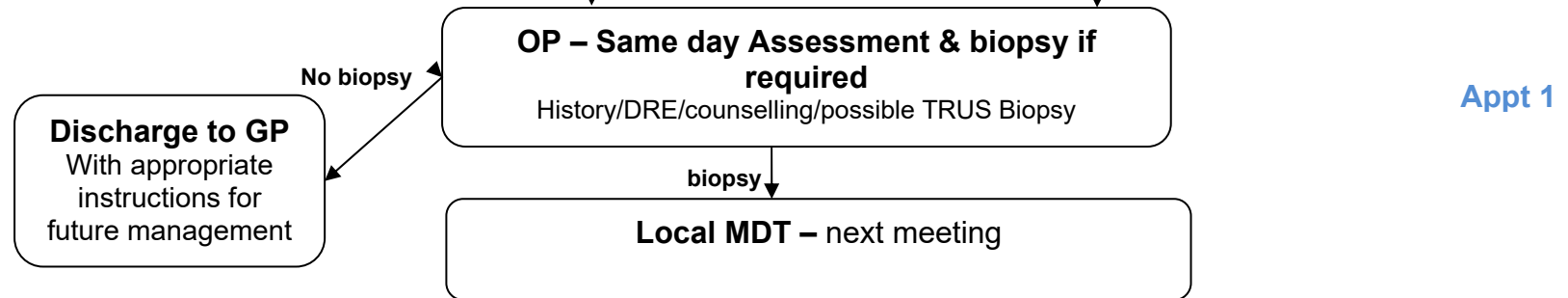
## Prostate Pathway

## Notes

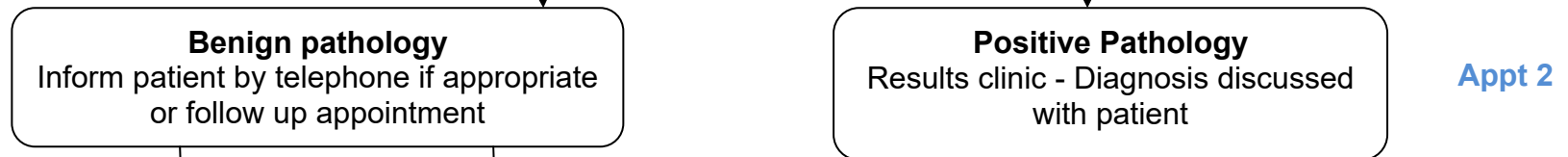
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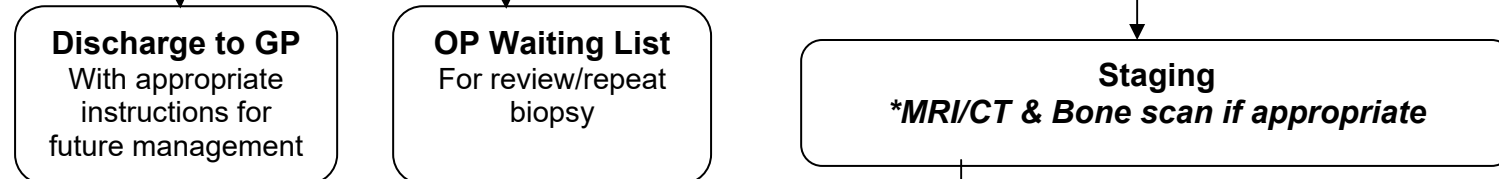
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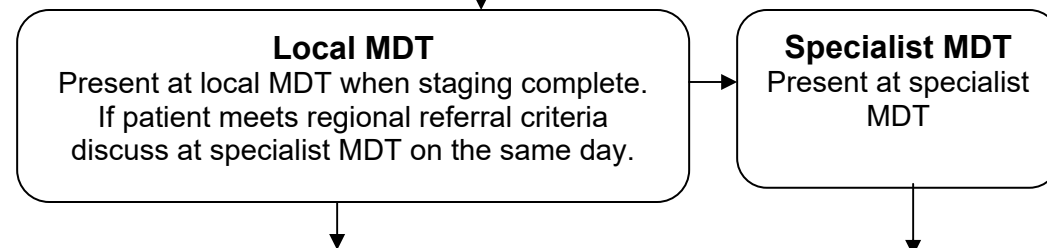


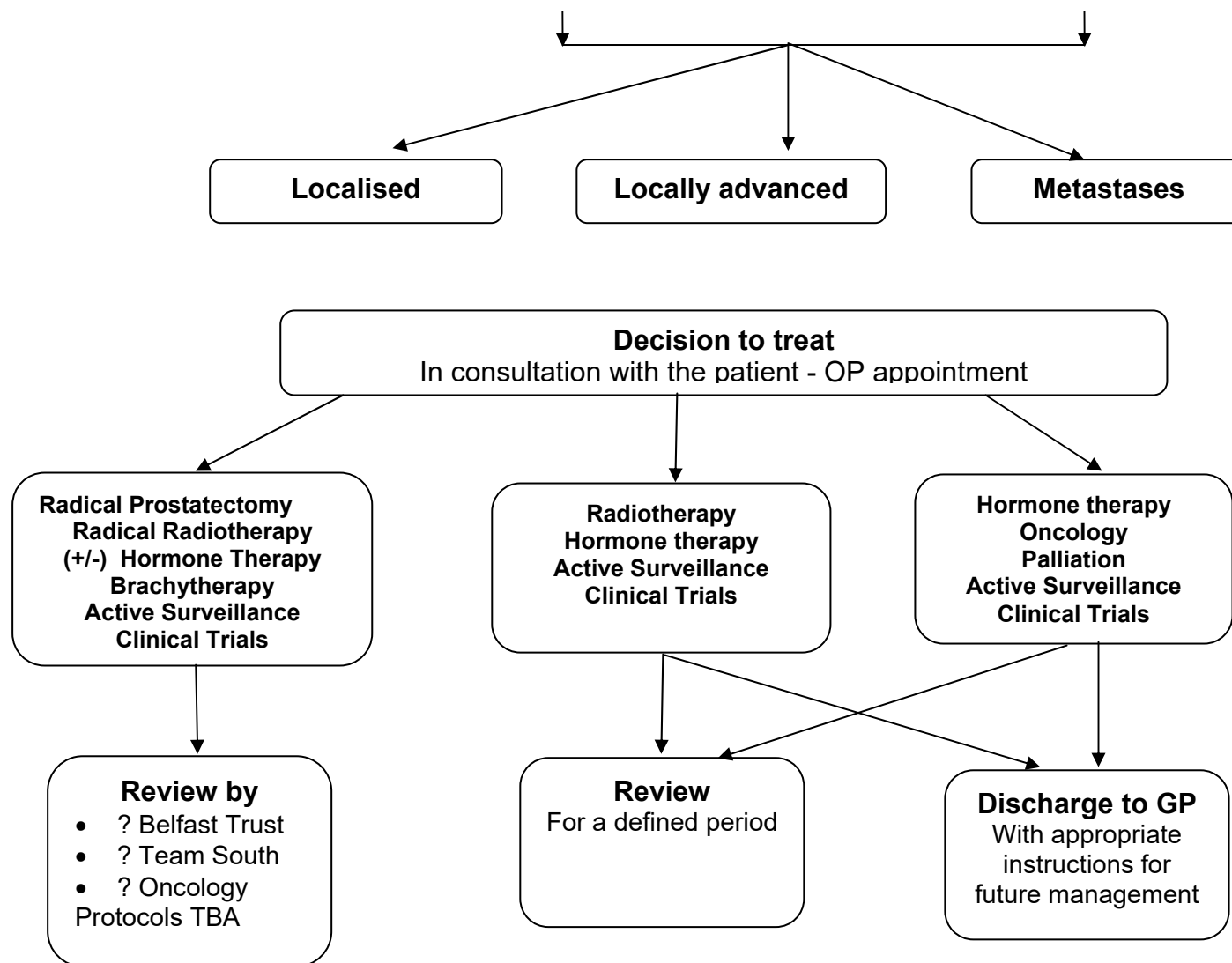
4



5

Inter Trust Transfer by Day 28





Appt 3



## Notes

1. **Referral protocol for GPs** is required. Also an information leaflet for GPs describing what will happen at the OP assessment/biopsy appointment so that they can inform and counsel the patient.
2. **First appointment** – assessment and where clinically indicated a biopsy. Results are normally back from Pathology in 5-10 days.

Specialist Nurse should assess at this appointment if the patient is suitable to receive the results (if benign) by telephone and should discuss this with the patient.

Scans should be booked at this point for those patients who have biopsy (to be cancelled if the biopsy is benign). **Note** another PC in Tutorial Room1 with access to NIPACS will be required to facilitate this.

Only Dr McClure and Mr Akhtar do biopsies at present. One or both of the new consultants will also need to be trained.

**248 new patients** attended TRUSA/TRUSB in 2009/10. Factoring in growth in the waiting list and also 18% of SHSCT activity for Fermanagh gives 316 patients @ 4 per session = 79 sessions = 1.7 per week. At 4 patients per clinic this will require **60 sessions** per annum.

**165 patients** attended TRUSB in 2009/10 (69% of patients who were assessed). Therefore approximately 30 patients from Fermanagh will require biopsy.

3. **Benign biopsy** – will need to consider management of the outpatient waiting list for patients who need future review or repeat biopsy to ensure they do not get lost in the system.
4. **Staging** – there is a 6 week suspension between biopsy and scanning. The MRI/CT and bone scan can be done on the same day if the MRI/CT is done first. However we need to check if both scans can be booked for the same day to save 2 journeys for the patient (NIPACS issue).

Reports need to be available within 2 – 5 days (need to be available for the next MDT).

5. **Local/Specialist MDT** – where appropriate inter Trust transfer must be made by day 28 from receipt of referral.
6. The review programme awaiting confirmation of who will review the patients managed by Belfast surgical team and also radiotherapy?

### Patients to be discussed at local MDT

All patients with biopsies for suspected cancer (NICE)

All patients diagnosed with prostate cancer (peer review)

(From NICAN Urology Network)

**Prostate cancer**

Patients with locally advanced or metastatic disease, to be referred for specialist discussion if clinically appropriate. Patients over 85 do not require discussion.



Southern Health  
and Social Care Trust

*Quality Care - for you, with you*

## **Regional Review of Urology Services**

### **Team South Implementation Plan**

**V0.3 revised 09 Nov 10**

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## Appendices

Appendix 1 Calculation of Sessions Required for Team South

## 1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

*'Develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'*

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

## **2. Current Service Model**

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are currently held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

### **The Urology Team**

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

### **The ICATS Service**

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

### **Current Sessions**

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

**Table 1: Current Urology Sessions**

|                           | <b>Craigavon</b>           | <b>South Tyrone</b> | <b>Banbridge</b> | <b>Armagh</b> | <b>Total</b> |
|---------------------------|----------------------------|---------------------|------------------|---------------|--------------|
| <b>Consultant Led OPs</b> |                            |                     |                  |               |              |
| General                   | 2.75 per week <sup>1</sup> | 1 per month         | 2 per month      | 2 per month   | 4 per week   |
| Stone Treatment           | 1 weekly                   |                     |                  |               | 1 week       |

| <b>ICATS</b>                           | <b>Weekly</b> | <b>Personnel</b>                                    |
|----------------------------------------|---------------|-----------------------------------------------------|
| Prostate Assessment                    | 1.5           | Specialist Nurse & Registrar                        |
| Prostate Biopsy                        | 1             | Consultant Urologist/Radiologist & Specialist Nurse |
| Prostate Histology                     | 1.5           | Specialist Nurse & Consultant/Registrar             |
| LUTS                                   | 3             | Specialist Nurse & Registrar                        |
| Haematuria                             | 2             | Specialist Nurse & Registrar                        |
| Andrology                              | 2.5           | GPwSI & Nurse Lecturer                              |
| General Urology/Stable Prostate Cancer | 2.5           | GPwSI                                               |
|                                        |               |                                                     |
|                                        | <b>14</b>     |                                                     |

| <b>Main Theatres (CAH)</b> | <b>Weekly</b> |                 |
|----------------------------|---------------|-----------------|
|                            | 6             | 3 all day lists |

|                     | <b>Craigavon</b>        | <b>South Tyrone</b> |
|---------------------|-------------------------|---------------------|
| <b>Day Surgery</b>  |                         |                     |
| GA                  | 1 weekly <sup>2</sup>   | 1 monthly           |
| Flexible Cystoscopy | 1.5 weekly <sup>3</sup> |                     |
| Lithotripsy         | 2 weekly                |                     |

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month

2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover

3) 2 lists/1 list on alternate weeks

## Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 240 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. This mistake has been corrected in the figures in Tables 2 and 3 below.

**Table 2: 2009/10 Actual Activity for the Urology Service**

|                |                        | <b>Core Activity</b> | <b>IHA</b> | <b>IS</b> | <b>Totals</b> |
|----------------|------------------------|----------------------|------------|-----------|---------------|
| <b>2009/10</b> | Cons Led New OP        | 850                  | 474        | 0         | <b>1324</b>   |
|                | ICATS/Nurse Led New OP | 1220                 | 30         |           | <b>1250</b>   |
|                | Total New OP           | 2070                 | 504        | 0         | <b>2574</b>   |
|                |                        |                      |            |           |               |
|                | Cons Led Review OP     | 2151                 | 70         | 0         | <b>2221</b>   |
|                | ICATS/Nurse Led Rev OP | 1509                 | 0          | 0         | <b>1509</b>   |
|                | Total Review           | 3660                 | 70         | 0         | <b>3730</b>   |
|                |                        |                      |            |           |               |
|                | Day Case               | 1502                 | 3          | 383       | <b>1888</b>   |
|                | Elective FCE           | 1199                 | 29         | 140       | <b>1368</b>   |
|                | Non Elective FCE       | 629                  | 0          | 0         | <b>629</b>    |

Activity by consultant for 2009/10 is provided in Table 3.

**Table 3: Activity by Consultant for 2009/10**

|                |                             | <b>Mr Young</b> | <b>Mr O'Brien</b> | <b>Mr Akhtar<sup>2</sup></b> | <b>All Core Activity</b> |
|----------------|-----------------------------|-----------------|-------------------|------------------------------|--------------------------|
| <b>2009/10</b> | New OP                      | 482             | 174               | 193                          | <b>849</b>               |
|                | Review OP                   | 724             | 903               | 327                          | <b>1954</b>              |
|                | Total OP                    | 1206            | 1077              | 520                          | <b>2803</b>              |
|                |                             |                 |                   |                              |                          |
|                | Day Case                    | 696             | 452               | 354                          | <b>1502</b>              |
|                | Elective FCE                | 380             | 512               | 307                          | <b>1199</b>              |
|                | Non Elective FCE            | 233             | 210               | 186                          | <b>629</b>               |
|                | FCEs + DCs                  | <b>1309</b>     | <b>1174</b>       | <b>847</b>                   | <b>3330</b>              |
|                | Day Case Rates <sup>1</sup> | 65%             | 47%               | 54%                          | 56%                      |

<sup>1</sup> INCLUDES flexible cystoscopies (M45) and DCs/FCEs with no primary procedure recorded.

<sup>2</sup>Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

### **Notes:**

- 1) Source is Business Objects
- 2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
- 3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).
- 4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.



There is a substantial backlog of patients awaiting review at consultant led clinics. The Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

### **Pre-operative Assessment**

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

### **Suspected Urological Cancers**

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The first part of the meeting is the local MDT meeting and the local team then link in with the regional MDT meeting.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. The Trust is transferring all radical pelvic operations to Belfast Trust.

### 3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position.

**Table 4: Regional Benchmarking**

|                                   |              | <b>2006/07</b> | <b>2007/08</b> | <b>2008/09</b> | <b>2009/10</b> |
|-----------------------------------|--------------|----------------|----------------|----------------|----------------|
| <b>New : Review Ratio</b>         | All Trusts   | 1.96           | 2.03           | 1.79           | 1.68           |
|                                   | <b>SHSCT</b> | <b>4.04</b>    | <b>3.27</b>    | <b>3.28</b>    | <b>2.09</b>    |
|                                   |              |                |                |                |                |
| <b>Day Case Rates</b>             | All Trusts   | 50.1           | 48.5           | 49.8           | 48.5           |
|                                   | <b>SHSCT</b> | <b>43.8</b>    | <b>45.5</b>    | <b>48.8</b>    | <b>40.0</b>    |
|                                   |              |                |                |                |                |
| <b>Average LOS (elective)</b>     | All Trusts   | 3.7            | 3.5            | 3.4            | 2.9            |
|                                   | <b>SHSCT</b> | <b>3.7</b>     | <b>4.3</b>     | <b>3.9</b>     | <b>2.7</b>     |
|                                   |              |                |                |                |                |
| <b>Average LOS (non elective)</b> | All Trusts   | 4.8            | 4.7            | 4.6            | 4.4            |
|                                   | <b>SHSCT</b> | <b>4.5</b>     | <b>4.8</b>     | <b>4.6</b>     | <b>4.7</b>     |

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1<sup>st</sup> January – 31<sup>st</sup> December 2009 for elective and non elective admissions.

**Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)**

| HRG v3.5                                                                                               | Spells | SHSCT LOS | Peer LOS |
|--------------------------------------------------------------------------------------------------------|--------|-----------|----------|
| L55 - Urinary Tract Findings <70 without complications & comorbidities                                 | 11     | 3.5       | 0.3      |
| L32 - Non-Malignant Prostate Disorders                                                                 | 16     | 3.6       | 2        |
| L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities                         | 670    | 0.3       | 0.1      |
| L14 - Bladder Major Open Procedures or Reconstruction                                                  | 4      | 11        | 6.7      |
| L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis                  | 3      | 4.3       | 0.5      |
| P21 - Renal Disease                                                                                    | 13     | 1.8       | 0.7      |
| L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities             | 21     | 4.4       | 3.1      |
| L52 - Renal General Disorders >69 or with complications & comorbidities                                | 9      | 5.9       | 3.7      |
| L69 - Urinary Tract Stone Disease                                                                      | 37     | 2.3       | 1.9      |
| L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities                 | 28     | 6.7       | 3.2      |
| L02 - Kidney Major Open Procedure >49 or with complications & comorbidities                            | 34     | 9.5       | 7.8      |
| L25 - Bladder Neck Open Procedures Male                                                                | 11     | 6.4       | 4.8      |
| L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities | 5      | 2         | 1.3      |
| L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities | 20     | 9.1       | 8.4      |
| L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities             | 78     | 5.3       | 4.2      |
| L17 - Bladder Major Endoscopic Procedure                                                               | 77     | 4.7       | 3.8      |
| L03 - Kidney Major Open Procedure <50 without complications & comorbidities                            | 9      | 5.7       | 4.8      |
| L13 - Ureter Intermediate Endoscopic Procedure                                                         | 91     | 2.3       | 1.6      |
| L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities                     | 61     | 4.2       | 3        |
| L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities         | 45     | 1.4       | 1.2      |
| L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities                 | 16     | 2.2       | 1.9      |

The British Association of Day Surgery (BADs) produces targets for short stay and day case surgery for the various surgical specialties. The Trust compared its performance to the BADs targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete) and submitted an analysis of its performance in version 0.2 of the Implementation Plan.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

#### 4. Demand for Team South Urology Service

The Trust has agreed the methodology for calculating the outpatient demand for the service with the Performance Management and Service Improvement Directorate, based on the actual activity for 2009/10. It is important that when the demand and the capacity of the current and future services are being calculated, that the **whole service** is considered. A significant amount of both new and review activity is undertaken within the ICATS service. However the service is not an independent ICATS service. Consultants triage all urology referrals and decide which are suitable to be treated at ICATS clinics. They also supervise the clinics. Table 6 presents the projected demand for **outpatient slots** for the overall service.

It has been assumed that the Trust's proposal to manage the review backlog will be funded separately and the capacity required to eradicate the backlog has not been included in the demand analysis.

Using actual activity for 2009/10 as a proxy for demand:

**Table 6: Projected Outpatient Activity for Team South**

|                                       | <b>New<br/>Attendances</b> | <b>Notes</b> |
|---------------------------------------|----------------------------|--------------|
| 2009/10 Actual Consultant Led         | 1084                       | 1            |
| 2009/10 Actual Stone Treatment Centre | 240                        | 2            |
| 2009/10 Actual ICATS                  | 1250                       | 3            |
| 2009/10 Fermanagh referrals           | 318                        | 4            |
| DNA rate @ 3%                         | 87                         | 5            |
| Growth @ 12%                          | <u>357</u>                 | 6            |
| <b>Total SLOTS</b>                    | <b>3336</b>                |              |
| 2009/10 Actual Newry & Mourne         | 610                        | 7            |
| DNA rate @ 3%                         | 18                         |              |
| Growth @ 12%                          | <u>75</u>                  |              |
|                                       | <b>704</b>                 |              |

**Notes:**

- 1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.
- 2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.
- 3) Actual attendances at ICATS clinics.
- 4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).
- 5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.
- 6) The same growth rate was used as in the Board's model.
- 7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

**For the purposes of calculating the required outpatient sessions 3336 new attendance slots has been used (ie excluding Newry and Mourne demand).**

Projected inpatient and daycase activity has not been changed since the submission of version 0.2 of the Trust's Implementation Plan. It is summarised in Table 7 overleaf.

**Table 7: Projected Activity for Team South**

|                |                  | 2009/10 Actual Activity |     |     |                 | SHSCT<br>Activity to<br>be Provided | Team<br>South<br>Capacity<br>Required <sup>3</sup> |
|----------------|------------------|-------------------------|-----|-----|-----------------|-------------------------------------|----------------------------------------------------|
|                |                  | Core Activity           | IHA | IS  | Growth<br>in WL |                                     |                                                    |
| <b>2009/10</b> | Day Case         | 1502                    | 3   | 383 | 47              | 1935                                | <b>2283</b>                                        |
|                | Elective FCE     | 1199                    | 29  | 140 | 28              | 1396                                | <b>1647</b>                                        |
|                | Non Elective FCE | 629                     | 0   | 0   |                 | 629                                 | <b>742</b>                                         |

1) Source is Business Objects

2) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs

3) 18% added for Fermanagh, based on population size relative to SHSCT population

## 5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The Trust has submitted the proposed pathways, as requested to the Performance Management and Service Improvement Directorate.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals (availability of sessions to be confirmed). Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

The majority of nurse led/ICATS sessions will be provided over 48 weeks with consultant led sessions being provided over 42 weeks. Due to the limited availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1. **Note** – as previously stated, demand from Newry and Mourne has not been included in the calculations.

**Table 8: Weekly Sessions for New Service Model**

|                                                        | <b>Weekly Sessions</b> | <b>Weeks</b> | <b>Personnel</b>                                        |
|--------------------------------------------------------|------------------------|--------------|---------------------------------------------------------|
| <b>Consultant Led OPs</b>                              |                        |              |                                                         |
| General                                                | 5.5                    | 42           |                                                         |
| Stone Treatment                                        | 1.5                    | 42           |                                                         |
|                                                        |                        |              |                                                         |
| <b>ICATS</b>                                           |                        |              |                                                         |
| Prostate Assessment                                    | 1.5                    | 48           | Registrar & Specialist Nurse                            |
| Prostate Biopsy <sup>1</sup>                           | 2                      | 48           | Consultant Urologist/<br>Radiologist & Specialist Nurse |
| Prostate Histology <sup>2</sup>                        | 1                      | 48           | Specialist Nurse &<br>Consultant/Registrar              |
| LUTS                                                   | 3                      | 48           | Specialist Nurse & Registrar                            |
| Haematuria                                             | 1.5                    | <b>42</b>    | Specialist Nurse & Registrar                            |
| Andrology/General<br>Urology/Stable Prostate<br>Cancer | 5                      | 42           | GPwSI & Nurse Lecturer                                  |
| Urodynamics                                            | 1.5                    | 48           | Specialist Nurse                                        |
|                                                        | <b>15.5</b>            |              |                                                         |
|                                                        |                        |              |                                                         |
| <b>Main Theatres</b>                                   | 9                      | 42           |                                                         |
|                                                        |                        |              |                                                         |
| <b>Day Surgery</b>                                     |                        |              |                                                         |
| GA                                                     | 4                      | 42           |                                                         |
| Flexible Cystoscopy                                    | 3                      | 42           |                                                         |
| Lithotripsy                                            | 2                      | 42           |                                                         |
|                                                        |                        |              |                                                         |
|                                                        |                        |              |                                                         |

The detail of job plans is to be agreed with the existing Consultants but they will be based around the sessions identified in Table 8. The expected weekly consultant led sessions, which are subject to confirmation and agreement with consultants, are given in Table 9 overleaf.



**Table 9: Proposed Consultant Led Sessions**

|                                                | <b>Weekly Sessions</b> |
|------------------------------------------------|------------------------|
| <b>Outpatients (including Stone Treatment)</b> |                        |
| Craigavon                                      | 4.5                    |
| South Tyrone                                   | 1                      |
| Armagh                                         | 0.5                    |
| Banbridge Polyclinic                           | 0.5                    |
| Erne                                           | 0.5                    |
| <b>Total OPD</b>                               | <b>7</b>               |
|                                                |                        |
| <b>Prostate Biopsy</b>                         | <b>2</b>               |
|                                                |                        |
| <b>Day Surgery</b>                             |                        |
| CAH                                            | 1                      |
| STH                                            | 2.5                    |
| Erne                                           | 0.5                    |
| Lithotripsy                                    | 2                      |
| <b>Total Day Surgery</b>                       | <b>6</b>               |
|                                                |                        |
| <b>Main Theatre</b>                            | <b>9</b>               |

The Trust accepts the need to move towards delivering activity volumes at outpatient clinics which comply with BAUS guidelines and has made good progress in this regard. The original consultant templates enabled the Trust to deliver the outpatient volumes in 2009/10 which are shown in Table 10.

**Table 10: Draft Outpatient Volumes at Consultant Clinics in 2009/10**

|         |                          | <b>Core Activity</b> |
|---------|--------------------------|----------------------|
| 2009/10 | Consultant Led New OP    | 850                  |
|         | Consultant Led Review OP | 2151                 |
|         | <b>Total Activity</b>    | <b>3001</b>          |

Revised templates which provide significantly more new outpatient capacity have been agreed with the consultant urologists and these have been implemented. They are shown in Table 11 overleaf.

**Table 11: Current Consultant Templates (Recently Revised and Extended)**

| Consultant                | Location  | Day     | Frequency | Sessions/<br>Annum | Travel<br>Time | New | Review | New/<br>Annum | Review/<br>Annum |
|---------------------------|-----------|---------|-----------|--------------------|----------------|-----|--------|---------------|------------------|
| Mr Young                  | BBP       | Mon am  | Monthly   | 10                 | 45             | 6   | 6      | 60            | 60               |
|                           | ACH       | Mon am  | Monthly   | 10                 | 50             | 6   | 6      | 60            | 60               |
|                           | CAH (STC) | Mon am  | Weekly    | 42                 | 0              | 5   | 11     | 210           | 462              |
|                           | CAH       | Fri pm  | 1,2,4 & 5 | 32                 | 0              | 5   | 7      | 160           | 224              |
|                           |           |         |           |                    |                |     |        |               |                  |
| Mr O'Brien                | BBP       | Mon am  | Monthly   | 10                 | 45             | 5   | 7      | 50            | 70               |
|                           | ACH       | Mon am  | Monthly   | 10                 | 50             | 5   | 7      | 50            | 70               |
|                           | CAH       | Tues pm | Weekly    | 42                 | 0              | 5   | 7      | 210           | 294              |
|                           |           |         |           |                    |                |     |        |               |                  |
| Mr Akhtar                 | CAH       | Mon pm  | Weekly    | 42                 | 0              | 4   | 7      | 168           | 294              |
|                           | STH       | Tues pm | Monthly   | 10                 | 60             | 6   | 3      | 60            | 30               |
|                           |           |         |           |                    |                |     |        |               |                  |
| <b>Total Annual Slots</b> |           |         |           |                    |                |     |        | <b>1028</b>   | <b>1564</b>      |

These templates will be used initially as the basis of the new (5 consultant) service model giving a projected capacity of 1533 new and 2310 review appointments at consultant clinics, subject to the agreement of consultant job plans (Table 12 overleaf). It is anticipated that an overall new to review ratio across the service (consultant led and ICATS) of 1:2 will be achieved initially.

Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates aligning all consultant templates with the BAUS guidelines. Draft templates which are subject to agreement with the consultants, are shown in Table 13 overleaf. Travelling time has been accommodated within the templates. The new to review ratio across the service (consultant led and ICATS) will be reduced to the recommended 1:1.5.

**Table 12: Draft Initial Consultant Outpatient Templates for 5 Consultant Model (for first 12 – 18 months)**

| Consultant                | Location     | Day      | Frequency | Sessions/<br>Annum | Travel<br>Time | New | Review | New/<br>Annum | Review/<br>Annum |
|---------------------------|--------------|----------|-----------|--------------------|----------------|-----|--------|---------------|------------------|
| Consultant 1              | CAH          | Fri am   | 2/Month   | 21                 | 0              | 6   | 8      | 126           | 168              |
|                           | STH          | Thurs pm | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
|                           | Stone Centre | Mon am   | 2/Month   | 21                 | 0              | 6   | 11     | 126           | 231              |
| Consultant 2              | CAH          | Tues pm  | Weekly    | 42                 | 0              | 6   | 8      | 252           | 336              |
|                           | ACH          | Mon am   | Monthly   | 10.5               | 50             | 5   | 8      | 52.5          | 84               |
|                           | Erne         | Mon pm   | Monthly   | 10.5               | 60             | 5   | 8      | 52.5          | 84               |
| Consultant 3              | CAH          | Mon pm   | 2/Month   | 21                 | 0              | 6   | 8      | 126           | 168              |
|                           | STH          | Tues pm  | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
|                           |              |          |           |                    |                |     |        |               |                  |
| Consultant 4              | CAH          | Fri am   | 2/Month   | 21                 | 0              | 6   | 8      | 126           | 168              |
|                           | ACH          | Mon am   | Monthly   | 10.5               | 50             | 5   | 8      | 52.5          | 84               |
|                           | Erne         | Mon pm   | Monthly   | 10.5               | 60             | 5   | 8      | 52.5          | 84               |
| Consultant 5              | CAH          | Mon pm   | 2/Month   | 21                 | 0              | 6   | 8      | 126           | 168              |
|                           | STH          | Thurs pm | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
|                           | Stone Centre | Mon am   | 2/month   | 21                 | 0              | 6   | 11     | 126           | 231              |
| <b>Total Annual Slots</b> |              |          |           |                    |                |     |        |               | <b>1533</b>      |
|                           |              |          |           |                    |                |     |        |               | <b>2310</b>      |

\* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

**Table 13: Draft Final Consultant Outpatient Templates for 5 Consultant Model**

| Consultant                | Location     | Day      | Frequency | Sessions/<br>Annum | Travel<br>Time | New | Review | New/<br>Annum | Review/<br>Annum |
|---------------------------|--------------|----------|-----------|--------------------|----------------|-----|--------|---------------|------------------|
| Consultant 1              | CAH          | Fri am   | 2/Month   | 21                 | 0              | 6   | 9      | 126           | 189              |
|                           | STH          | Thurs pm | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
|                           | Stone Centre | Mon am   | 2/Month   | 21                 | 0              | 6   | 11     | 126           | 231              |
| Consultant 2              | CAH          | Tues pm  | Weekly    | 42                 | 0              | 6   | 9      | 252           | 378              |
|                           | ACH          | Mon am   | Monthly   | 10.5               | 50             | 5   | 8      | 52.5          | 84               |
|                           | Erne         | Mon pm   | Monthly   | 10.5               | 60             | 5   | 8      | 52.5          | 84               |
| Consultant 3              | CAH          | Mon pm   | 2/Month   | 21                 | 0              | 6   | 9      | 126           | 189              |
|                           | STH          | Tues pm  | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
| Consultant 4              | CAH          | Fri am   | 2/Month   | 21                 | 0              | 6   | 9      | 126           | 189              |
|                           | ACH          | Mon am   | Monthly   | 10.5               | 50             | 5   | 8      | 52.5          | 84               |
|                           | Erne         | Mon pm   | Monthly   | 10.5               | 60             | 5   | 8      | 52.5          | 84               |
| Consultant 5              | CAH          | Mon pm   | 2/Month   | 21                 | 0              | 6   | 9      | 126           | 189              |
|                           | STH          | Thurs pm | 2/Month   | 21                 | 60             | 5   | 8      | 105           | 168              |
|                           | Stone Centre | Mon am   | 2/month   | 21                 | 0              | 6   | 11     | 126           | 231              |
| <b>Total Annual Slots</b> |              |          |           |                    |                |     |        | <b>1533</b>   | <b>2436</b>      |

\* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

## 6. Timetable for Implementation

| <b>Task</b>                                                | <b>Timescale</b> |
|------------------------------------------------------------|------------------|
| Submission of Team South Implementation Plan               | 23 June 10       |
| Re-submission of Team South Implementation Plan            | 09 Nov 10        |
| Approval to Proceed with Implementation from HSCB          | 17 Nov 10        |
| Completion of Job Plans/Descriptions for Consultant Posts  | Nov 10           |
| Completion of Job Plans/Descriptions for Specialist Nurses | Nov 10           |
| Consultant Job Plans to Specialty Advisor                  | Dec 10           |
| Advertisement of Consultant Posts                          | January 11       |
| Advertisement of Specialist Nurse Posts                    | January 11       |
| New Consultants and Specialist Nurses in post              | July 11          |

***APPENDIX 1***  
**Calculation of Sessions Required  
for Team South**

## Calculation of Sessions Required for Team South

### Prostate Pathway (Revised)

A reduction from the current 4 appointments to 3 appointments is planned in the current service model with the assessment and prostate biopsy taking place on the same day (for appropriate patients).

**1<sup>st</sup> appointment** – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 434 patients will require biopsy.

321 patients for assessment @ 5 per session = 64 sessions per annum = 1.4 assessment sessions per week.

378 patients had prostate biopsy in 2009/10 (Note some patients will come directly for biopsy from the ward or OPD). Uplifting this for Fermanagh region gives a requirement for 434 slots @ 5 per session = 87 sessions per annum. 2 biopsy sessions per week (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

**2<sup>nd</sup> appointment** will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. 180 patients had positive pathology. Uplifting this for Fermanagh region gives a requirement for 215 patients needing a second appointment. These patients will be seen by a consultant or registrar.

**3<sup>rd</sup> appointment** will be discussion of treatment with the estimated 215 patients per annum, following MDT. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2<sup>nd</sup> and 3<sup>rd</sup> prostate appointments,
- Check urodynamic results/patients
- Other urgent cases.



**LUTS**

419 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 336 reviews.

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

103 + 42 = 147 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

**Haematuria (Revised)**

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar.

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

241 new patients @ 5 per session = 48.2 sessions = **1.5 per week** (over 42 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

**Andrology/General Urology ICATS**

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

639 @ 3 new per session = 213 sessions = **5 per week** (over 42 weeks)

**Urodynamics**

These will be located alongside consultant clinics.

306 cases at 5 per all day session = 61 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

**Consultant Clinics**

1405 new patient slots are required at consultant clinics, including the capacity to review urodynamics results/patients. The table below provides the draft outpatient clinic templates for the 5 consultant model. These templates will provide a capacity for 1533 new and 2310 review outpatient slots initially as shown below. Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates increasing the templates to provide 1533 new and 2436 review slots.

**Stone Treatment**

311 attendances @ 6 news = 52 sessions. 1.3 session per week will be required.

**Day Cases****Flexible Cystoscopy**

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving 1042.

Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

## Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

## Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.5 lists (over 42 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

**Inpatients**

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

**Investment Proposal Template (IPT3)**

Revenue funding &gt; £500,000 &lt; £1,500,000

*(unless in exceptional circumstances and approved by Commissioner for >£1,500,000)*Commissioner's Statement

|                                     |                                                         |
|-------------------------------------|---------------------------------------------------------|
| <b>Reference Number</b>             |                                                         |
| <b>Commissioner Representative</b>  | <u>Mrs Lyn Donnelly</u>                                 |
| <b>Title</b>                        | <u>Assistant Director of Commissioning for the SLCG</u> |
| <b>Contact Tele No. &amp; Email</b> | Personal Information redacted by the USI                |
| <b>Date</b>                         | <u>December 2011</u>                                    |

1. **Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**

Outline of Strategic Context within which the Commissioner is seeking service proposals.

Reference should be made as appropriate to:

- Priorities for Action.
- HWIP.
- Strategy, Policy or Service Review documents, Local, Regional, National.
- Compliance with NICE, SMC and other appropriate recognised guidance on effectiveness.
- Likely Board/LCG service shares.
- Legislative/Statutory requirements.

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. The overall purpose of the review was to develop a modern, fit for purpose in the 21<sup>st</sup> century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN)

The review made a wide range of recommendations that are required to be implemented (see appendix A). A number of the key recommendations have been highlighted below.

- Acute services should be reconfigured into a 3 team model, to achieve long term stability and viability. The three teams are as follows:
  - Team East comprising of the catchment area of Belfast HSCT, SET and the southern sector of the Northern HSCT. Team increasing from 11 consultants to 12 consultants.
  - Team Northwest comprising of the catchment area of northern sector of the Northern HSCT and the catchment area of Altnagelvin hospital and Tyrone County Hospital in the Western HSCT. Team increasing from 5 consultants to 6 consultants.
  - Team South comprising of the catchment area of the Southern HSCT and the Erne Hospital catchment in the Western HSCT. Team increasing from 3 consultants to 5 consultants.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Surgeons carrying out small numbers of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- To modernise and redesign outpatient clinic templates and administrative booking processes to maximise capacity for new and review patients.
- The requirement to redesign and enhance capacity to provide single visit outpatient

and assessment for suspected urological cancer patients.

The formation of a Team South ensures that patients receive safe and effective care within clinically recommended timeframes and PfA targets. It will also ensure that staff are equipped and motivated to adopt innovative and efficient ways of working.

The recommendations are in line with the regional strategy, *Developing Better Services* (2002). It also reflects the Southern Trust's commitment to localise services where possible, protect elective services and reduce any unnecessary duplication of services.

2. Description of Services - (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)

The current service model is an integrated consultant led and ICATS model. The service base is at Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are General Surgery inpatient beds at Daisy Hill Hospital, Newry and at the Erne Hospital.

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the Urology team also undertakes some Urology outpatient and day case work.

### **Network Development**

A Urology Review Project Implementation Board has been established consisting of clinical representation from all Trusts. This group meets regularly to agree the key actions required to deliver the review recommendations.

### **Activity Assumptions**

New indicative activity levels have been agreed with Team South and work is underway to finalise these volumes.

Table 1 below details the full year effect of the outpatient and finished consultant episode activity for each team.

| FYE Team South Outpatients |             |             |
|----------------------------|-------------|-------------|
|                            | New         | Review      |
| MY                         | 504         | 756         |
| AOB                        | 504         | 756         |
| MA                         | 504         | 756         |
| Cons4                      | 504         | 756         |
| Cons5                      | 504         | 756         |
| Total                      | 2520        | 3780        |
| Less Travel Impact         | 192         | 99          |
| Total                      | 2328        | 3681        |
| ICATS                      | 1620        | 1724        |
| <b>Overall Total</b>       | <b>3948</b> | <b>5405</b> |

| Team South Proposed FCE Activity |             |             |
|----------------------------------|-------------|-------------|
|                                  | DC          | Admissions  |
| MY                               | 877         | 248         |
| AOB                              | 877         | 248         |
| MA                               | 877         | 248         |
| Cons4                            | 877         | 248         |
| Cons5                            | 877         | 248         |
| Total                            | 4385        | 1240        |
| Less Travel Impact               |             | 40          |
| <b>Overall Total</b>             | <b>4385</b> | <b>1200</b> |

### Pathway Development

The Urology Review Implementation Project Board has discussed and is finalising the details of patient pathways for the following areas:

- Diagnosis and management of an acutely obstructed kidney with sepsis
- Diagnosis and management if acute urinary retention
- Diagnosis and management of suspected renal colic
- Haematuria Single Visit Pathway
- Lower Urinary Tract Symptoms (LUTS) Pathway
- Prostate Pathway
- Scrotal lumps or swelling (in discussion)

### Performance Indicators

The HSCB PMSI directorate is working with Trust management and clinicians across each of the Trusts concerned to agree a range of service quality indicators and clinical quality indicators which will help all stakeholders to measure the quality of the urology service and the long term benefits and outcome for patients.

**Objectives**

- Implement recommendations of Urology Review
- Deliver agreed volumes of activity
- Establish Team South – to be based at the Southern Trust and to treat patients from the southern area and also the lower third of the western area (Fermanagh)
- To increase from a 3 consultant team to a 5 Consultant team plus two nurse specialists
- Meet PfA target for outpatients (within 9 weeks) and IPDC (within 13 weeks)

**3. Funding -Summary of sources and amounts of available funding including:**

- Recurrent and/or non recurrent funding from commissioners (detailed by LCGs as appropriate)
- Potential recurrent/non-recurrent funding from other agencies e.g. Supporting People monies from NIHE.
- Capital funding where appropriate.

The HSCB has confirmed to the Trust that an additional £1.233m uplifted for 2011/12 is available to fund the full year impact of the new 5 Consultant team known as Team South and the associated activity. This funding also covers the support staff costs including radiology, theatre staff, anaesthetics, nurse specialists, secretarial, administration and goods and services associated with each new consultant appointments.

The Trust is asked to submit a Business Case outlining all capital and recurrent costs concerning the development of Team South.

**4. Timescale and process for submitting**

Timescale within which providers should submit the completed investment decision making proformas to commissioners.

Timescales which providers will be advised of the commissioner's decision.

Arrangements for submitting completed documents.

Trusts must submit the completed IPT by 31 January 2012 to allow for HSCB approval in the final quarter of 2011/12 and ensure that the service is fully operational by 1<sup>st</sup> April 2012.

Completed proposals should be submitted to Mrs Lyn Donnelly, SLCG, Tower Hill Armagh BT61 9DR



**PROVIDER SECTIONS**

|                                       |                                                                                                                                      |                 |           |
|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------|
| Provider                              | Southern Health and Social Care Trust                                                                                                | Submission date | 06 Feb 12 |
| Scheme Title                          | Urology Team South Business Case<br><b>FINAL V1.0 (Approved SMT 08 Feb 12)</b>                                                       |                 |           |
| Responsible Officer - including title | Mrs Heather Trouton, Assistant Director of Acute Services, Surgery and Elective Care                                                 |                 |           |
| Contact Details - Tele no. & Email    | <div style="background-color: black; color: white; font-size: 0.8em; padding: 2px;"> Personal information redacted by the USI </div> |                 |           |

- This business case should be prepared in line with the Green Book and NIGEA Guidance
- Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

**1a) Explain how this proposal specifically meets the needs for this investment (linked directly to the Commissioner statement)**

**Background**

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

*'Develop a modern, fit for purpose in 21st century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'*

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended. The Team South share of the available funding to implement the review has been estimated at £1.233m.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans and business cases to take forward the recommended team model.

The Trust's preferred option which is described in more detail later in this document is to appoint the necessary staff to enable the recommendations made in the regional review to be implemented for the population of Armagh and Dungannon, Craigavon and Banbridge, Newry and Mourne and Fermanagh.

**1b Describe how this proposal will reduce inequalities in Health and Wellbeing**

The specialty of urology predominantly covers the care of urogenital conditions involving diseases of the kidneys, bladder, prostate, penis, testes and scrotum. Bladder dysfunction, male and female continence surgery and paediatric peno-scrotal conditions are also included. The proportion of the male population over 50 years old has risen by approximately 20% over the last 20 years and referrals to secondary care have been rising at 5-10% per year<sup>1</sup>.

Prostate cancer is the most common cancer in men. Each year in the UK about 36,000 men are diagnosed with prostate cancer. It accounts for 25% of all newly diagnosed cases of cancer in men. The chances of developing prostate cancer increase with age. Most cases develop in men aged 70 or older. The causes of prostate cancer are largely unknown.<sup>2</sup>

This proposal will enable the Trust to provide an equitable service to residents of the Southern area and Fermanagh. Reduced waiting times for outpatient assessment and inpatient and day case treatment will be facilitated.

**2a) Objective(s) of this development - these will be examined in more detail in section 10 and 11)**

*Please complete the list below - please note that this list is not exhaustive but is a minimum requirement*

| OBJECTIVES                                                                                                             | DATE/ACTIVITY                                                                                                                  | EXPLANATORY TEXT IF REQUIRED                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Development implemented by what date?                                                                                  | End of August 2012                                                                                                             | The Trust expects to have the new consultants in post by August 2012                                                                                                                                              |
| Target met by what date?                                                                                               | March 2013                                                                                                                     | Compliance with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013. |
| Provide the total capacity (agreed with the HSCB) within the integrated urology service on completion of the project - | March 2014<br>3,948 new outpatient appts<br>5,405 review outpatient appts<br>4,385 day cases/23 hour stays<br>1,200 inpatients | The first full fiscal year for delivery of the increased volume of activity will be 2013/14                                                                                                                       |
| Facilitate the establishment of Team South as specified in the regional review                                         | End of August 2012                                                                                                             | The Trust expects to have the new consultants in post by August 2012                                                                                                                                              |
| Provide an accessible service across the Team South                                                                    | March 2013                                                                                                                     | The first full year for delivery of the enhanced service will be 2012/13                                                                                                                                          |

<sup>1, 2</sup> British Association of Urological Surgeons

|                |  |  |
|----------------|--|--|
| catchment area |  |  |
|----------------|--|--|

**2b) What are the Constraints of the Project?**

*Availability of staff, recruitment difficulties, Constraints in, space, time and funding etc.*

- Availability of Consultant staff
- Funding for equipment
- Access to additional theatre & outpatient sessions

**Current Service Model**

The current service model is an integrated model comprising a consultant led outpatient, day case and inpatient service supported by a range of outpatient clinics delivered by a GP with special interest in urology (GPwSI), a nurse practitioner and two specialist nurses. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The GPwSI/specialist nurse services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital. Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes some urology outpatient and day case work.

**The Urology Team**

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2012 and one post is currently vacant),
- 2 Trust Grade Doctors (2 posts are currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either a GPwSI, specialist nurse or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided by the GPwSI and specialist nurses:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics
- Andrology
- Uro-oncology
- General urology clinic
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

### **Current Sessions**

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

**Table 1: Current Urology Sessions**

|                           | <b>Craigavon</b>           | <b>South Tyrone</b> | <b>Banbridge</b> | <b>Armagh</b> | <b>Total</b> |
|---------------------------|----------------------------|---------------------|------------------|---------------|--------------|
| <b>Consultant Led OPs</b> |                            |                     |                  |               |              |
| General                   | 2.75 per week <sup>1</sup> | 1 per month         | 2 per month      | 2 per month   | 4 per week   |
| Stone Treatment           | 1 weekly                   |                     |                  |               | 1 week       |

| <b>GPwSI &amp; Specialist Nurse</b> | <b>Weekly</b> |
|-------------------------------------|---------------|
| Prostate Assessment                 | 1.5           |
| Prostate Biopsy                     | 1             |
| Prostate Histology                  | 1.5           |
| LUTS                                | 3             |
| Haematuria                          | 2             |
| Andrology                           | 2.5           |
| General Urology/Uro Oncology        | 2.5           |
|                                     |               |
|                                     | <b>14</b>     |

| <b>Main Theatres (CAH)</b> | <b>Weekly</b> |                 |
|----------------------------|---------------|-----------------|
|                            | 6             | 3 all day lists |

|                     | <b>Craigavon</b>        | <b>South Tyrone</b> |
|---------------------|-------------------------|---------------------|
| <b>Day Surgery</b>  |                         |                     |
| GA                  | 1 weekly                | 1 monthly           |
| Flexible Cystoscopy | 1.5 weekly <sup>2</sup> |                     |
| Lithotripsy         | 2 weekly                |                     |

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month

2) 2 lists/1 list on alternate weeks

**Current Activity**

Activity for 2010/11 for the service is shown in Table 2. Core activity and in house additionality have been included in the table

**Table 2: 2010/11 Actual Activity for the Urology Service**

|                |                         | <b>Core Activity</b> | <b>IHA</b> | <b>Totals</b> |
|----------------|-------------------------|----------------------|------------|---------------|
| <b>2010/11</b> | <b>New OP Activity</b>  |                      |            |               |
|                | Consultant Led          | 1086                 | 375        | 1461          |
|                | GPwSI                   | 475                  |            | 475           |
|                | Specialist Nurse Led    | 825                  |            | 825           |
|                | <b>Total New OPs</b>    | <b>2386</b>          | <b>375</b> | <b>2761</b>   |
|                |                         |                      |            |               |
|                | <b>Review OPs</b>       |                      |            |               |
|                | Consultant Led          | 2843                 | 90         | 2933          |
|                | GPwSI                   | 971                  |            | 971           |
|                | Specialist Nurse Led    | 571                  |            | 571           |
|                | <b>Total Review OPs</b> | <b>4385</b>          | <b>90</b>  | <b>4475</b>   |
|                |                         |                      |            |               |
|                | Day Cases               | 1589                 | 152        | 1741          |
|                | Elective FCEs           | 1021                 | 61         | 1082          |
|                | Non Elective FCEs       | 613                  | 0          | 613           |

The current service is unable to meet the demands of the Southern area and a significant amount of in house additionality was required in 2010/11 to meet agreed back stop access targets for outpatients and inpatients/day cases.

A 9 week waiting time for new outpatient appointments is currently being achieved but only with a high level of in house additionality, which is not sustainable. The waiting time for routine inpatient procedures has risen to 56 weeks and for day cases to 62 weeks. The Trust is striving to reduce these waiting times to 36 weeks by the end of the fiscal year.

**3) Option one: Status Quo or Base Case**

Option 1 involves continuing to provide the current level of core activity as shown in Table 1.

**Advantages**

There would be no requirement for additional recurrent investment (although if the Trust continued to provide in house additionality non recurrent funding would be required to support this).

**Disadvantages**

The Trust would be unable to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits

longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could not be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service would not be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would not be achievable for all patients.

The Trust would be unable to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

The additional investment required to enable the Trust to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, would not be provided.

#### **4) Option Two – Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients**

Option 2 involves expanding the current service in line with the recommendations of the regional view to meet the demand from the Southern and Fermanagh areas.

##### Advantages

The Trust would be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

The recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would be appointed;
- The service would be expanded to encompass patients from the Fermanagh area;
- The 62 day cancer target would be achieved.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

A sustainable service model would be facilitated and the Trust would be able to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

##### Disadvantages

Additional recurrent revenue investment will be required.

### **5) Option Three - Provide the Current Level of Service within the Trust and Supplement with Independent Sector Provision.**

Option 3 involves continuing to provide the current level of core activity and supplementing this with independent sector provision to meet the demand from the Southern and Fermanagh areas.

#### Advantages

There would be the potential for the Trust to be able to comply with the 2011/12 PfA outpatient target that all patients are seen within 21 weeks and the inpatient/day case target that no patient waits longer than 36 weeks for treatment by the end of March 2013.

Some, though not all of the recommendations set out in the regional review could be implemented eg:

- The service would be expanded to encompass patients from the Fermanagh area;

The Trust may be able to deliver the annual levels of service which are expected by the HSCB by using IS provision:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

#### Disadvantages

Additional non recurrent revenue investment will be required.

A sustainable service model would not be facilitated and the Trust would be unable to move forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases.

The service would be difficult to manage and the current 3 consultant model would not enable any outreach services to the Fermanagh area. The service would therefore not be an equitable service.

Not all of the recommendations set out in the regional review could be implemented eg:

- 2 additional consultants and associated support staff would not be appointed;
- The service provided to patients from the Fermanagh area would be limited.
- Compliance with the 62 day cancer target for all patients would be a challenge within the current staffing levels.

Independent sector provision is comparatively expensive and this option would therefore not represent good value for money.

**7) Identify and evaluate the overall benefits of all of the options***Consider costs and benefits to other parts of the public and private sectors***PLEASE LIST & SCORE BENEFITS THEN SHOW RANK OF OPTIONS**

|   |                                           |               | <b>1 Base case</b> |                | <b>2 Expand Service<br/>- Create Team South</b> |                | <b>3 Current Service + IS</b> |                |
|---|-------------------------------------------|---------------|--------------------|----------------|-------------------------------------------------|----------------|-------------------------------|----------------|
|   | <b>Criterion</b>                          | <b>Weight</b> | Score              | Score x Weight | Score                                           | Score x Weight | Score                         | Score x Weight |
| 1 | Implement Regional Review recommendations | 45            | 6                  | 270            | 9                                               | 405            | 7                             | 315            |
| 2 | Provide agreed capacity                   | 20            | 6                  | 120            | 10                                              | 200            | 9                             | 180            |
| 3 | Compliance with targets                   | 20            | 6                  | 120            | 9                                               | 180            | 9                             | 180            |
| 4 | Accessible service across Team South area | 15            | 7                  | 105            | 9                                               | 135            | 8                             | 120            |
|   |                                           |               |                    |                |                                                 |                |                               |                |
|   | <b>Totals</b>                             | <b>100</b>    |                    | <b>615</b>     |                                                 | <b>920</b>     |                               | <b>795</b>     |
|   | <b>RANKING</b>                            |               |                    | <b>3</b>       |                                                 | <b>1</b>       |                               | <b>2</b>       |

**Robustness/Bias Test  
(Sensitivity Analysis)****If benefits are not delivered as expected above would the ranking change?**

There is a considerable difference between the total scores of options 2 and 3 which suggests that the ranking is relatively robust. The biggest risk to the scores achieved by the preferred option is around the ability to appoint one or more of the consultant urologists (this risk is addressed in more detail in section 13 below). However, it is the Trust's view that any detrimental effect on the benefits would be short term – ie if both consultant posts cannot be filled immediately, they will be able to be filled later.

**How much would costs increase before VFM (Ref Box 9 is impacted?)**



**8) Financial Quantification of chosen option***Express Costing in total rather than incremental terms to expose full resource consequences*Please note which option is the preferred option -

| OPTION NUMBER AS ABOVE                                                       | Option Name | Total £ (Rec)   | Total £ (Non-Rec) |
|------------------------------------------------------------------------------|-------------|-----------------|-------------------|
| BASE CASE                                                                    |             | £1,346,611      |                   |
| OPTION 2                                                                     |             | £1,494,081      |                   |
| OPTION 3                                                                     |             |                 |                   |
| OPTION 4                                                                     |             |                 |                   |
| Additional Cost (Marginal Increase: Preferred Option less Status Quo Option) |             | <b>£147,470</b> |                   |

**Note: Detail to be contained in costing appendix.**

The estimated funding indicated in the 'Review of Urology Services in NI, A Modernisation & Investment Plan', uplifted for 2011/12 pay and prices has been stated at £1.233m. The staffing identified in the modernisation and investment plan has been replicated in Appendix 2. However as Appendix 2 indicates, if these are re-costed at HSCB rates (yellow columns), then the total recurrent funding is £1,346,611 (ie an additional £113,611). This figure has been used as the base case revenue cost above.

Appendix 1 provides the Trust's required staffing levels and associated costs for the Team South model detailed in option 2. The Trust's staffing and costs are shown in the first two (grey) columns. For ease of comparison the second two (pink) columns show the staffing and costs given in the urology review investment plan and the third two (orange) columns show these costs uplifted to HSCB rates.

The main areas of deficit have been denoted with a red bar. The following notes apply to the Trust's costs:

Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.

The consultant urologist posts have been costed at 11 PAs as 11 PA contracts will maximise the amount of direct clinical PAs. If these are reduced to 10 PAs there will be an associated reduction in activity. The Trust also wishes to highlight the fact that no staff were included in the review investment plan for either Labs or Pharmacy. Both of these support services will be impacted upon by the increase in urology activity.

**9) Value for Money****A) Efficiency Savings (Where applicable)**

- Provide an accurate costing of any savings. Are these savings to be cash released or redeployed? If redeployed please provide full details of redeployment (cost, activity, outcomes etc).

It is not anticipated that this proposal will generate efficiency savings.

**B) Further demonstrate overall Value for Money by including benchmarking evidence**

*B1) Breakdown the elements of the option and compare cost and activity to Status Quo option and benchmarking statistics eg Community Statistical Indicators, Reference Costs, Specialty Costs, HRGs etc.*

*B2 Please explain the reason for any positive or negative variances that exist when the preferred option is compared to B1 above.*

*Positive Variances: eg Better working practices, more efficient use of resources etc. These will indicate VFM.*

*Negative Variances: eg Increased complexity of services etc. These will not initially indicate VFM – More information required below in B3.*

*B3) If there are negative variances shown in B2 above explain how are these offset by, for example Qualitative benefits and the context of the project.*

**10) Preferred Option (Insert option number )**

*Please rank costs and benefits and summarise reasons for selection.*

|                                     | Current<br>Funded<br>Position | 1 Base case | 2 Expand Service<br>- Create Team<br>South | 3 Current<br>Service + IS |
|-------------------------------------|-------------------------------|-------------|--------------------------------------------|---------------------------|
| Benefit Appraisal<br>Weighted Score | -                             | 615         | 920                                        | 795                       |
| Ranking                             | -                             | 3           | 1                                          | 2                         |
| Revenue                             |                               |             |                                            |                           |
| Ranking                             |                               |             |                                            |                           |

Option 2 - Expand the Service to Facilitate Treatment of All Southern Area Patients and Fermanagh Patients is the Trust's preferred option.

Option 2 will enable the Trust to implement the recommendations set out in the regional review of urology services and will facilitate the delivery of the annual levels of service which are expected by the HSCB.

The urology service will be able to comply with the 2011/12 PfA access targets by the end of March 2013 and a sustainable service model would be facilitated.

**11) What are the Specific Outcomes of the preferred option***Quality, Timescales, Quantity (detailed in box 11)*

The recommendations set out in the regional review of urology service could be implemented.

A sustainable service model for the urology service would be facilitated forward with planned reform initiatives such as the introduction of one stop assessment for cancer patients and for haematuria cases, where appropriate.

2 additional consultants and associated support staff would be appointed;

The service would be expanded to encompass patients from the Fermanagh area;

The 62 day cancer target would be achieved for all patients.

The Trust would be able to deliver the annual levels of service which are expected by the HSCB:

- 3,948 new outpatient appointments
- 5,405 review outpatient appointments
- 5,585 inpatient FCEs/day cases

**12) Activity Outcomes***Activity, contacts, placements, procedures etc, please identify***SBA Activity**

|                              | New OP <sup>1</sup> | Review OP <sup>2</sup> | FCEs  | Day Cases/ 23 Hour Stays |
|------------------------------|---------------------|------------------------|-------|--------------------------|
| Original Baseline Activity   | 1,014               | 2,390                  | 1,596 | 1,239                    |
| Additional Baseline Activity | 2,934               | 3,015                  | - 396 | 3,146                    |
| New Baseline Activity        | 3,948               | 5,405                  | 1,200 | 4,385                    |

1) New outpatient appointments comprise 2328 slots at consultant led clinics & 1,620 at support staff clinics.

2) Review outpatient appointments comprise 3,681 slots at consultant led clinics & 1,724 at support staff clinics.

*If approved, activity will be added to Indicative volumes in Organisation's Service and Budget Agreement (if applicable)*

*The above table must be completed for each discreet element of the service in question, please replicate as required. If activity is for more than one LCG please detail separately.*

**13) Assess Risks and Uncertainties**

*Identify the main risks associated with the proposal and how can these be mitigated - these should be scored using the Providers recognized risk scoring method*

The following main risks have been identified in relation to this project:

- Inability to appoint consultant urologists
- Inability to appoint other key staff
- Activity projections are not achieved

These have been assessed using the Trust's scoring methodology:

| Consequence     | Likelihood       |
|-----------------|------------------|
| 1 Insignificant | 1 Rare           |
| 2 Minor         | 2 Unlikely       |
| 3 Moderate      | 3 Possible       |
| 4 Major         | 4 Likely         |
| 5 Catastrophic  | 5 Almost certain |

The consequence and likelihood are combined to provide a risk rating

#### Risk Rating

|           |                                 |
|-----------|---------------------------------|
| <b>H</b>  | Red Risk - High = 20 - 25       |
| <b>M</b>  | Amber Risk - Moderate = 12 - 19 |
| <b>L</b>  | Yellow Risk - Low = 6 - 11      |
| <b>VL</b> | Green Risk - Very Low = 1 - 5   |

| Description of Risk                               | Consequence | Likelihood | Risk Rating |
|---------------------------------------------------|-------------|------------|-------------|
| <i>Inability to appoint consultant urologists</i> | 4           | 3          | M           |
| <i>Inability to appoint other key staff</i>       | 4           | 3          | M           |
| <i>Activity projections are not achieved</i>      | 2           | 3          | L           |

#### *Inability to Appoint Consultant Urologists*

There is a risk that whilst projected activity levels may be accurate, that they may not be achievable if consultant urologists cannot be appointed. This would have a major impact and is possible. However the Trust believes that if one or both posts are not filled immediately they will be filled if advertised again when further staff qualify and are able to apply.

#### *Inability to Appoint Other Key Staff*

There is also a risk that other key staff such as anaesthetic and radiology staff may not be appointed immediately. As with the urologists the Trust would advertise again until posts are filled. In the interim sessions would be provided on and in house additionality basis.

#### *Activity Projections are Not Achieved*

There is a risk that the activity projections may be too high and that they may not be achievable within the available outpatient and theatre sessions. BAUS

recommendations have been used to model the projected activity and the Trust is aware that BAUS is in the process of reviewing its standards and guidelines to reflect current clinical practice. The outcome of this review is awaited.

**14) Monitoring and Post Implementation Evaluation Process – please also refer to detail contained within the Commissioner’s Statement**

Mrs Heather Trouton Assistant Director of Acute Services, Surgery and Elective Care will manage the implementation of this scheme. Depending on the date of approval it is anticipated that the development will be fully implemented by March 2013 (2012/13 will be the first full year for delivery of the enhanced service).

**Timetable for Implementation**

| <b>Task</b>                                               | <b>Timescale</b> |
|-----------------------------------------------------------|------------------|
| Submission of Team South Implementation Plan              | 23 June 10       |
| Approval to Proceed with Implementation from HSCB         | July 11          |
| Completion of Job Plans/Descriptions for Consultant Posts | End December 11  |
| Consultant Job Plans to Specialty Advisor                 | January 2012     |
| Advertisement of Consultant Posts                         | End February 12  |
| New Consultants in post                                   | August 2012      |

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation of the proposal if approved. This evaluation will be undertaken by the Head of Service for ENT and Urology.

**15) Other relevant information**

Please note any other appendices or attachments

**HSCB Costing Schedule**

**Appendix 1 Team South Staffing and Costs**

**Appendix 2 Estimated Team Costs form the ‘Review of Urology Services in NI, A Modernisation & Investment Plan’**

**16) Signature of individuals responsible for this bid – Provider Section**

|                           |  |      |
|---------------------------|--|------|
| Trust Authorising Officer |  | Date |
| Title                     |  |      |

|                                                                                            |                           |                                     |
|--------------------------------------------------------------------------------------------|---------------------------|-------------------------------------|
| Trust Director of Finance<br>Signature                                                     |                           | Date                                |
| Trust Chief Executive<br>Signature                                                         |                           | Date                                |
| 17) Approval or rejection (Local/Regional Commissioning Use only-HSCB and PHA)             |                           |                                     |
|                                                                                            | Approved                  | Rejected (if yes<br>detail reasons) |
| Yes/No                                                                                     |                           |                                     |
| <u>Responsible Person</u>                                                                  |                           |                                     |
| Signature                                                                                  | Date                      | Position                            |
| <u>Authorising Person</u>                                                                  |                           |                                     |
| Signature                                                                                  | Date                      | Position                            |
| Director of Finance Authorisation or delegated officer                                     |                           |                                     |
| Signature                                                                                  | Date                      | Position                            |
| Chief Executive Authorisation                                                              |                           |                                     |
| Signature                                                                                  | Date                      | Position                            |
| <b>SUMMARY OF FUNDS APPROVED - IF THIS DIFFERS FROM PREFERRED OPTION<br/>PLEASE DETAIL</b> |                           |                                     |
| <b>TO BE UPDATED<br/>BY THE<br/>RESPONSIBLE<br/>OFFICER FOR<br/>TRAFFACS</b>               | <b>FYE of project (£)</b> | <b>CYE of project (£)</b>           |
|                                                                                            |                           |                                     |
| <b>SOURCE OF FUNDS</b>                                                                     |                           |                                     |

|                                                                   |  |                |  |            |  |
|-------------------------------------------------------------------|--|----------------|--|------------|--|
| Summary Costing schedule for Investment Decision Making Templates |  |                |  | Ref Number |  |
| Provider                                                          |  | SOUTHERN       |  |            |  |
| Hospital Site or Community development                            |  | CRAIGAVON      |  |            |  |
| Scheme Title                                                      |  | UROLOGY REVIEW |  |            |  |
| Pay and Price Levels                                              |  | 2011/12        |  |            |  |

WIT-39531

DRAFT

|                                   |
|-----------------------------------|
| Commissioner Use only             |
| Sign and Date for TRAFFACS update |
|                                   |

\*\*\*\*PLEASE NOTE ATTACHED FINANCIAL COSTINGS APPENDIX 1 AND 2 PROVIDE MORE DETAILED ANALYSIS OF AMOUNTS NOTED IN COSTING SCHEDULE\*\*\*\*

| Pay Costs                                                                                                                  | Description | Base Case - option 1 |       |           |     | Option 2       |       |           |     | Option 3       |      |     |     | Option 4       |      |     |     |
|----------------------------------------------------------------------------------------------------------------------------|-------------|----------------------|-------|-----------|-----|----------------|-------|-----------|-----|----------------|------|-----|-----|----------------|------|-----|-----|
|                                                                                                                            |             | months claimed       | wte   | fye       | cye | months claimed | wte   | fye       | cye | months claimed | wte  | fye | cye | months claimed | wte  | fye | cye |
| BAND 1                                                                                                                     |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 2                                                                                                                     |             |                      |       |           | 0   | 0.00           | 3.43  | 73,433    | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 3                                                                                                                     |             |                      |       |           | 0   | 0.00           | 3.45  | 81,472    | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 4                                                                                                                     |             |                      |       |           | 0   | 0.00           | 2.10  | 56,644    | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 5                                                                                                                     |             |                      |       |           | 0   | 0.00           | 6.50  | 216,287   | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 6                                                                                                                     |             |                      |       |           | 0   | 0.00           | 2.36  | 94,056    | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 7                                                                                                                     |             |                      |       |           | 0   | 0.00           | 1.70  | 81,003    | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 8A                                                                                                                    |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 8B                                                                                                                    |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 8C                                                                                                                    |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 8D                                                                                                                    |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| BAND 9                                                                                                                     |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| Non-AFC posts please detail below                                                                                          |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| Consultant Urologist                                                                                                       |             |                      |       |           | 0   | 0.00           | 2.00  | 282,460   | 0   |                |      |     | 0   |                |      |     | 0   |
| Consultant Anaesthetist                                                                                                    |             |                      |       |           | 0   | 0.00           | 1.00  | 125,941   | 0   |                |      |     | 0   |                |      |     | 0   |
| Consultant Radiologist                                                                                                     |             |                      |       |           |     | 0.00           | 0.60  | 75,565    | 0   |                |      |     |     |                |      |     |     |
| Consultant Pathologist                                                                                                     |             |                      |       |           |     | 0.00           | 0.10  | 12,594    | 0   |                |      |     |     |                |      |     |     |
| Upgrade 2 Band 5 nurse posts to Band 6                                                                                     |             |                      |       |           |     | 0.00           | 0.00  | 12,172    | 0   |                |      |     |     |                |      |     |     |
| Base Case assumed to be proposed funding of £1.233m, restated at HSCB Costing Schedule 11-12 rates (Pay)                   |             | 0.00                 | 18.04 | 991,538   | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| Exceptional Recruitment and Retention costs for posts above the mean plus x% (please provide detail)                       |             |                      |       |           | 0   |                |       |           | 0   |                |      |     | 0   |                |      |     | 0   |
| TOTAL PAY COSTS                                                                                                            |             |                      | 18.04 | 991,538   | 0   |                | 23.24 | 1,111,627 | 0   |                | 0.00 | 0   | 0   |                | 0.00 | 0   | 0   |
| Non-Pay Costs - please detail below                                                                                        |             |                      |       |           |     |                |       |           |     |                |      |     |     |                |      |     |     |
| Base Case assumed to be proposed funding of £1.195m, uplifted by 3.18% to 11-12 rates to £1.233m . (Goods proportion only) |             | 0.00                 |       | 355,073   |     |                |       |           |     |                |      |     |     |                |      |     |     |
| Outpatient Attendances 1540 new & 334 review                                                                               |             |                      |       |           | 0   | 0.00           |       | 95,574    |     |                |      |     |     |                |      |     |     |
| Day Case/23 hr stays 3146                                                                                                  |             |                      |       |           | 0   | 0.00           |       | 314,600   |     |                |      |     | 0   |                |      |     | 0   |
| FCE's -396                                                                                                                 |             |                      |       |           | 0   | 0.00           |       | -27,720   |     |                |      |     | 0   |                |      |     | 0   |
| TOTAL NON-PAY COSTS                                                                                                        |             |                      |       | 355,073   | 0   |                |       | 382,454   | 0   |                |      | 0   | 0   |                |      | 0   | 0   |
| GRAND TOTAL                                                                                                                |             |                      |       | 1,346,611 | 0   |                |       | 1,494,081 | 0   |                |      | 0   | 0   |                |      | 0   | 0   |

| Phasing/Timescale                                                       | (Can development be phased, if so provide details in this box) | (Can development be phased, if so provide details in this box) | (Can development be phased, if so provide details in this box) | (Can development be phased, if so provide details in this box) |
|-------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------|
| PROGRAMME OF CARE                                                       | acute                                                          | acute                                                          |                                                                |                                                                |
| SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known | daycases                                                       | daycases                                                       |                                                                |                                                                |
| LCG                                                                     | Southern                                                       | Southern                                                       |                                                                |                                                                |
| If more than one LCG in option above please give details                |                                                                |                                                                |                                                                |                                                                |
| LGD                                                                     |                                                                |                                                                |                                                                |                                                                |
| If more than one LGD in option above please give details                |                                                                |                                                                |                                                                |                                                                |

## Urology Staffing and Costs

v0.1 updated 12 Jan 2012

## APPENDIX 1

|                                              |              | Full Year<br>Cost per<br>SHSCT | Funding per<br>HSCB | Deficit         | Funding per<br>HSCB<br>restated at 11<br>12 rates | Deficit         | Main areas<br>of deficit |
|----------------------------------------------|--------------|--------------------------------|---------------------|-----------------|---------------------------------------------------|-----------------|--------------------------|
|                                              | WTE          | £                              | £                   |                 |                                                   |                 |                          |
| <b>Recurring</b>                             |              |                                |                     |                 |                                                   |                 |                          |
| <b>Medical Staff</b>                         |              |                                |                     |                 |                                                   |                 |                          |
| Consultant Urologist                         | 2.00         | 282,460                        | 208,000             | -74,460         | 244,530                                           | -37,930         |                          |
| Consultant Anaesthetist                      | 1.00         | 125,941                        | 124,800             | -1,141          | 146,718                                           | 20,777          |                          |
| Consultant Radiologist                       | 0.60         | 75,565                         | 62,400              | -13,165         | 73,359                                            | -2,206          |                          |
|                                              | <b>3.60</b>  | <b>483,966</b>                 | <b>395,200</b>      | <b>-88,766</b>  | <b>464,607</b>                                    | <b>-19,359</b>  |                          |
| <b>Specialist Nursing</b>                    |              |                                |                     |                 |                                                   |                 |                          |
| Upgrade 2 Band 5 posts to Band 6             |              | 12,172                         |                     | -12,172         |                                                   | -12,172         |                          |
| Band 5                                       | 1.00         | 33,275                         | 103,605             | 70,330          | 119,123                                           | 85,848          |                          |
|                                              | <b>1.00</b>  | <b>45,447</b>                  | <b>103,605</b>      | <b>58,158</b>   | <b>119,123</b>                                    | <b>73,676</b>   |                          |
| <b>Theatres/Recovery Nurses</b>              |              |                                |                     |                 |                                                   |                 |                          |
| Band 6                                       | 0.26         | 10,362                         |                     | -10,362         |                                                   | -10,362         |                          |
| Band 5                                       | 4.74         | 157,724                        | 106,754             | -50,970         | 126,778                                           | -30,946         |                          |
| Band 3                                       | 0.43         | 9,906                          | 17,870              | 7,964           | 21,195                                            | 11,289          |                          |
| Band 2                                       | 1.21         | 24,657                         |                     | -24,657         |                                                   | -24,657         |                          |
|                                              | <b>6.64</b>  | <b>202,649</b>                 | <b>124,624</b>      | <b>-78,025</b>  | <b>147,973</b>                                    | <b>-54,676</b>  |                          |
| <b>Preassessment</b>                         |              |                                |                     |                 |                                                   |                 |                          |
| Band 6                                       | 0.13         | 5,181                          |                     | -5,181          |                                                   | -5,181          |                          |
| Band 5                                       | 0.26         | 8,652                          | 13,833              | 5,182           | 13,833                                            | 5,182           |                          |
|                                              | <b>0.39</b>  | <b>13,833</b>                  | <b>13,833</b>       | <b>0</b>        | <b>13,833</b>                                     | <b>0</b>        |                          |
| <b>Outpatients</b>                           |              |                                |                     |                 |                                                   |                 |                          |
| Band 3                                       | 0.52         | 11,980                         | 11,980              | 0               | 11,980                                            | 0               |                          |
|                                              | <b>0.52</b>  | <b>11,980</b>                  | <b>11,980</b>       | <b>0</b>        | <b>11,980</b>                                     | <b>0</b>        |                          |
| <b>Radiography</b>                           |              |                                |                     |                 |                                                   |                 |                          |
| Radiographer Band 7                          | 1.00         | 47,649                         |                     | -47,649         |                                                   | -47,649         |                          |
| Radiographer Band 6                          | 1.00         | 39,854                         |                     | -39,854         |                                                   | -39,854         |                          |
| Radiographer Band 5                          | 0.50         | 16,638                         | 100,782             | 84,145          | 119,790                                           | 103,153         |                          |
| Radiography Helper Band 3                    | 1.00         | 23,038                         |                     | -23,038         |                                                   | -23,038         |                          |
|                                              | <b>3.50</b>  | <b>127,179</b>                 | <b>100,782</b>      | <b>-26,397</b>  | <b>119,790</b>                                    | <b>-7,389</b>   |                          |
| <b>Laboratory</b>                            |              |                                |                     |                 |                                                   |                 |                          |
| Consultant Pathologist                       | 0.10         | 12,594                         |                     | -12,594         |                                                   | -12,594         |                          |
| BMS Cellular Pathology Band 6                | 0.20         | 7,971                          |                     | -7,971          |                                                   | -7,971          |                          |
| BMS Blood Sciences Band 6                    | 0.77         | 30,688                         |                     | -30,688         |                                                   | -30,688         |                          |
|                                              | <b>1.07</b>  | <b>51,252</b>                  | <b>0</b>            | <b>-51,252</b>  | <b>0</b>                                          | <b>-51,252</b>  |                          |
| <b>Pharmacy</b>                              |              |                                |                     |                 |                                                   |                 |                          |
| Clinical Pharmacist Band 7                   | 0.70         | 33,354                         |                     | -33,354         |                                                   | -33,354         |                          |
| Pharmacy Technician Band 4                   | 0.60         | 16,184                         |                     | -16,184         |                                                   | -16,184         |                          |
|                                              | <b>1.30</b>  | <b>49,538</b>                  | <b>0</b>            | <b>-49,538</b>  | <b>0</b>                                          | <b>-49,538</b>  |                          |
| <b>CSSD</b>                                  |              |                                |                     |                 |                                                   |                 |                          |
| Band 3                                       | 0.38         | 10,745                         |                     | -10,745         |                                                   | -10,745         |                          |
| ATO Band 2                                   | 0.76         | 19,024                         | 29,770              | 10,746          | 29,770                                            | 10,746          |                          |
|                                              | <b>1.14</b>  | <b>29,770</b>                  | <b>29,770</b>       | <b>0</b>        | <b>29,770</b>                                     | <b>0</b>        |                          |
| <b>Admin Support</b>                         |              |                                |                     |                 |                                                   |                 |                          |
| PAS/Clinical Coding Band 4                   | 0.50         | 13,487                         | 11,632              | -1,855          | 13,487                                            | 1               |                          |
| Personal Secretary Band 4                    | 1.00         | 26,973                         | 23,265              | -3,708          | 26,973                                            | 0               |                          |
| Booking Clerk Band 3                         | 0.62         | 14,284                         | 31,438              | 17,154          | 36,400                                            | 22,116          |                          |
| Health Records Band 2                        | 0.48         | 9,781                          |                     | -9,781          |                                                   | -9,781          |                          |
| Radiology support Band 3                     | 0.30         | 6,911                          | 6,618               | -293            | 7,602                                             | 691             |                          |
| Theatres Band 2                              | 0.14         | 2,853                          |                     | -2,853          |                                                   | -2,853          |                          |
|                                              | <b>3.04</b>  | <b>74,289</b>                  | <b>72,953</b>       | <b>-1,336</b>   | <b>84,462</b>                                     | <b>10,173</b>   |                          |
| <b>Hotel Services</b>                        |              |                                |                     |                 |                                                   |                 |                          |
| Band 2                                       | 0.84         | 17,118                         |                     | -17,118         |                                                   | -17,118         |                          |
| <b>Stores</b>                                |              |                                |                     |                 |                                                   |                 |                          |
| Band 3                                       | 0.20         | 4,608                          |                     | -4,608          |                                                   | -4,608          |                          |
| <b>TOTAL RECURRING PAYROLL COSTS</b>         | <b>23.24</b> | <b>1,111,627</b>               | <b>852,747</b>      | <b>-258,880</b> | <b>991,538</b>                                    | <b>-120,089</b> |                          |
| <b>Goods &amp; services</b>                  |              |                                |                     |                 |                                                   |                 |                          |
| Outpatient attendances 1540 new & 334 review |              | 95,574                         | 14,187              | -81,387         | 15,459                                            | -80,115         |                          |
| Day case/23 hour stays 3146                  |              | 314,600                        | 328,230             | 13,630          | 339,614                                           | 25,014          |                          |
| FCEs -396                                    |              | -27,720                        |                     | 27,720          |                                                   | 27,720          |                          |
| <b>TOTAL GOODS &amp; SERVICES</b>            |              | <b>382,454</b>                 | <b>342,417</b>      | <b>-40,037</b>  | <b>355,073</b>                                    | <b>-27,381</b>  |                          |
| Inflation at c3.18%                          |              |                                | 37,836              | 37,836          |                                                   |                 |                          |
| <b>TOTALS</b>                                |              | <b>1,494,081</b>               | <b>1,233,000</b>    | <b>-261,081</b> | <b>1,346,611</b>                                  | <b>-147,470</b> |                          |

## Notes:-

1. Cons Urologist costed at 11 pa's and Cat A 1:5 to 1:8 rota (5%)
2. Cons Anaesthetist costed at 10 pa's and Cat A 1:9 rota or less (3%)
3. Cons Radiologist costed at 10 pa's and Cat A 1:9 rota or less (3%)
4. Outpatient attendances costed at marginal goods and services rate using 10-11 TFR (unit cost of £51)
5. Day Case/23 hr stays costed at marginal goods and services rate using TFR 10-11 Day Case rate (unit cost of £100)
6. FCE net off costed on same basis as Day Cases.
7. CSSD staff costed at unsocial hrs rates from HSCB 11-12 costing schedule.



**Appendix 2**

Estimated Team Costs for the 'Review of Urology Services in NI, A Modernisation &amp; Investment Plan' Recommendations.

|                                                                  | Team South | Recosted at HSCB General Costing 11-12 rates | Whole Time Equivalent | Team North | Team East | Total    | No   | Unit Cost | Total    |
|------------------------------------------------------------------|------------|----------------------------------------------|-----------------------|------------|-----------|----------|------|-----------|----------|
| <b>Staffing Costs</b>                                            |            |                                              |                       |            |           |          |      |           |          |
| Consultant Urologist – additional wte team allocation            | 2 wte      |                                              |                       | 1 wte      | 3 wte     | 6        | 6    |           |          |
| Consultant Urologists wte                                        | £208,000   | £244,530                                     | 2.00                  | £104,000   | £312,000  | £624,000 |      | £104,000  | £624,000 |
| Consultant Anaesthetist @ 0.6 wte per Con. Urologist             | £124,800   | £146,718                                     | 1.20                  | £62,400    | £187,200  | £374,400 | 3.6  | £104,000  | £374,400 |
| Consultant Radiologist @ 0.3 wte per Con. Urologist              | £62,400    | £73,359                                      | 0.60                  | £31,200    | £93,600   | £187,200 | 1.8  | £104,000  | £187,200 |
| Band 5 Radiographer @ 6 per wte Con Radiologist                  | £100,782   | £119,790                                     | 3.60                  | £50,391    | £151,173  | £302,346 | 10.8 | £27,995   | £302,346 |
| Band 5 Theatre Nursing @ 1.8 wte per Con. Urologist              | £100,782   | £119,790                                     | 3.60                  | £50,391    | £151,173  | £302,346 | 10.8 | £27,995   | £302,346 |
| Band 3 Nursing @ 0.46 wte per Con. Urologist                     | £17,870    | £21,195                                      | 0.92                  | £8,935     | £26,805   | £53,610  | 2.7  | £19,856   | £53,611  |
| Band 7 Specialist Nursing *1                                     | £103,605   | £119,123                                     | 2.50                  | £0         | £103,605  | £207,210 | 5    | £41,442   | £207,210 |
| Band 5 Nursing @ 0.64 wte (day surgery)                          | £5,972     | £6,988                                       | 0.21                  | £2,986     | £8,958    | £17,916  | 0.64 | £27,995   | £17,917  |
| Band 4 Personal Secretary @ 0.5 wte per consultant urologists    | £23,265    | £26,973                                      | 1.00                  | £11,633    | £34,897   | £69,795  | 3    | £23,265   | £69,795  |
| Band 3 Admin support to radiologists at 0.5 wte per Radiologist  | 6,618      | 7,602                                        | 0.33                  | 3,309      | 9,927     | £19,854  | 1    | £19,856   | £19,856  |
| Band 3 Admin Support to Specialist Nurses @ 0.5 wte per Nurse *2 | £31,438    | £36,400                                      | 1.58                  | £0         | £28,129   | £59,567  | 3    | £19,856   | £59,568  |
| Band 4 Medical Records support 0.5 per unit *3                   | £11,632    | £13,487                                      | 0.50                  | £23,265    | £23,265   | £58,162  | 2.5  | £23,265   | £58,162  |

|                                                        | Team South        | Recosted at HSCB General Costing 11-12 rates | Whole Time Equivalent | Team North      | Team East         | Total             | No   | Unit Cost | Total             |
|--------------------------------------------------------|-------------------|----------------------------------------------|-----------------------|-----------------|-------------------|-------------------|------|-----------|-------------------|
| Band 7 MLSO – Bio-medical Science *4                   |                   |                                              |                       |                 | £41,442           | £41,442           | 1    | £41,442   | £41,442           |
| <b>Staffing Costs Sub Total</b>                        | <b>£797,164</b>   | <b>£935,955</b>                              | <b>18.04</b>          | <b>£348,510</b> | <b>£1,172,174</b> | <b>£2,317,848</b> |      |           | <b>£2,317,853</b> |
| <b>Support Costs</b>                                   |                   |                                              |                       |                 |                   |                   |      |           |                   |
| Surgical G&S @ £94,500 per Con. Urologist              | 189,000           | 195,010                                      |                       | 94,500          | 283,500           | £567,000          | X 6  | £94,500   | £567,000          |
| Theatre Goods/Disposables @ £50,000 per Con. Urologist | 100,000           | 103,180                                      |                       | 50,000          | 150,000           | £300,000          | X 6  | £50,000   | £300,000          |
| Radiology G&S per Con. Urologist                       | 5,000             | 5,159                                        |                       | 2,500           | 7,500             | £15,000           | X 6  | £2,500    | £15,000           |
| CSSD @ £32,000 per Con. Urologist                      | 64,000            | 66,035                                       |                       | 32,000          | 96,000            | £192,000          | X 6  | £32,000   | £192,000          |
| Outpatients Clinics @ 2 per Con. Urologist             | 40,000            | 41,272                                       |                       | 20,000          | 60,000            | £120,000          | X 12 | £10,000   | £120,000          |
| <b>Support Costs Sub Total</b>                         | <b>£398,000</b>   | <b>£410,656</b>                              |                       | <b>£199,000</b> | <b>£597,000</b>   | <b>£1,194,000</b> |      |           |                   |
| <b>Sub Total</b>                                       | <b>£1,195,164</b> | <b>£1,346,611</b>                            |                       | <b>£547,510</b> | <b>£1,769,174</b> | <b>£3,511,848</b> |      |           | <b>£3,511,853</b> |
| Less funding in 2008/09                                |                   |                                              |                       |                 | <b>£637,076</b>   | <b>£637,076</b>   |      |           | <b>-£637,076</b>  |
| <b>Less Funding allocated</b>                          |                   | <b>£1,233,000</b>                            |                       |                 |                   |                   |      |           |                   |
| <b>DEFICIT</b>                                         |                   | <b>£113,611</b>                              |                       |                 |                   |                   |      |           |                   |
| <b>FINAL TOTAL</b>                                     | <b>£1,195,164</b> |                                              |                       | <b>£547,510</b> | <b>£1,132,098</b> | <b>£2,874,772</b> |      |           | <b>£2,874,777</b> |

Please note this analysis is based on the team figures included in the Review shown in Appendix 7 page 60.

3.18% inflation

\*1 – this is based on the existing CNS nurse establishment and the sub specialty consultants within each of the teams. The remaining 1 CNS has been allocated to Team East for the Radical Pelvic Surgery undertaken at the Cancer Centre.

|            | Existing Establishment |  |  | Number of consultants with a sub-specialty interest | Additional CNS |
|------------|------------------------|--|--|-----------------------------------------------------|----------------|
| Team South | 0                      |  |  | 2                                                   | 2              |
| Team North | 2                      |  |  | 2                                                   | 0.5            |
| Team East  | 2                      |  |  | 4                                                   | 2.5            |

\*2 – 0.5 allocated to each Team as per the Specialist Nurse

\*3 – 0.5 allocated to each Trust Unit within each Team

\*4 – 1 wte allocated to Belfast – for increased demand for pathology

Please note this is the notional funding for each team and is subject to the agreed Commissioning arrangements of the Board

**Cunningham, Hannah**

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**From:** Rankin, Gillian Personal Information redacted by the USI  
**Sent:** 17 April 2010 15:12  
**To:** Stinson, Emma M  
**Subject:** FW: for action - FW: Urology Review  
**Attachments:** Review of Urology Services update april 10.doc

**Importance:** High

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

-----  
**From:** Clarke, Paula  
**Sent:** Saturday, April 17, 2010 3:11:55 PM  
**To:** Waddell, Sandra  
**Cc:** Corrigan, Martina; Trouton, Heather; Rankin, Gillian; Lappin, Lynn; O'Neill, Helen  
**Subject:** for action - FW: Urology Review  
**Importance:** High  
 Auto forwarded by a Rule

Sandra please see attached assessment from martina against urology review recommendations. We had phone conference with beth molloy Friday which was very helpful in clarifying action needed to move team south developments along asap. I have left my notes in the office but from memory please note the following action required:

- As previously agreed you will be a member of the project team that will report to the project board. We agreed outline membership on Friday for these groups
- RHSCB are funding a band 7 project mgr to support the implementation process for 12 months from date of appt – this will be extremely valuable in informing the devlpt of the business case and actually driving implementation. Heather will take forward options for filling this post.
- There will be a first mtg of team south project board on 13/5 10am - ? 2pm hold. Beth molloy and mark Fordham will attend. The attached paper will be one agenda item. I would also suggest that a PID is another item including draft project structure/membership/TOR/deliverables/timescales. Could you start to develop this with Martina please? Also hold this date in your diary as well
- There is £2.9m available regionally to implement the review of which we are earmarked for £1.1m. This excluded any additional beds required which could be problematic given our own productivity drive and reduction to 13 beds already. We will need to develop the resource requirements to see if the 1.1m is sufficient considering the need for beds. This will be informed by the bed modelling that is ongoing for CAH and includes anticipated flows from WHSCT. It will need to be refined to take account of benchmarking in the review paper and what DC activity may be delivered in WHSCT sites. Could you get up to speed on this with Lynn please?
- Lynn will also be able to update re most recent cap/demand position. Again we will need to factor in 2 additional consultants + additional demand to consider job plan potential and again ensure we are using expected outputs by cslt as advised in review (page 41). One complication with the cap/demand is the direction from RHSCB that from 10/11, cap/demand will be consistently modelled across the region using what we have come to call the "peter McL" formulae! i.e diff between WL end of march one yr and the next + IHA + IS = demand and capacity = SBA. I understand RHSCB are to model this up for all specialties and provide to Trusts to QA. Beth is to check what yr/timescales for urology.
- Needless to say the bus case is needed as soon as feasible but cant be developed until the above issues are addressed/progressed. Useful to develop an action plan to determine the interdependencies – if you and martina could work on this it can then be taken on by the project mgr.

Remembered more than I thought! Happy to discuss.

(HELEN have ccd you in as clearly finance input will be required although perhaps a bit early yet)

Thanks

Paula Clarke  
Acting Director Performance and Reform

Personal Information redacted by the USI

From: Corrigan, Martina  
Sent: 16 April 2010 18:23  
To: Rankin, Gillian; Clarke, Paula  
Subject: FW: Urology Review  
Importance: High

Dear Dr Rankin/Paula,

As discussed, please find attached a summary of where we are currently at in respect to the implementation of the Urology Review.

Also to advise I have contacted Joe Lusby's office and his secretary has held the afternoon of the 10 May to meet with Heather, Mr Young and I. Joe is actually out of the country until Tuesday so I have left a message for him to contact me then, as his secretary advises that he has CMT and a meeting with Chief Executive on 13th May, so I want to get the opportunity to talk to him about the meeting with Mark Fordham.

Any queries, please do not hesitate to contact me.

Kind regards

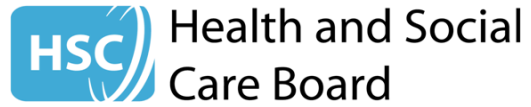
Martina

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

Tel: Personal Information redacted by the USI

Mobile: Personal Information redacted by the USI

Email: Personal Information redacted by the USI



## **REGIONAL REVIEW OF ADULT UROLOGY SERVICES**

**April 2010**

This document makes a total of 26 Recommendations, which are set out in Table 1 below.

| Recommendation                                                                                                                                                                                                                                                                                   | Update 15 April 2010                                                                                                                                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial portion of a surgeon's practice (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team. | Only the Urologist's in the Southern Trust undertake these urological procedures.                                                                                                                     |
| 2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team                                                                                  | The Trust will keep this under review as Consultant Surgeons retire and make appropriate plans to transfer the "N" code work to urologists.                                                           |
| 3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance. (Section 2 – Introduction and Context, pg 5)                                                                                         | The Trust need to undertake this review and to take into account the service pathways from Primary Care to both Urology and Gynae services.<br><b>Action: Group to be set up to take this forward</b> |
| 4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.                                                                                                                                             | This process was reviewed by the Trust last Summer and is in place.                                                                                                                                   |

|                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.</p>                                                           | <p>The Trust has a number of representatives that sit and attend meetings for this Group and have been involved in the discussion in respect to the referral guidelines and pathways. The Trust commenced its formal Multi-disciplinary Team meetings on 1 April on Thursday afternoons were suspected and confirmed urological cancer pathways and referrals are discussed.</p> |
| <p>6. Deployment of New Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.</p>                                                                       | <p>The Trust will take this into account when preparing job descriptions and job plans.</p>                                                                                                                                                                                                                                                                                      |
| <p>7. Urologists, in collaboration with General Surgery and A&amp;E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).</p> | <p>The Trust have commenced work on this, for example patients presenting with Urinary Tract Retention. These have been shared with A&amp;E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways.</p>                                                            |
| <p>8. Urologists, in collaboration with A&amp;E colleagues, should develop and implement protocols/care pathways for those patients requiring direct</p>                                                                                                                                                | <p>The Trust have commenced work on this, for example</p>                                                                                                                                                                                                                                                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>transfer and admission to an acute Urology Unit. (Section 3 –Current Service Profile, pg 5).</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <p>patients presenting with Urinary Tract Retention. These have been shared with A&amp;E and a meeting is planned for beginning of May to get agreement on this and then implementation. The Trust will continue to work on other protocols and care pathways</p>                                                                                                                                                                                                                                    |
| <p>9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5).</p>                                                                                       | <p>This recommendation will be actioned as part of the implementation of the review and will include representatives from Urology, A&amp;E and General Surgeons from the those hospitals that do not have a Urology Unit.</p> <p><b>Action:- Meeting to be set up to include all as mentioned above to take this forward</b></p>                                                                                                                                                                     |
| <p>10. In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5).</p> | <p>This recommendation has commenced as from week beginning 5 April the protected Urology Thursday slot will look at each of the ICATS services. 8<sup>th</sup> April looked at Andrology and it was agreed that this service would be split in two and one part will deal with erectile dysfunction. Today the discussions were concentrating on benign prostatic disease. Notes from these meetings will be available and then discussions and recommendations from these will be implemented.</p> |



|                                                                                                                                                                                                                                               | <b>Action: these weekly meetings to continue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 11. Trusts (Urology departments) will be required to evidence (in their implementation plans) delivery of the key elements of the Elective Reform Programme.                                                                                  | The Trust currently adhere to key elements of the Elective Reform Programme, for example, IEAP, pre-op assessment, monitor admission on day of surgery, etc and through weekly dashboard reports etc will be able to evidence. For example the Trust are also looking at methods of operation e.g. TURP to increase day surgery and recognise that some investment is required for equipment to meet these targets and other of the key elements are being taken into consideration for Urology. |
| 12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6). | This redesign is all part of the protected ‘Thursday’ meetings and are currently aiming through Thorndale unit to facilitate a single visit for suspected urological cancer patients. we are currently drawing up a timetable at what will be discussed at each of these meetings so as to assist in taking forward these recommendations                                                                                                                                                        |
| 13. Trusts should implement the key elements of the elective reform programmed with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.                                                     | This is currently on-going as per recommendation 11                                                                                                                                                                                                                                                                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6).</p>                                                                                       | <p>This point will part of the implementation plan and still needs to be actioned with Consultants. Mr Mark Fordham is visiting the Trust on 13 May and can be included in discussions with the Urologists.</p>                                                                                                                                                                                     |
| <p>15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6).</p> | <p>This point will part of the implementation plan and still needs to be actioned with Consultants along with their colleagues in other Trusts</p>                                                                                                                                                                                                                                                  |
| <p>16. Trusts should review their outpatient review practice, design other methods/staff where appropriate and subject to casemix/complexity issues reduce new: review ratios to the level of peer colleagues.</p>                                                                                                                                                                                     | <p>This has partially commenced in the Dr Rodgers, General Practitioner with Specialist Interest (GPWSI) attends Mr Young's weekly CAH outpatient clinic to see reviews. Also Shirley Tedford the Urology Nurse Co-ordinator has started to do chart, letter and results reviews on review patients and then discusses their outcome with the consultants and agrees the best pathway for them.</p> |
| <p>17. Trust must modernise and redesign outpatient clinic templates and admin/booking processes to ensure their capacity for new and review patients and to prevent backlogs occurring in the future.</p>                                                                                                                                                                                             | <p>The admin/booking processes are in place. As part of the whole review each Urologist will be met to</p>                                                                                                                                                                                                                                                                                          |

|                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                 | discuss their clinic templates and ensure that there is enough capacity for the new and review. This will also depend on the availability of Registrars/Junior Staff to assist at the clinics as there had been a deficit for a while. <b>Action: On-going</b> |
| 18. The NICA Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG. (Section 7 – Urological Cancers, pg 6).                                                                                                            | This is on-going with representatives of the Trust attending and actioning recommendations from the NICA group                                                                                                                                                 |
| 19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6). | There is ongoing discussions taking place regarding this recommendation                                                                                                                                                                                        |
| 20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6).                                                                     | There is ongoing discussions taking place regarding this recommendation                                                                                                                                                                                        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6).</p>                                                                                                                                                                                                         | <p>A business case needs to be prepared for two additional Consultant Urologists for the Southern Trust to include their support and any equipment required in order that they will take into account specialist interests as per Recommendation 6. Work has commenced on team job plans and job descriptions will now have to be drawn up.</p> |
| <p>22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6).</p>                                                                                       | <p>Work has commenced on team job plans and job descriptions will now have to be drawn up.</p> <p>Discussions need to take place with Theatres to identify the additional operating sessions and take into account the other sites within the catchment area.</p>                                                                               |
| <p>23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6).</p> | <p>Job plans, job descriptions will have to be developed as part of the implementation plan.</p>                                                                                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <p>24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7).</p>                                                                                                                                                                                                                                                                                                                  | <p>Agreement that this is part of the implementation plan</p>                                                                               |
| <p>25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7).</p>                                                                                                                                                                            | <p>Not applicable to this Trust</p>                                                                                                         |
| <p>26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7).</p> | <p>Meeting being set up for beginning of May with the Western Trust to begin to work in partnership to discuss the implementation plan.</p> |



*Performance and Corporate Services*

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Mrs Aldrina Magwood  
Acting Director of Performance & Reform  
Southern HSC Trust  
Trust Headquarters  
Craigavon Area Hospital  
68 Lurgan Road  
PORTADOWN  
BT63 5QQ

Tel : [Personal Information redacted by the USI]  
Email: [Redacted]

Our Ref: MB334  
Date: 26 June 2015

Dear Aldrina

## **Review of OP booking processes**

Earlier this year, the HSCB Scheduled Care Team carried out a series of reviews of OP booking processes in all Trusts to assess compliance with the Integrated Elective Access Protocol (IEAP), with a particular focus on chronological management of patients.

The final version of the Report detailing the findings of the review in the Southern Trust is enclosed. The Report confirms that generally there is a high level of compliance with IEAP in the Trust. There are however a number of recommendations detailed in the appendix to the Report which will further strengthen the arrangements, and these should be addressed by the end of December 2015.

If you have any queries in relation to this Report or the actions to be taken, please contact Sara Long [Personal Information redacted by the USI] Assistant Director of Performance Management.

Yours sincerely

[Personal Information redacted by the USI]

**MICHAEL BLOOMFIELD**  
**Director of Performance and Corporate Services**

Enc Outpatient Pathway Review  
Appendix 1

cc Sara Long, PMSI  
David McCormick, PMSI  
Maria Wright, PMSI  
Rosemary Hulatt, PMSI





**SHSCT PERFORMANCE  
MANAGEMENT FRAMEWORK  
PROGRESS REPORT**

**Version 0.1 - Draft**

June 09

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- i) Performance Management Framework (October 2007)
- ii) Proposed process and timescale for SBA/SDP performance monitoring



## **Background**

Performance management is a key element of the Trust's Assurance Framework through which the organisation can assure itself and others as to its ability to achieve its objectives. This paper aims to:

- Review the status of the core elements of the Performance Management Framework approved by the Board in October 2007 with particular emphasis on Integrated performance reporting (appendix i)
- Make recommendations for future development for consideration

## **2.0 Status of Core Elements of the Performance Management Framework**

The core elements of the performance management framework include

- Strategic Direction, Corporate Objectives and annual delivery targets
- Clearly defined responsibility and accountability
- Integrated reporting of performance
- Performance reporting available at all levels of the organisation

The current provision against each of the above is as follows

### **2.1 Strategic Direction, Corporate Objectives and annual delivery targets**

- Rolling corporate plan – setting out 3-5 year objectives and annual targets is in place.
- Annual Trust Delivery Plan (TDP) which details Trust response to annual commissioning priorities and targets is in place

### **2.2 Clearly defined responsibility and accountability**

- Accountability arrangements are set out in the Board Assurance Framework.
- Objectives and targets in the corporate plan are assigned to Directors in line with areas of management and these are reflected in Directorate Work Plan, Team Work Plans and individual performance review plans.

### 2.3 Integrated Reporting of Performance

The performance management report identified a number of key domains to assure integrated reporting. The current provision against these domains is identified below:

Monthly Board Performance Report in place providing integrated reporting against key performance indicators, priority for action targets and Directorate specific indicators including:

- **Clinical and Social Care Quality** – a range of corporate indicators and additionality reporting is in place including via the monthly performance report which complements the governance reporting processes. These include
  - o Healthcare acquired infection, Re-admission rates, crude mortality, review of look after children, unallocated child care cases and patient safety/quality improvement indicators
- **Achievement of Access and Targets** – performance against the Ministerial PfA targets is reported in the monthly performance report, supplemented by quarterly reports on progress against ‘supplementary’ targets and service development objectives.
- **Efficient Delivery of Care** – a range of corporate indicators that provide assurance that the organisation is making best use of resources are included in the monthly performance report including:
  - o Daycase rates, Ave Length of Stay, Discharge performance, complaints processing and Direct Payments

Monthly Board reporting is in place via Director reporting to Board for

- **Workforce** – workforce performance, including levels and duration of sickness, vacancy, etc, is reported in the Director of HROD monthly Board report. Absence indicators and reported in the monthly performance report.
- **Finance** – finance performance is reported in the Director of Finance monthly Board report.

Board Reporting is in place quarterly/annually for

- **Staff Satisfaction** – staff satisfaction is evaluated to ascertain the organisational ‘climate’ via survey for the Board to consider

the outputs of this evaluation in conjunction with other perspectives of performance.

- **Patient and Client Satisfaction** – progress will be reported by Director of OPPC who has lead for this area and also as part of the priority for action targets.

Reporting is under development for

- **Strategy and Effectiveness** - The perspective of strategy & effectiveness includes market and business development, key trends and forecasts. This area requires development. Benchmarking has been established via the CHKS tool for a range of clinical and efficiency indicators and SRF, HRG reference costing is ongoing. The integration of this work requires to be refined.

## **2.4 Performance reporting available at all levels of the organisation**

A range of information and performance reporting mechanisms are in place at Directorate level including:

- Monthly Directorate Information reports collating a range of information on Directorate activities
- Service level reporting against all PfA targets on a weekly/monthly basis.
- Service level information for HR and Finance information continues to be developed
- Objective specific dashboards/reporting to support key projects including
  - o daily A&E performance, Daily/Weekly/Monthly inpatient flow for acute sites, monthly congestive heart failure, monthly Medical Assessment Unit performance

Integrated 'dashboard' reporting at all level of organisations is not in place but continues to be developed in response to specific projects although no organisational strategy has been agreed to co-ordinate this activity

### **3.0 Recommendations for future development**

Whilst integrated reporting at corporate level is in place, there is need to continuously develop and improve organisational performance intelligence. Specific needs to strengthen the clinical and social care elements of the performance framework and to develop reporting against Service and Budget agreements to maximise income from contractual performance and minimise risks associated with reduced income due to underperformance, have been identified.

#### **3.1 Clinical Indicators**

To complement the governance arrangements in place further reporting is required from a performance perspective to identify trends in clinical indicators including;

- Mortality; crude and risk adjusted, and
- Re-admission rates

Current reporting focuses on crude mortality indicating deaths as a percentage of deaths and discharges at the corporate level. To provide assurance on performance of all specialty areas, and negate the risk from any smoothing effects at corporate level, it is proposed that risk adjusted mortality will be reported and examined at Directorate, Divisional and specialty level.

It is proposed that this reporting will be framed in a context, to be agreed, provided via the Medical Directors office. This context will facilitate Senior Clinical engagement in the process with clearly defined follow up actions on any apparent risks, including sampling, audit review and cross reference to existing mandatory audit (eg NCEPOD) and peer review as indicated.

Re-admission rates will be reported in the same form and examined in the same context.

This information will be reported quarterly in arrears to allow for the robust application of the clinical coded information required to assign risk.

Propose timescales: Information for January – March 2009 will be reported and examined in Quarter 2, 2009/10 with a summary report from Medical Directors office on examined risk to Board no

later than September 2009. This process will be supported by the Head of Performance and the Head of Patient Safety.

### **3.2 Social Care Indicators**

To complement the processes and annual reporting on Discharge of Statutory Functions, indicators have been explored by Assistant Director of Social Care Governance and Head of Performance which would allow for more frequent reporting on indicators of social care performance for child care. It is proposed this includes:

- Stability of placements for Looked after Children, and
- Length of time on Child Protection Register

This reporting would provide monthly information to Board on the number of children with unplanned moves as a percentage of the total number of permanent Looked After Children

Quarterly reports would also indicate the trend associated for the percentage of children on the Child Protection Register for two years or more as a percentage of all children on Child Protection Register

Proposed timescales: this information is now available and can be encompassed in the monthly performance report immediately.

### **3.3 Service & Budget Agreement (SBA) & Service Delivery Plan (SDP)**

No formal corporate reporting on SBA has been in place to date, however is integral to Corporate and Directorate performance in:

- raising awareness of the importance of delivering SBA volumes in preparation for Payment by Results and
- maximising income from contractual performance and identifying risks associated with reduced income due to potential underperformance and
- appraising SMT of performance against SBA and the Service Delivery Process (SDP) for elective access as a collective process

The attached process (appendix ii) details the actions to be taken to establish a robust performance management process for SBA and SDP.

This process includes the establishment of the following :

#### Directorate level

- Monthly reporting on SDP to Directorates, at specialty/areas level highlighting areas of variance against both indicative volumes and financial allocations.
- Monthly information to Directorates on SBA performance against contract for all areas
- Quarterly analysis of performance against SBA by Directorate supported by rolling programme of Quarterly contract performance meetings at Directorate level for CYP, MHD and OPFC. For Acute Directorate a rolling programme of monthly contract performance meetings is proposed to facilitate Divisional analysis.

#### SMT

- Monthly reporting to SMT on variance against SDP and risk by Directorate against both indicative volumes and financial allocations.
- Quarterly reporting to SMT presenting corporate analysis of risk in performance against SBA and SDP collectively, highlighting risk and opportunities for maximising income. Any SBA issues that need escalated to SMT before the quarterly report is due will be added onto the SMT monthly SDP report.

This proposed process will supplement regular meetings with Commissioners, analysis of performance at purchaser level and engagement at an early stage to identify areas where non-recurrent or recurrent investment is sought.

Proposed Timescales: Monthly SDP reporting to commence in July for June data

First Quarterly reporting on SBA/SDP performance to commence in July for April - June data, anticipating that finalisation of both the SBA contracted volumes and SDP allocations is reached, in June.

### 3.4 Performance Information at Directorate and Service level

The PM Framework identifies the need for performance management information at all levels.

Whilst initial work was undertaken in 2007/08 to identify a range of Key Performance Indicators (KPIs) which would prove useful to operational and functional Directorates this work was not progressed due to constraints in defining and producing Information to support this whilst simultaneously developing a range of mandatory reporting requirements for new PFA and associated targets.

The Directorate of Performance and Reform propose a the development of Directorate level performance management reporting as below:

#### Interim Solution 09/10

The development of Directorate level performance management share points for centralising information and performance reports. These share points will provide a central hub for a range of existing performance management information in the first instance and could include

- Quantitative updates on performance against key Directorate priorities at divisional/service line reporting levels identified in workplans
- Access to performance information for all PFA and SDU targets
- A 'hub' of information containing statutory, service level, and ad hoc reports produced for the Directorate

'Share point' technology is available within the Trust albeit constrained by the current status of the network infrastructure. This technology is currently operational in another NI Trust and has been developed to include real-time updating of workplans and quarterly reporting avoiding duplicative requests.

It is proposed that whilst the network infrastructure is being developed the Trust exploring the potential development of performance management hubs.

### Longer Term Solution

To integrate the use of performance management information into all layers of management the SHSCT requires to develop its dashboard reporting into a real time automated processes.

Organisational Benefits of an automated dashboard system will unpick current layers of reporting and facilitate corporate, directorate and service level drill down to a range of key information immediately facilitating access to a wider range of management information and enabling informed decision making and risk reporting to become more mainstream.

To achieve the benefits of a performance management dashboard as identified above would require the establishment of a Trust e-dashboard with data warehouse capability and a review of the associated structural processes in place supporting performance management arrangements.

Experience from the UK would indicate a timeline of 18 – 24 months for development of an e-dashboard with reporting to service line.

It is proposed that a scoping exercise is undertaken to examine the options for procurement and implementation of an e-dashboard considering:

- The full range of benefits to be acquired
- The work already undertaken by the SDU in the development of the region e-dashboard in the first instance and exploiting any synergies from this work.
- Resources required including:
  - o project management;
  - o input from informatics (data quality, systems, IT and information) and performance management support development and population of KPIs and data /information flows
  - o input from Operation Directorates and Heads of Service in defining KPIs, and
  - o Input from Support Directorate staff to support service line reporting functions particularly for HR and Finance
  - o Capital/revenue costs, consultancy implementation costs, maintenance, training and development costs.
- Realistic timelines



- Experience of other UK based NHS Trusts who have undertaken e-dashboard development.

#### **4.0 Conclusion**

The Directorate asks for consideration on the range of recommendations made to enhance the Trusts Performance Management Framework, and approval to proceed as indicated in respect of further work to be undertaken to support Directorate level reporting.

Appendix I



# **SHSCT PERFORMANCE MANAGEMENT FRAMEWORK**

**Version 0.1**

October 07

Performance management is a key element of the Trust's Assurance Framework through which the organisation can assure itself and others as to its ability to achieve its objectives.

There are a number of key drivers which require the Trust to have a robust and comprehensive Performance Management Framework and associated performance reporting systems. These include:

- The need to provide strategic direction, corporate priorities and annual performance targets for the organisation, and clarity in respect of the accountability and performance management arrangements.
- The drive for improved performance, effectiveness and efficiency to ensure best use of public funds.
- The commitment by this Trust to the core value of integrity - being open, honest and fair with our stakeholders
- The developments in commissioning arrangements, including the proposed introduction of an activity-based payment regime and potentially a Northern Ireland version of Payment by Results.

Through the effective operation of the Performance Management Framework, the Trust will be able to provide assurance throughout the organisation and to external stakeholders that:

- its strategic objectives are being met,
- there is a focus on the continual improvement of service delivery, and
- there is effective utilisation of all its resources - financial, management and clinical - to support the achievement of high quality, safe and effective services and the delivery of other key organisational objectives and targets.

The Performance Management Framework must be integrated with and be complementary to the Trust's Governance arrangements, within the overarching Board Assurance Framework. The differentiating factor between the performance management and governance systems is:

- **Performance Management** will focus on those areas of the Trust's business where improvements can be made or targets must be achieved.
- **Governance** will provide assurance that the standards and obligations set for the Trust are met as a minimum, and that organisational, clinical and social care and financial governance systems are in place and operating effectively. The output from the governance systems and reporting will provide a valuable and independent quality assurance of the performance management systems and reporting.

The diagram below provides an overview of this concept.

### Trust Assurance Framework

| <b>Performance Framework</b><br>assures:                                                                                                                                                                                                                                                                                                                                                                              | <b>Governance Framework</b><br>assures                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Strategic Direction</li> <li>• Clear Corporate Objectives</li> <li>• Annual performance targets</li> <li>• Effective Performance monitoring and reporting</li> <li>• Identification of variance and reasons for same</li> <li>• Effective corrective action</li> <li>• Roll out of successful reform/innovation</li> <li>• Embedding of system and process reform</li> </ul> | <ul style="list-style-type: none"> <li>• Minimum standards are met (RQIA, Controls Assurance, etc)</li> <li>• Statutory obligations are met and statutory functions are delivered</li> <li>• Effective Risk Management is in place</li> <li>• Quality Assurance of Performance through reporting of complaints, Serious Adverse Incidents, etc.</li> </ul> |

### Principles

There are a number of key principles underpinning the development of the Trust's performance management framework to ensure focus on the achievement of corporate objectives and the delivery of high quality, safe, effective services. These are that the Performance Framework will:

- Enable the establishment and review of strategic direction, translated into challenging Corporate Objectives and annual targets which describe expected levels of performance, clearly

linked to day to day performance goals for Directors, their teams and individual staff.

- Provide clear accountability for performance targets throughout all levels of the organisation.
- Create a supportive mechanism for measuring, managing and improving performance, with agreed indicators that clearly demonstrate whether the Trust is achieving its objectives and targets.
- Provide the internal source of assurance to the Board on performance as part of the Trust's Assurance Framework, and be complementary to the Governance Framework

In adhering to these principles, the Performance Framework will have the following key features:

1. **Strategic Direction, Corporate Objectives and annual delivery targets** which cascade throughout the organisation.
2. **Clearly defined responsibility and accountability** throughout the organisation for the delivery of the above.
3. **Integrated reporting of performance** which looks at a range of performance indicators under agreed domains to enable informed assessment of performance and the contributors to variations in performance (both above and under performance targets).
4. The integrated performance reporting will be **available at all levels of the organisation** in a format and level of detail appropriate to their management needs.

# **1. Strategic Direction, Corporate Objectives and annual delivery targets**

The Performance Framework will set out the above through two key documents:

- The rolling Corporate Plan which sets out 3-5 year objectives and annual targets

- The annual Trust Delivery Plan which details the Trust's response to annual commissioning priorities and targets.

## 2. Clearly defined responsibility and accountability

The broader accountability arrangements within the HPSS, including the accountability of Trust Board, are set out in the Board Assurance Framework. In relation to Performance Management, the specific accountabilities are:

|                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Trust Board            | <ul style="list-style-type: none"> <li>• Determine and review strategic direction</li> <li>• Set and approve Corporate Objectives</li> <li>• Approve annual Corporate Plan</li> <li>• Approve Trust Delivery Plan</li> <li>• Approve Performance Framework</li> <li>• Organisational Performance Monitoring</li> <li>• Agree the assessment of performance risks</li> <li>• Ensure plans for corrective action are in place</li> </ul>                                                                                         |
| Senior Management Team | <ul style="list-style-type: none"> <li>• Develop Strategic Direction and Corporate Objectives for approval by Trust Board</li> <li>• Develop Corporate Plan and TDP for approval by Trust Board</li> <li>• Develop Performance Framework and provide organisational performance reports which enable comparison through use of benchmarks.</li> <li>• Assign accountability for performance targets</li> <li>• Weekly monitoring of performance risks</li> <li>• Develop plans for corrective action where required</li> </ul> |

The objectives and targets set out in the Corporate Plan are assigned to Directors in line with their areas of management, professional and clinical responsibility. These responsibilities will be reflected in:

- Directorate Work Plans which detail responsibilities, actions and timescales for the assigned targets. These Plans may be further refined into Team Work Plans
- Individual Performance Review Plans which detail the expected contribution of individual members of staff.

## 3. Integrated Reporting of Performance

Performance can be judged in a variety of ways and from a range of perspectives. It is critical that a range of perspectives are reported in an integrated way so that performance can be accurately judged across the crucial ingredients of success in financial, operational and quality terms. The key performance perspectives proposed for the Trust's Integrated Performance Framework are listed under the following domains:

- **Clinical and Social Care Quality** – a range of indicators that will be developed by working with each Director and their teams, and with clinical and professional staff particularly, drawing on accredited indicators from UK and beyond.
- **Patient and Client Satisfaction** – as part of the Trust's User and Community Engagement Strategy, to develop ways of assessing user satisfaction with the services provided by the Trust. This is currently in development and may take the form of an annual report to Trust Board.
- **Achievement of Access and Targets** – 'real time' (where possible) performance reporting against the Ministerial PfA Principal and Supplementary targets, summarised to Trust Board on a monthly basis, supplemented by quarterly reports on progress against Trust-specific targets in Corporate Plan.
- **Efficient Delivery of Care** – a range of indicators that provide assurance that the organisation is making best use of resources.
- **Workforce** – a range of workforce issues can impact on performance (levels and duration of sickness, vacancy levels, etc.)
- **Finance** – Trusts are expected to perform at high levels and achieve financial balance, so it is critical to include financial performance indicators in any integrated performance framework.
- **Staff Satisfaction** – while it is difficult to identify measures of staff satisfaction in any 'real time' or even monthly basis, it is critical that the organisation evaluate the organisational 'climate' at least annually and for Trust Board to consider the outputs of this evaluation in conjunction with other perspectives of performance.
- **Strategy and Effectiveness** - The perspective of strategy & effectiveness includes market and business development, key trends and forecasts. This will be developed as part of the

ongoing refinement of the Integrated Performance Management Framework.

A sample of performance indicators and benchmarks, at corporate and Directorate level, for those domains suitable for regular (at least monthly) reporting is included in Appendix 1.

#### **4. Performance reporting available at all levels of the organisation**

Performance measurement information will be provided at a strategic, tactical and operation level, offering an integrated view of operational performance across the Trust under the agreed domains. This performance management approach will allow the Trust to view performance from multiple perspectives, interpret information, gain insight and judgment and enable effective decision making.

A 'dash board' will be developed to present organisational performance against the key performance indicators developed, initially, for the domains of:

- Finance
- Workforce
- Access and Targets
- Clinical and Social Care Quality
- Efficient Delivery of Care

This dashboard will provide a 'traffic light' assessment of performance risks with exception reporting where areas of both success and concern will be highlighted. Where possible, benchmarks will be included to provide a basis for judging performance against each indicator. The dashboard indicators must be suitable for regular (at least monthly) reporting.

The content of the dashboard will be subject to continual review and iterative development, due to the changing nature of Departmental and Trust-specific performance targets, development of new performance measurements and benchmarks and in response to performance issues identified through governance and other management processes.



The information will cascade through the organisation through the performance 'dashboard', with each layer of the organisation having access to that level of detail appropriate to their management responsibilities, professional and clinical needs, but also providing the ability to 'drill down' to further detail if required.

It is critical that performance information is made available in the level of detail to which recognises the responsibilities and accountabilities of that level of the organisation as set out below.

- Trust Board – Corporate and Directorate level
- Senior Management Team – Corporate and Directorate level
- Directors - Directorate and Service level
- Assistant Directors – Service level
- Professional/clinical leads – Assistant Medical Directors, Clinical leads, Service, Team and Practitioner level
- Heads of Service/Team Leaders – Service, Team level and practitioner level
- Governance leads – Service and Team level
- Individual staff - for their individual areas of responsibility as set out in IPR.

While every effort will be made to make the dashboard reporting as comprehensive as possible, this cannot be the only source of performance reporting within the Trust. Additional assurance on performance will be provided by a range of detailed quantitative and qualitative performance reports, provided monthly, quarterly, bi-annual or annually.

These include:

- Priorities for Action Principal and Supplementary Targets
- Progress against the Trust's Corporate Plan
- Patient/Client engagement/satisfaction
- Workforce Vacancies, sickness levels, etc
- Reform, Modernisation and Efficiency/Productivity
- Staff Training and Development
- Progress on skill mix across staff groups/Directorates
- Performance against Equality/Section 75 requirements
- Staff satisfaction

These reports are either in place or under development.

In addition to the above internal reporting arrangements, external reporting is required to DHSSPS and Commissioners. This includes regular reporting on PfA performance, Reform, Modernisation and Efficiency, and performance against Service and Budget Agreements including written reports on quality outcomes.

## Summary

Trust Board will require a range of reports to assure itself that performance is at the expected level and properly managed.

- Corporate and Directorate-specific Integrated Performance Dashboard reporting, provided on a monthly basis. This provides a strategic overview through the use of performance-sensitive indicators initially across the domains of finance; workforce; achievement of access and targets; clinical and social care quality, and efficient delivery of care.
- Monthly reports on performance against Principal Priorities for Action targets: As these targets are the most high profile indicators of the Trust's performance, a report detailing performance and risk will be brought to Trust Board on a monthly basis.
- Quarterly reports on performance against Supplementary Priorities for Action targets: While these are also high profile performance targets for the Trust, the reporting requirement to DHSSPS and commissioners is quarterly and it is proposed to bring these to Trust Board following submission (due to the timescales involved).
- Quarterly reports on performance against trust-specific targets in Corporate Plan.
- A range of detailed quantitative and qualitative performance reports, provided monthly, quarterly, bi-annual or annually. These include:
  - o Patient/Client engagement/satisfaction
  - o Workforce Vacancies, sickness levels, etc
  - o Reform, Modernisation and Efficiency/Productivity
  - o Staff Training and Development
  - o Progress on skill mix across staff groups/Directorates
  - o Performance against Equality/Section 75 requirements
  - o Staff satisfaction

**Development Timetable**

|                                                                                 |                                             |
|---------------------------------------------------------------------------------|---------------------------------------------|
| Development of Corporate Aim and Objectives                                     | Agreed April 2007                           |
| Development of TDP                                                              | Approved May 2007                           |
| Development of Corporate Plan                                                   | Approved June 2007                          |
| Monthly reporting on performance against Principal PfA targets                  | In place since May 2007                     |
| Quarterly performance reporting on Supplementary PfA targets                    | From October 2007                           |
| Performance Management Framework                                                | To Trust Board for approval in October 2007 |
| Development of agreed set of performance indicators for 'performance dashboard' | September to October 2007                   |
| 'Dashboard' integrated performance reporting                                    | December 2007                               |
| Quarterly report on performance against targets in Corporate Plan               | From December 2007                          |
| Annual Report on staff satisfaction                                             | From April 2008                             |

Complementary to the Trust Board performance reporting arrangements, work will be commissioned to provide access to the performance dashboard at all levels within the organisation. It is anticipated that work on this development will commence in December 2007.

## Appendix ii

### Proposed SABA Contracts Monitoring/Performance Process

#### Aim:

- Raise awareness of importance of delivering SBA volumes as preparation for Performance by Results
- Maximise income from contractual performance and minimising risks associated with reduced income due to underperformance
- To appraise Directors and Assistant Directors of performance against SBA and SDP, providing analysis on areas of variance, identifying organisation risk
- Support ADs and HoS in the identification of key management actions necessary to improve performance

#### Objectives:

- Agree a process for the agreement of contract baselines with Directorates to ensure there is a robust understanding of the impact and consequences
- Produce regular information on SBA and SDP performance against contract at Corporate, Directorate and Service Line level
- Produce regular information on SDP current and estimated predicted spend
- Utilise SABA monitoring system as single source of information and avoid duplication/reporting in different formats
- Identify how information can be accessed/shared with key staff in a user friendly format
- Provide overview and analysis on performance against SBA and SDP at Directorate level via a rolling programme of contract performance meetings
- Support key staff in the analysis of performance/identification of risk and development of actions to support recovery or achievement of acceptable level of performance against SBA and SDP

| No. | Issue                                                                                                                                            | Action                                                                                                                                                                                                                                                                                                                                                                                              | Timescale                          |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1   | Agree with Directorate contract baselines for 09/10                                                                                              | <p>1. Discuss with Directors/ADs 09/10 proposals considering</p> <ul style="list-style-type: none"> <li>• Variations in 09/10 baselines from 08/09 baselines, and</li> <li>• New developments/ significant variation which will affect baseline volumes</li> </ul> <p>2. Support Ads/HoS in discussions with clinicians/commissioners in areas where baseline variation is proposed as required</p> | <p>April – June</p> <p>Ongoing</p> |
| 2   | Produce regular information on SBA performance<br>- Current SBA monitoring system provides information inclusive of in-house additionality (IHA) | <p>1. Agree with Acute Directorate process for identifying IS OP additionality</p> <p>2. Establish and QA report for Information Team to produce that will identify all IHA and IS</p>                                                                                                                                                                                                              | <p>Completed</p> <p>Completed</p>  |

|  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |
|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
|  |  | <p>activity on a monthly basis at site, sub-specialty and purchaser level</p> <p>3. Input SBA activity into monitoring system minus IHA. Input IHA and IS into monitoring system on monthly basis</p> <p>4. Extract corporate level reports from SBA monitoring system for EI IP, Non-EI IP, DC, OP new, OP Review, OBD, Births &amp; Attendances and put onto excel tabbed file/adobe format for sharing</p> <p>5. Extract Specialty level reports by purchaser for EI IP, Non-EI IP, DC, OP new, OP Review, OBD, Births &amp; Attendances and put onto excel tabbed file/adobe in line with Directorate rolling</p> | <p>Completed Acute Information Team</p> <p>July for June Data</p> <p>July for June data</p> |
|--|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|

|   |                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                |                                                                    |
|---|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
|   |                                                                                                                                                | programme of meetings.                                                                                                                                                                                                                                                                                                                                                                         |                                                                    |
| 3 | Identify how information can be accessed/shared with key staff in a user friendly format                                                       | <p>1. Liaise with Directorates/ IT and consider options for sharing of contract reports via Shared Files/Intranet site</p> <p>2. Consider direct access to SBA monitoring system for OSL/HoS in supporting Ads/Directors</p>                                                                                                                                                                   | <p>July</p> <p>To be agreed at contract performance meetings</p>   |
| 4 | Provide overview and analysis on performance against SBA and SDP at Directorate level via a rolling programme of contract performance meetings | <p>1. Discuss with Directors programme for contract performance meetings;</p> <ul style="list-style-type: none"> <li>• CYP – Quarterly meeting (Acute/Community Paed OP, Acute IP/DC, NNU OBDs)</li> <li>• MHD – Quarterly meetings (Acute MH OBDs, Learning Dis OBDs, MHD Acute and LD Ops, Day Hospital attendances)</li> <li>• OPPC – Quarterly meeting (Non-Acute OBDs, OP, Day</li> </ul> | To be arranged with individual Directors further to SMT agreement. |

|   |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                  |                                         |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|
|   |                                                                                                                                                       | <p>Hospital attendances)</p> <ul style="list-style-type: none"> <li>• Acute – Monthly meeting: Rolling programme: TBA; by Division –v- EI, Non-EI, Other</li> </ul> <p>2. Prepare quarterly report for each Directorate providing analysis of areas of variation for discussion and determination of necessary management actions</p>                                                            | To correspond with Directorate meetings |
| 5 | Appraise Directors and Assistant Directors of performance against SBA and SDP, providing analysis on areas of variance, identifying organisation risk | <p>1. Prepare quarterly report for SMT, providing:</p> <ul style="list-style-type: none"> <li>• Corporate analysis of risk in performance against SBA and performance against SDP</li> <li>• Highlight areas of risk at Speciality level</li> <li>• Highlight opportunities for maximising income</li> <li>• Management actions necessary to minimise risk (reflecting discussions at</li> </ul> | July for June data                      |



|   |                                                                                                                          | Directorate meetings)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |
|---|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| 6 | Maximise income from contractual performance and minimising risks associated with reduced income due to underperformance | <p>1. Undertake quarterly analysis by Purchaser on performance against SBA and highlight areas of significant variation.</p> <ul style="list-style-type: none"> <li>• For areas of sustained projected variation engage with Commissioners to highlight potential variation seeking non-recurrent funding in-year at early stage/recurrent funding</li> </ul> <p>2. Undertake monthly monitoring for areas identified in SBA negotiations as high risk and/or subject to potential quarterly invoicing:</p> <ul style="list-style-type: none"> <li>• Obstetrics – all purchaser</li> <li>• T&amp;O – all purchasers</li> <li>• NNU beddays - all</li> <li>• ICU beddays – all</li> <li>• Cardiology/A&amp;E - WHSSB</li> <li>• Geriatric beddays-NHSSB</li> </ul> | <p>First report July after contract levels agreed.</p> <p>July onwards</p> |

|   |                                                                                                                                                                                                             |                                                                                                                                                                                                                       |                                                         |
|---|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
|   |                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>• Mental health IP - EHSSB</li> </ul> <p>This list may be added to</p> <p>3. Undertake monthly analysis of SDP performance with estimated financial over/under performance</p> | <p>July onward pending agreement on SDP allocations</p> |
| 7 | <p>Agree proposals with AD/directorate for contract monitoring and prepare paper for SMT</p> <p>-Consider interface with Finance and how we model financial impact of significant variations on SBA/SDP</p> |                                                                                                                                                                                                                       | <p>June</p>                                             |
|   |                                                                                                                                                                                                             |                                                                                                                                                                                                                       |                                                         |

**Minutes of the confidential meeting of the Board of Directors held on Thursday, 30<sup>th</sup> September 2010 at 10.00 a.m. in the Boardroom, Daisy Hill Hospital, Newry**

**PRESENT:**

Mrs A Balmer, Chairman  
 Mrs M McAlinden, Acting Chief Executive  
 Mrs D Blakely, Non Executive Director  
 Mrs R Brownlee, Non Executive Director  
 Mr E Graham, Non Executive Director  
 Mr A Joynes, Non Executive Director  
 Mrs H Kelly, Non Executive Director  
 Mrs E Mahood, Non Executive Director  
 Dr R Mullan, Non Executive Director  
 Mr B Dornan, Director of Children and Young People's Services/Executive Director of Social Work  
 Dr P Loughran, Medical Director  
 Mr S McNally, Acting Director of Finance and Procurement

**IN ATTENDANCE:**

Dr G Rankin, Interim Director of Acute Services  
 Mr K Donaghy, Director of Human Resources and Organisational Development  
 Mrs P Clarke, Acting Director of Performance and Reform  
 Mrs A McVeigh, Acting Director of Older People and Primary Care  
 Mrs J Holmes, Board Secretary  
 Mrs R Rogers, Head of Communications  
 Mrs S Judt, Committee Secretary (Minutes)

1. **APOLOGIES**

Apologies were recorded from Mr F Rice, Director of Mental Health and Disability Services/Executive Director of Nursing.

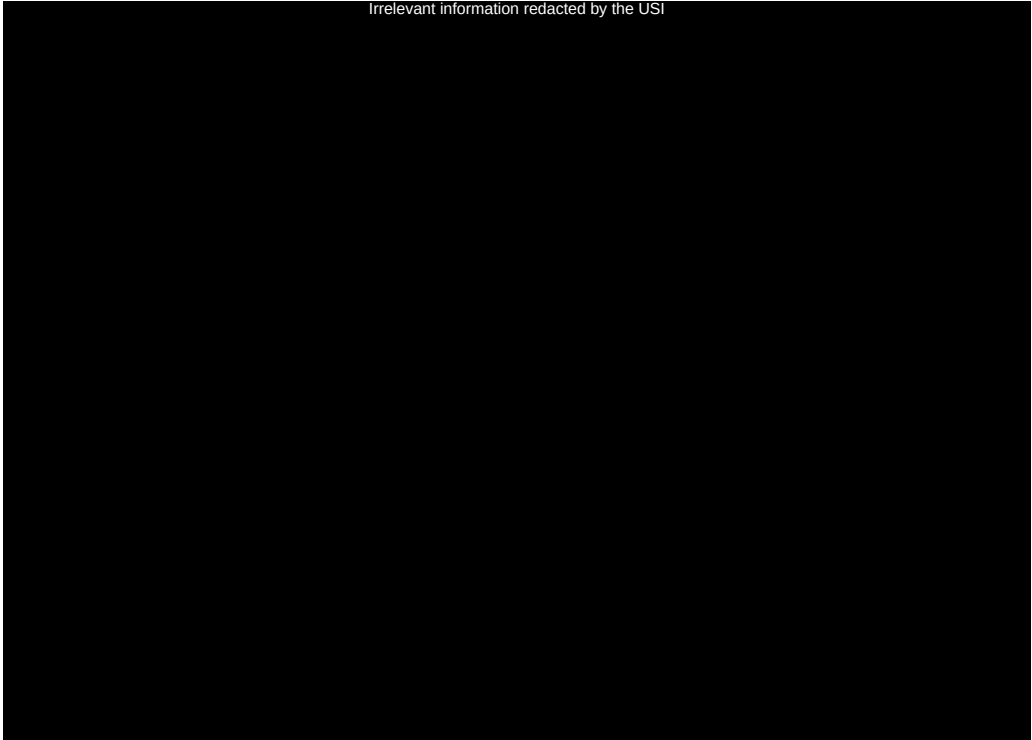
2. **MINUTES OF PREVIOUS MEETING**

The minutes of the meeting held on 26<sup>th</sup> June 2010 were agreed as an accurate record and duly signed by the Chairman.

3. **MATTERS ARISING**

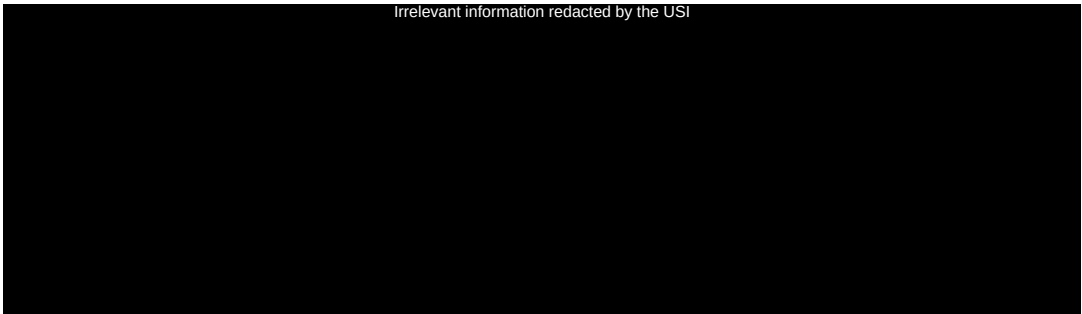
i)

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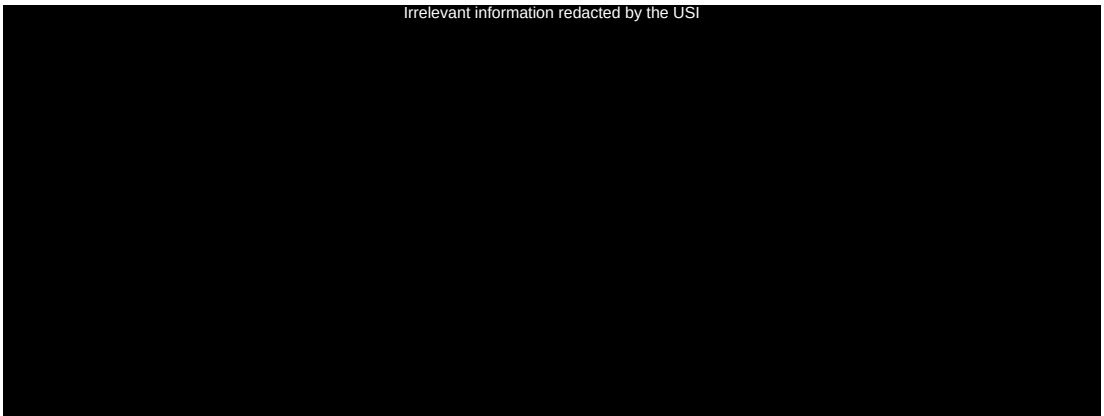
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5.

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6. **COVERAGE IN LURGAN MAIL – TRUST DOMICILIARY CARE SERVICE**

The Acting Chief Executive spoke of the recent negative media coverage in the Lurgan Mail, primarily as a result of a client directly contacting this paper which was followed up by supporting comments from a number of home care workers. The Trust has met with the Editor and a statement from the Trust, together with an article on a Trust's homecare worker and an appreciative client, has since been published in the Lurgan Mail as rebuttal. The client concerned has also been contacted in relation to their issues of complaint.

7. **CLINICAL ISSUES IN UROLOGY SERVICE**

Dr Rankin outlined the clinical issues in the Urology Service as detailed in the briefing note and the action being taken:-

**IV Fluids and Antibiotics**

An immediate review is underway of a cohort of 10 patients who are receiving IV therapy.

**Cystectomies**

The Commissioner had drawn to the Trust's attention a slightly increased rate of cystectomy for benign pathology in Craigavon Hospital compared with the rest of the NI region. The Associate Medical Director for Surgery and Elective Care has commenced a review, which includes a case note review of each patient who has undergone cystectomy in the past 10 years.

**Regional Urology Review**

One of the requirements of the implementation of the review is that all radical pelvic urological surgery is moved to the Belfast

Trust. There are currently 5 patients within the Southern Trust whose care is being transferred to the Belfast H&SC Trust.

8.

Irrelevant information redacted by the USI

9. **FINANCIAL STABILITY PROGRAMME – RATINGS**

The Chairman noted the outcome of the assessment review. The Southern Trust was assessed as 'amber/green' and she stated that this demonstrates a high degree of confidence in the Trust's systems, processes and ability to deliver the agreed cost savings. On behalf of Board members, the Chairman paid tribute to the Acting Chief Executive, Directors, Mrs Magwood and staff involved in this process.

10. **OUTSTANDING MEDICAL NEGLIGENCE CASES**

The Acting Chief Executive advised of a recent Assembly debate on a Sinn Fein motion at the delay in resolving some medical negligence cases. Dr Loughran stated that the Southern Trust has 10 medical negligence cases outstanding for 10 years or more and he assured members that these are being dealt with appropriately and there were no undue delays in their processing by the Trust.

11.

Irrelevant information redacted by the USI

## 12. **ANY OTHER BUSINESS**

### i) **Update on NNU/MRSA events**

Mrs G Maguire, Assistant Director, Specialist Child Health and Disabilities, Dr Damani, Clinical Director, Infection Prevention and Control and Mr C Clarke, Lead Nurse, Infection Prevention and Control, joined the meeting for a discussion on this item. Mrs Maguire advised that there are currently four babies in the neo-natal unit at Craigavon Area Hospital who have been identified as carrying MRSA on the skin. The MRSA was identified during routine screening that is carried out on all babies in the unit. All babies are well, with three of them due for discharge very shortly. She also advised of three babies who had also been identified as carrying MRSA and who have been discharged home. Dr Damani explained the range of extra infection control measures put in place, in addition to existing measures and these include:-

Segregating the babies with MRSA;  
Additional deep cleaning of the Unit;  
Increasing the daily clean to three times a day;  
Continued awareness raising of infection control procedures for all staff.

All affected babies (a total of 7) were colonized. Staff screening has commenced and 84 staff have been screened; three were positive for MRSA and decolonization therapy has been started.

The Acting Chief Executive paid tribute to the staff in the NNU and the Infection Control Team for their management of this outbreak.

ii) **MLU, Lagan Valley Hospital**

Dr Rankin advised that discussions continue with the Commissioner in relation to the movement of births from Lagan Valley Hospital to Craigavon Area Hospital upon cessation of the Consultant led service to be replaced by a MLU. The issue for this Trust is how to manage the potential number of deliveries in Craigavon Area Hospital safely given that the funding which may be provided could be significantly less than what is required to deliver the estimated additional 200 births.

iii) **Administrative Error in Breast Screening Programme**

Dr Rankin reported on an administrative error that occurred in February 2009. This came to light in July 2010 when the patient presented with breast cancer. A Root Cause Analysis is nearing completion on this incident.

iv) **Maternal Death**

Dr Rankin advised of the death of a mother in the maternity ward, Craigavon Area Hospital the previous day. She assured members that all appropriate clinical interventions were carried out for the mother and that the baby had been delivered safely and is well. The case has been referred to the Coroner and there will be a post-mortem.

v) **Case of suspected TB**

Dr Rankin advised of a healthcare worker in A&E with suspected Tuberculosis. A review group has been established, involving the Public Health Agency, to assess the potential risk to patients and staff. GPs in the Trust area have been notified. There was some coverage on this issue in the Irish News at the week-end.





**Quality care – for you, with you**

## **CORPORATE PERFORMANCE DASHBOARD**

**January 2011**

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## Introduction

The Corporate Performance Dashboard supplements the Corporate Performance Management Report. It includes trend analysis and narrative update on key performance indicators of particular interest to the SMT, Board and public.

Whilst primarily an exception reporting tool for targets or performance at risk it can also be used by SMT as a source document to include areas of particular interest or sensitivity which require discussion and monitoring

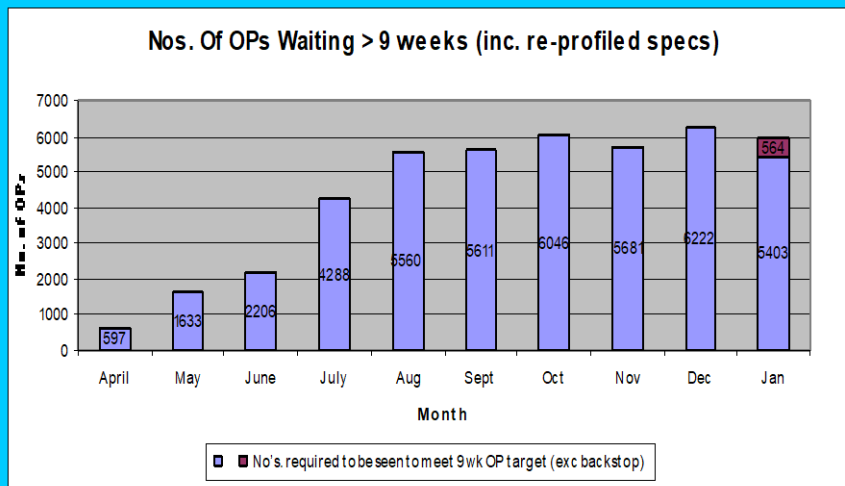
Areas for inclusion will fall into the following areas:

- Area identified in red risk status on the Corporate Performance Report
- Areas identified by SMT for close monitoring
- Areas identified as sensitive and of particular interest to the SMT

The content of the dashboard will change frequently to reflect the areas of essential review. Indicators and reporting will be removed as risk alleviates and others added on as required and agreed via SMT.

## Key Areas

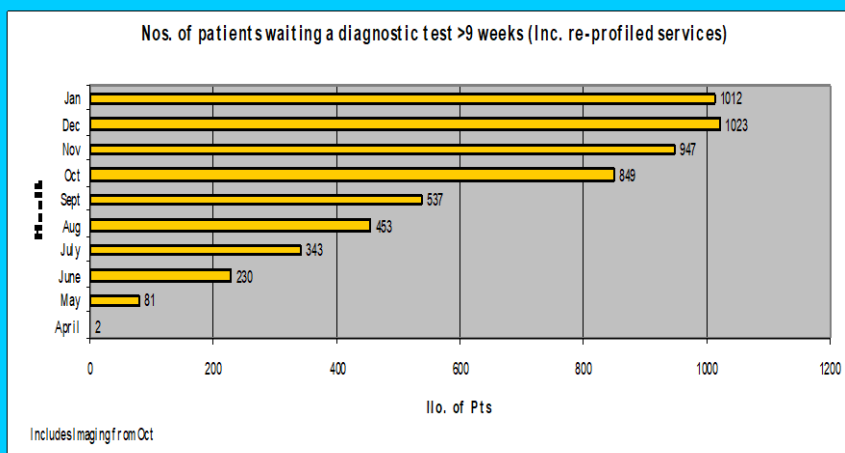
**Target: 1<sup>st</sup> OP Appointment** - By March 2011 no patient should wait longer than nine weeks for a first outpatient appointment



### Comments:

- Backstop access targets have been agreed for 3 visiting services and 4 SHSCT specialties. Visiting services include ophthalmology (52), oral surgery (41), paediatric cardiology (21) weeks. SHSCT internal specialties with agreed backstops include cardiology (19), rheumatology (17) and dermatology (15) weeks. Internal backstop agreements have been secured with HSCB acknowledging consultant manpower issues in these specialty areas.
- Discussions are ongoing to determine the backstop position with Orthopaedics. Currently the Trust can achieve up to 13 weeks; and may seek to secure 9 weeks with continued usage of Independent Sector capacity, however this is subject to ongoing discussion and agreement with HSCB.
- All other specialty areas are profiled to achieve a maximum 9 week waiting time by March 2010. Management plans are in place and close monitoring initiated at specialty level. Whilst ophthalmology is likely to achieve a position better than target at 41 weeks some specialties remain challenging, including neurology, where there are also medical manpower issues. The impact of lost capacity in Dec due to adverse weather conditions continues to make achievement of targets challenging.

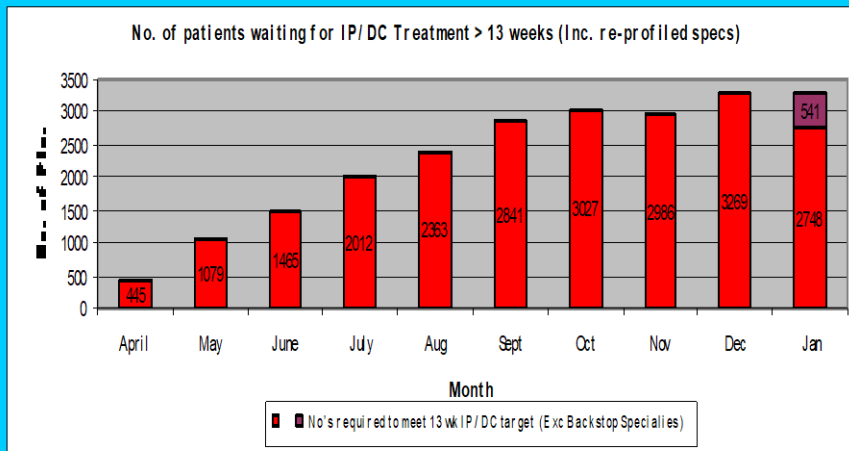
**Target: Diagnostic Test** - By March 2011 no patient should wait longer than nine weeks for a diagnostic test



### Comments:

- Backstop targets have been agreed for Neurophysiology at 52 weeks. All other diagnostic services are profiled to achieve 9 weeks.
- Trust continues to seek assurances re neurophysiology services for which a regional solution is required and in discussion with BHSCT has arranged a process for the management of urgent referrals. It is proposed that management of this service is centralised to BHSCT as an interim measure to provide a regional single waiting list to ensure equity of access and BHSCT have submitted plans to HSCB detailing their proposals.
- Non-recurrent funding has been secured for Dexa scans and Trust is profiling to achieve 9 weeks by March 2011.

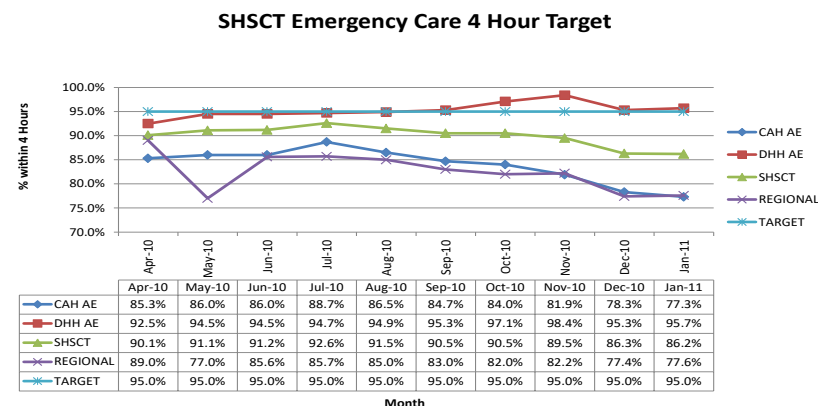
**Target: IP/DC Treatment** - By March 2011 the majority of IP/DC should be treated within 13 weeks and no patient waits longer than 36 weeks for treatment



#### Comments:

- Backstop targets have been agreed for orthopaedics, urology, scopes, rheumatology and pain at 36 weeks; general surgery at (31), cardiology (27) and dermatology (26) weeks.
- Changes to backstop targets for cardiology have been agreed acknowledging the impact of increase demand in this area
- Whilst dermatology will have waiters extending to 26 weeks which are outside the skill set of current Trust operators, all patients who can be treated within the Trust will be seen within 13 weeks. Options continue to be developed to seek a reduction in these waits for specialist surgery.
- Management plans are in place for all targets and whilst the Trust is on target to ensure no patient waits longer than 36 weeks all available capacity has been utilised leaving marginal scope to deal with any variance from current plans.

**Target: A&E** - From April 2010 95% of patients attending any A&E Dept should be either treated and discharged home, or admitted within 4 hours of their arrival in the department. No patient should wait longer than 12 hours.



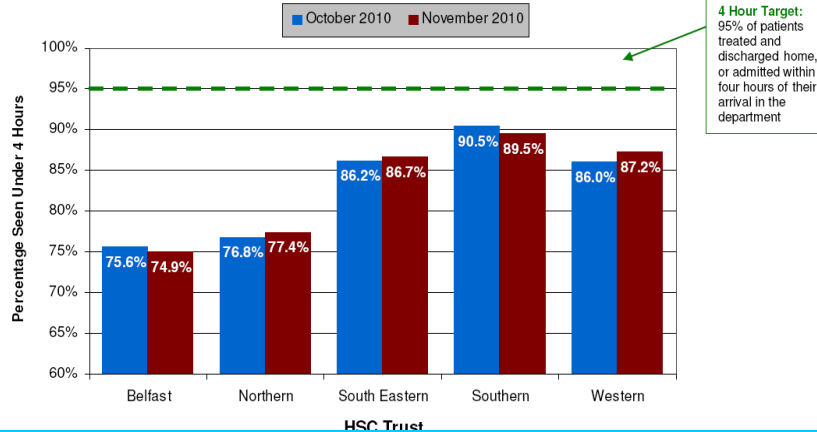
Note:  
Minor Injury Units at South Tyrone and Armagh sites are included in SHSCT figure but not reported individually due to sustainment of 100%. Regional Figure is sourced from HSC Information Management Portal and includes all Emergency Care Departments.

#### Comments:

- Performance continues to be low associated with ongoing medical manpower issues.
- Pathway currently in place in A&E to identify and place patients known to system directly. In addition with the implementation of the Acute physician model, in place from December 10, GPs can seek direct admission bypassing A&E. The service provides a GP advisory service, including opportunity for discussing a direct admission or advice on a patient's management or fast track outpatients. This facilitates management of cancer patients needing admission directly into appropriate bed bypassing A&E.
- Service currently trying to reinstate the expeditor role.
- Trust has submitted plans to the commissioner for development of a consultant delivered A&E service.

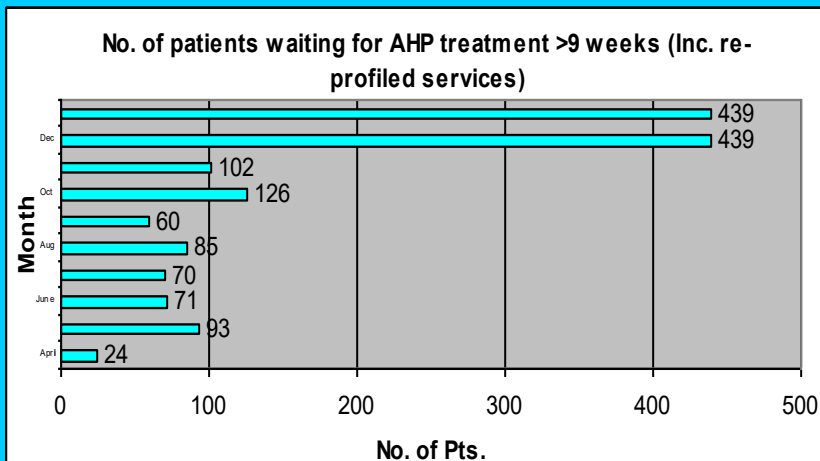
## HSC Trust Performance against the 4 Hour Component of the PfA Emergency Care Waiting Times Target

Figure 2: HSC Trust Performance against the 4 Hour Component of the PfA Emergency Care Waiting Times Target (October 2010 - November 2010)



- In November across HSC Trusts, the percentage of patients being treated and discharged or admitted within 4 hours of their arrival in the emergency care department ranged from 89.5% in the Southern HSC Trust to 74.9% in the Belfast HSC Trust.
- The SHSCT continues to perform well comparatively. In November none of the 5 trusts have achieved the target.

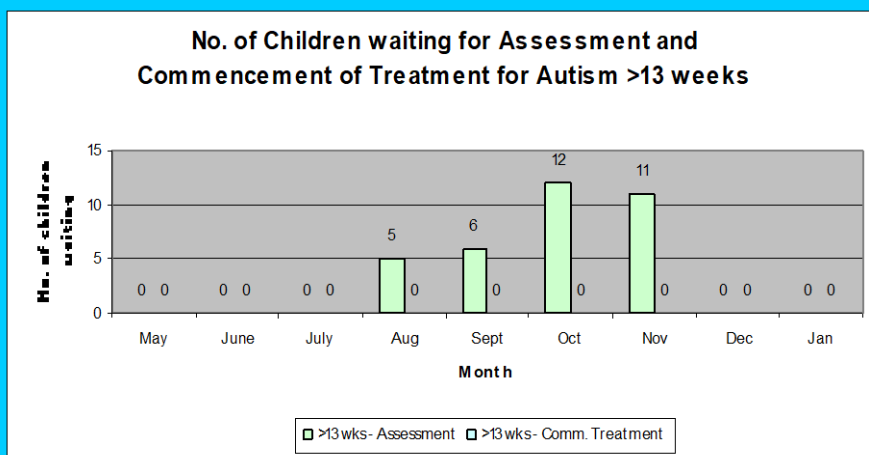
**Target: AHP** – From April 2010, no patient waits longer than 9 weeks from referral to commencement of AHP treatment



### Comments:

- Trust has identified risk to HSCB associated with achievement of 9 week position for all AHP services.
- Physiotherapy risk relates predominantly to increase in demand and Trust has proposals in place to provide additional capacity to work towards securing a 9 week waiting time.
- Backstop of 17 weeks agreed for orthoptics as inability to recruit suitably qualified personnel make the 9 week position unachievable for this area.
- Other risk associated with ongoing breaches in OT and SLT should be manageable and recovery plans are in place to return to profile and achieve 9 weeks by March.

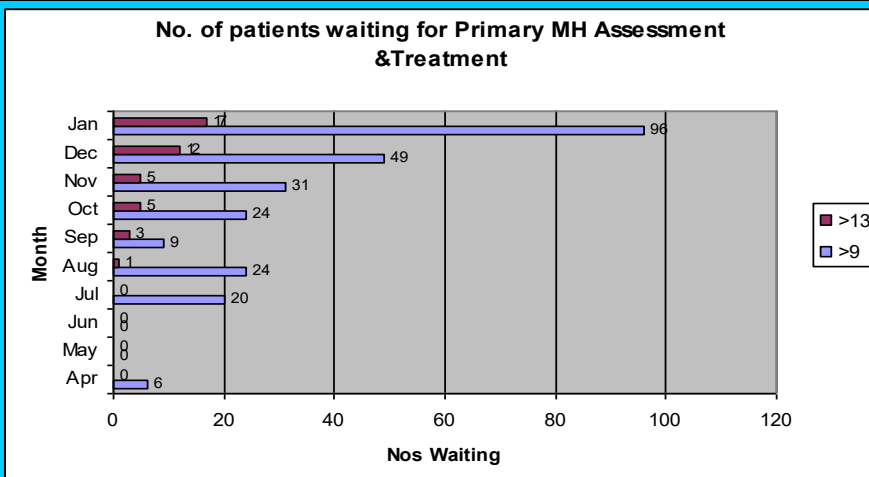
**Target: Autism** – From April 2010 all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention



**Comments:**

- Performance improved in January with eradication of breach position.
- The referral rate remains variable but there was some reduction in Sept /Oct, which has allowed some catch-up re the PFA target
- Whilst this position is improved sustainability of this position remains to be ascertained and Trust will keep under review. .
- It is hope that by February that all vacancies will be filled / team will be at full capacity and the new Paediatric screening tools will more effectively Triage / reduce referrals to the Specialist Clinics.

**Target: Primary Mental Health Assessment & Treatment** – From April 2010 no patient waits longer than 9 weeks from referral to assessment and commencement of treatment (exception psychological therapies for which no patient should wait longer than 13 weeks)

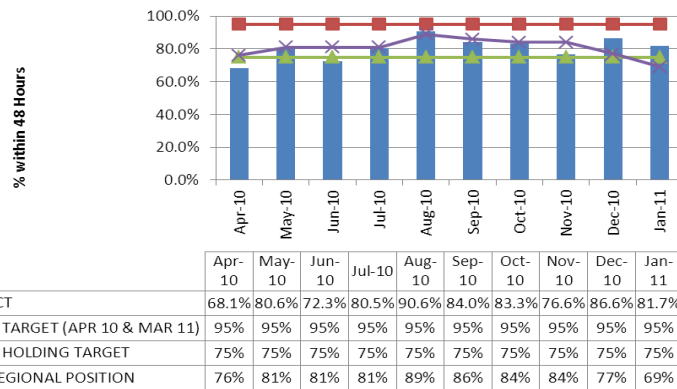


**Comments:**

- Service Delivery Plans prepared to profile return to 9/52 position for PMHC and discussed with HSCB
- Analysis of the step model is underway with regard to PMHC to assess the capacity that can be sustained in the absence of year 3 funding.
- PMHC currently facing staffing issues as staff migrate into new roles and 2 staff on long term sick leave.
- A procurement exercise is currently underway to secure additional new assessment appointments to provide additional capacity. This target remains challenging.

**Fractures:** From April 2010 95%, where clinically appropriate should wait no longer than 48 hours for IP fracture treatment.

**SHSCT - Fracture Access (% 48 Hour Target)**

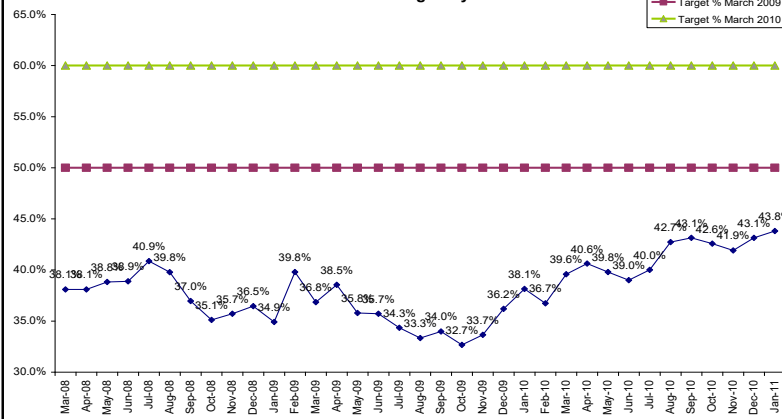


**Comments:**

- Cumulative comparative regional performance (April – mid January 11) reflects an average of 81% with the Trust achieving 80% for the same period.
- 6th consultant model implemented with 2 additional trauma lists in place further to recurrent investment.
- Trust has developed a pathway to enable flow of trauma demand from Newry & Mourne locality to increase activity in line with recurrent investment.
- Jan performance has dropped due to ongoing winter pressure issues.

**Target: Renal Services** – From April 2010 at least 60% of patients should receive dialysis via a fistula

**SOUTHERN HEALTH AND SOCIAL CARE TRUST**  
**% Patients Receiving Dialysis via Fistula**

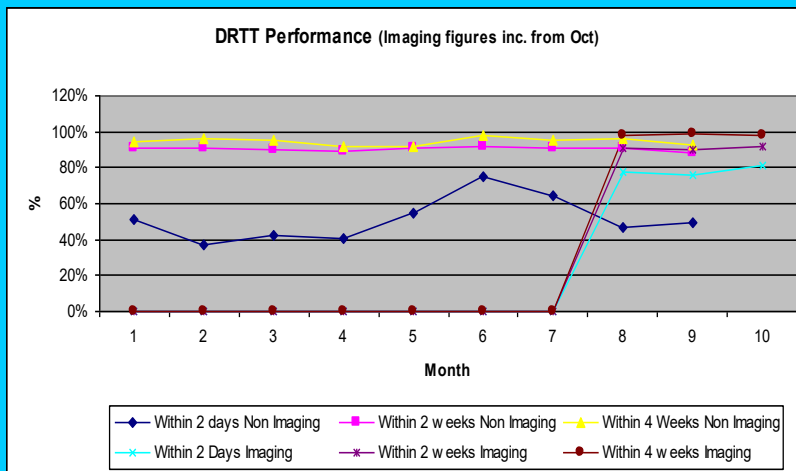


**Comments:**

- With the development of local surgery, the number of in-house fistula created has shown an overall increase in performance against the target as fistulas mature and patients start to receive dialysis through these. Performance at the end of January reflects a steady state from August of 43% but is well below the target of 60%.
- A Training programme is now in place for staff on button hole technique, recommended as best practice to preserve the longevity of the fistula.
- Work is ongoing to increase patient uptake via education and support in pre dialysis stage
- Target will not be attained but several patients have new fistulae which take time to mature to enable use for dialysis.
- Meeting is scheduled 25th February with Vascular surgeon & Nephrologists to review how current processes are working in terms of referral system, booking of patients and reviewing ways that in which numbers can be increased.



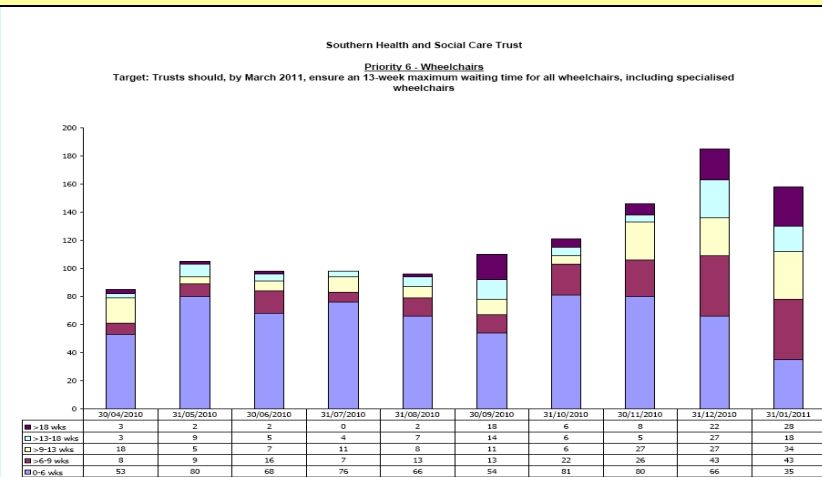
**Target: Diagnostic Reporting Turnaround Time (DRTT)** - From April 2010 ensure all urgent diagnostic tests reported within 2 days, with 75% routine test being reported within 2 weeks 100% routine tests within 4 weeks



**Comment:**

- Key areas of poor performance relates to achievement of target to report urgent cases within 2 days in imaging and non-imaging, specifically cardiac investigations
- Reporting against routine targets is good and exceeds the requirements.
- Improvement plan in place to secure necessary management actions to seek improvement in this performance
- Validation of current reporting mechanisms is ongoing to ensure robustness of information returned.
- Pilot in place within cardiac investigations, supported by regional cardiology network, to re-define routine/urgency status at triage and report accordingly to assess impact of There is ongoing regional discussion on how urgency should be defined
- This target is unlikely to be achieved in full

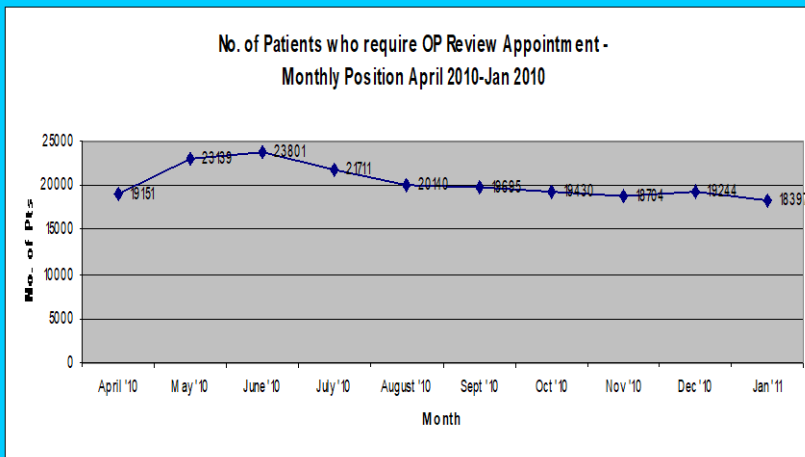
**Target: Wheelchairs** - By March 2011 ensure a 13 week maximum waiting time for all wheelchairs including specialist wheelchairs



**Comment:**

- Whilst the Trust saw an improvement in the performance of wheelchairs access times against the target in October/November the December/January position has performed less well.
- Key issues remain associated with ability to manage intra-trust transfers for specialist regional assessment or delivery of specialist chairs. Trust continues to work with Regional Wheelchair Pathway review group led by HSCB to reduce bottlenecks in this pathway
- SHSCT continue to perform well in all aspects of service delivery for which it has direct responsibility.
- SHSCT Staff have completed a review of the every Client on the waiting list and where there were discrepancies identified which were not recorded by RDS Therapists have returned the correct details to RDS to be amended. This will ensure that accurate information is shown at end of Feb.
- Risk to achievement of target at year end.

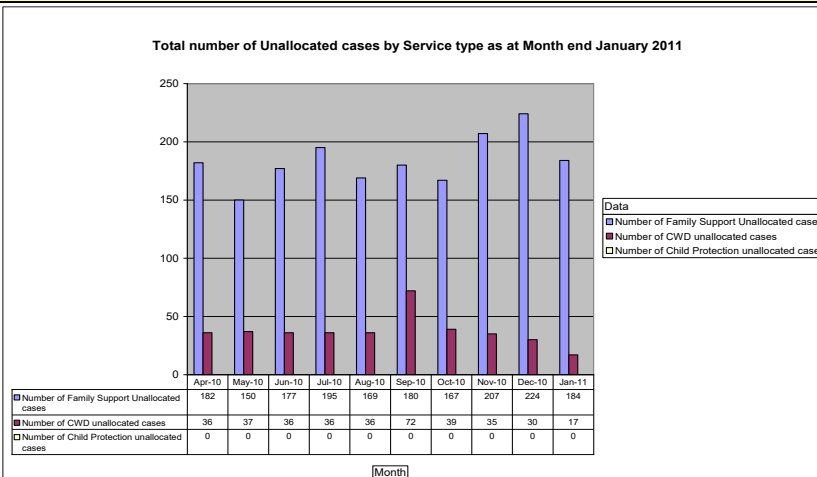
**Target: OP Review Backlog:** From March 2012 all reviews (outpatients) should be completed within the clinically indicated time



**Comment:**

- Trust submitted Op review backlog management plan and associated bids for additional capacity which were approved and non-recurrent funding secured.
- Whilst funding is now available ability to secure capacity is challenging when capacity is absorbed with access pressures.
- Whilst actions are ongoing at specialty level to manage the backlog risk with validation and treatment of backlogged patients, efforts also focus on changing practice as appropriate to prevent further backlog build up. Divisions have prepared OP RV backlog management plans which detail key milestones and actions required to address the backlog.
- Work is also ongoing to develop tools to allow effective profiling of backlogs and recurrent backlog gaps.

**Target: Unallocated Child Care Cases:**



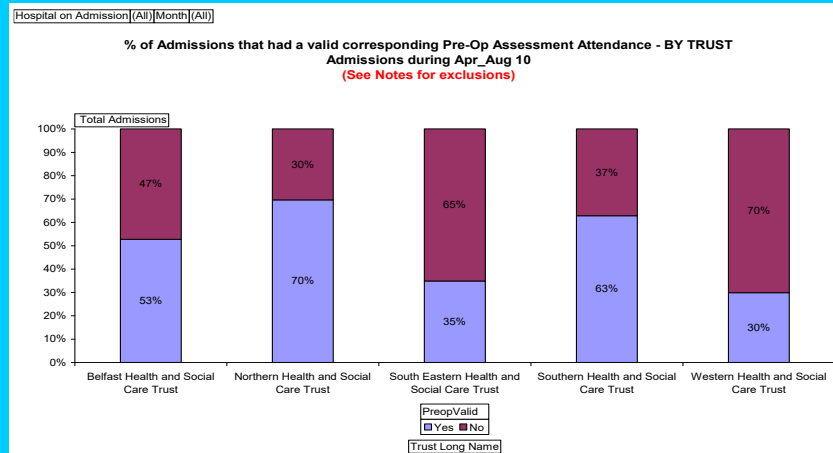
**Comments:**

At week ending 31<sup>st</sup> January there were 201 Unallocated cases – 184 Family Support and 17 disability.

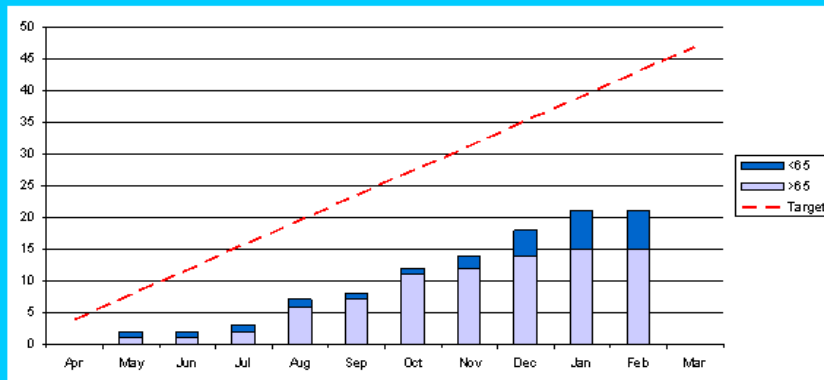
**Action taken to mitigate risks and strengthen our system:**

- There are no unallocated Child Protection Cases.
- Heads of Service, the APSW and Team Managers regularly review and prioritize unallocated cases for allocation.
- Close liaison between Heads of Service and Human Resources to review staff waiting lists and forward plan recruitment
- An additional Social worker was placed within the Central Gateway team but this has not provided additional capacity to undertake work due to sick leave within this team
- Trust participation in a regional review of thresholds for referrals entering the Gateway Service
- Review of the Gateway Duty system to ascertain if changes need to be made to make our current system more efficient to respond to contacts/referrals.

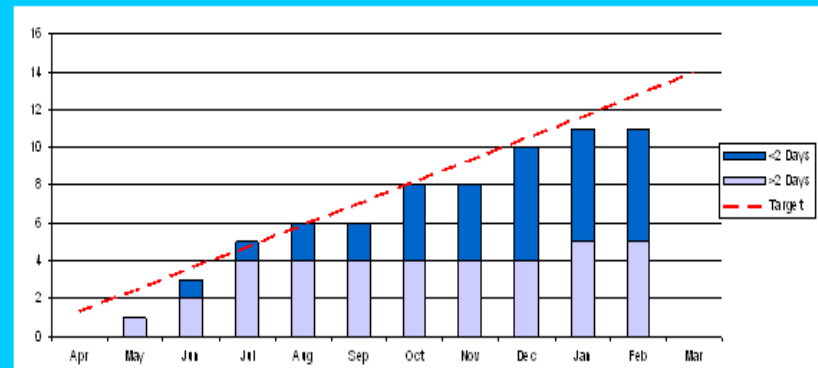
## Target: Pre-operative Assessment - From April 2010, all surgical patients should have appropriate pre-operative assessment



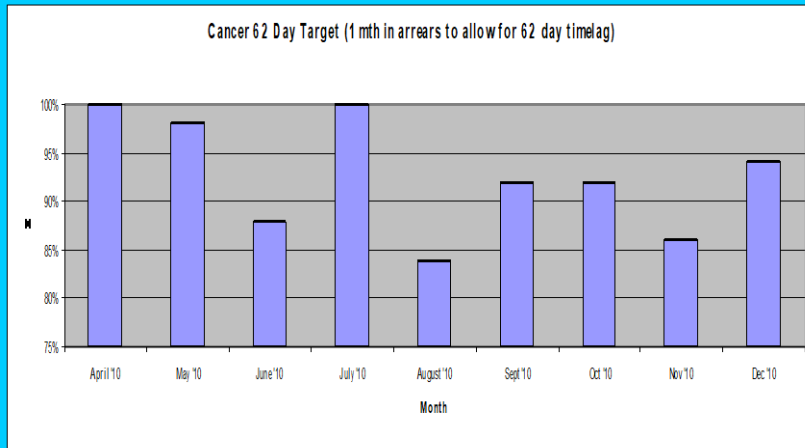
### C Diff



### MRSA



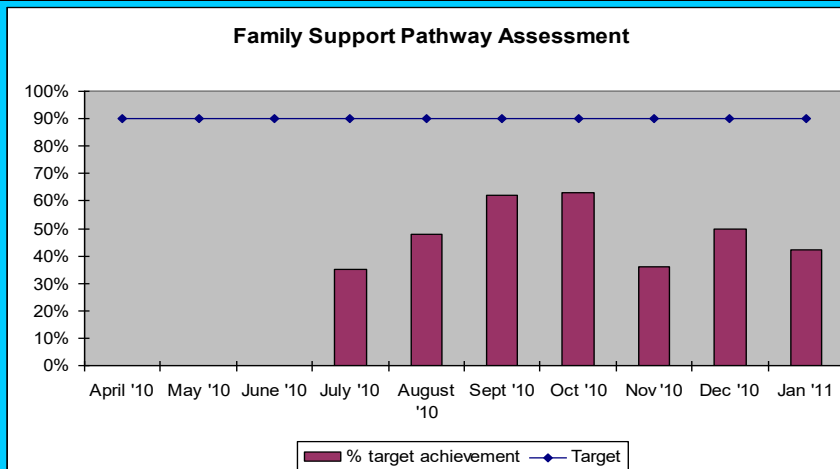
## Target: Cancer 62 Day Target



### Comment:

- Performance against 62 day target has been affected by, downtime of regional PET scanner over the summer and the associated backlog, reduction in beds in Thoracic surgery and delays in oncology appointments.
- With regard to the impact on the target, January projections expect performance to come in around 92%.
- The risks are ongoing and breaches are expected for both February and March at present in the 62 day pathway.

## Target: Family Support Pathway Assessment



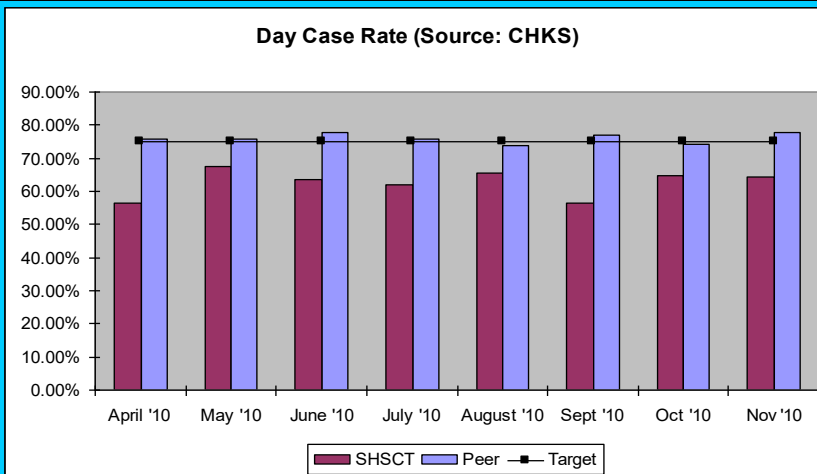
### Reasons for underperformance

- Pressures in the system
- Down staff (sick leave & maternity leave)
- Volume of referrals
- Rise in CP and LAC- we have an increase in Children on the CPR (511)

### Actions being taken to mitigate the risk

- Currently reviewing our duty system to endeavor to reduce inappropriate referrals and respond to NFA's in a more efficient way.
- There is regional work underway to achieve consistency in thresholds.
- The demand and capacity analysis.
- New SOSCAR regional agreement.
- Brought additionality into CWO Service, but offset by CWO on Sick leave.
- Non-recurrent monies to recruit into FIT, impact not realised until Feb/March.
- Utilise, where appropriate our Family Support packages, to address/divert cases.
- Strengthened Adolescent Service, to enable flow of referrals.
- Protocol in place for transfer of cases to LAC, which is working.

## Target: Day Case Rate



### Comment:

- SHSCT continues to underperform against this target
- Progress has commenced to increase the numbers of day cases.
- The Trust is unlikely to achieve this target in year.
-

Quality care – for you, with you

REPORT SUMMARY SHEET

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Meeting:<br>Date:                    | Trust Board<br>26 <sup>th</sup> September 2013                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Title:                               | Monthly Performance Management Report                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Lead Director:                       | Paula Clarke, Director of Performance and Reform                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Corporate Objective:                 | <ul style="list-style-type: none"> <li>• Provide safe high quality care</li> <li>• Maximise independence and choice for our patient and clients</li> <li>• Support people and communities to live healthy lives and to improve their health and wellbeing.</li> <li>• Make best use of resources.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Purpose:                             | For Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Summary of Key Areas:                | <p><b>High level context:</b></p> <p>This report reviews performance at the end of August 2013 against the Commissioning Plan standards and targets and provides an assessment of current performance.</p> <p>The report highlights a number of areas of risk predominantly with respect to elective access standards.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Summary of Key Areas:<br>(continued) | <p><b>Key issues/risks for discussion:</b></p> <p>1. <b>Elective Access</b> – Whilst initial focus was on the maintenance of the end March 2013 performance into 2013/2014 the HSCB now seeks the Trust to deliver the end of March 2014 access targets in the main in September, ie. backstop maximum waiting time of 9-weeks for diagnostics, 15-weeks for out-patient waiting and 26-weeks for inpatient/daycase waits.</p> <p>Whilst the majority of specialty areas will achieve the maximum waiting time for outpatients of 15-weeks by the end of September the Trust is projecting that 4 areas: dermatology, rheumatology, orthopaedic ICATs and urology and two visiting services, Ophthalmology and paediatric cardiology will not achieve this position. Further all but 2 Inpatients/daycase specialty areas, cardiology and urology, will achieve a maximum wait of 26-weeks. Urodynamics is the only area of diagnostics that will exceed the 9-week maximum waiting time by September 2013.</p> <p>Whilst this projected position has been recognised by HSCB as good in regional comparisons, with a low number of specialty areas not attaining the target access times, key performance risks still remain, relating to a number of common factors:</p> |

- recurrent investment has not yet been completed nor embedded in our systems to allow teams to routinely achieve the required level of performance. This means that teams are continuing to seek to maintain an additional level of capacity beyond the core and/or source and manage additional capacity in the IS;(see No 2 below for detail)
- the impact of disproportionate lost core capacity associated with bank holidays and the summer leave period;
- the impact of sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general and within current funded resources;
- continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and
- lead time for procurement processes, and ability to secure additional capacity in the independent /NHS UK sector for emerging areas of risk e.g. cardiology.

Performance challenges are set in the context of an increased focus on delivery of service and budget agreed (SBA) levels of core activity and achievement of the SBA continues to be variable across all specialities and activity areas.

HSCB have indicated that Trusts with material underperformance against SBA for 2 quarters will be subject to potential retraction of funding and have identified a number of areas of substantial underperformance in SHSCT, based on the Q1 position including Cardiology, ENT, General Medicine, Gynaecology- Colposcopy, Rheumatology and Urology outpatient performance for first patient consultations and Gynaecology, Endoscopy and Urology inpatient and daycase treatments.

The Chair and Chief Executive have met with the HSCB Chair and Chief Executive to discuss these areas (update included in Chair's Report at August meeting) and a briefing note issued to Trust Board members as discussed at this meeting, indicating recovery plans in all areas identified to improve SBA and reduce risk of potential retraction of funding. In the main there has been improvement in the majority of these positions in Quarter 2 to date.

Urology continues to present an on-going risk which is the subject of regular discussion with HSCB and they have accepted the workforce constraints affecting this area of performance. During August the Trust successfully recruited to the vacant Consultant Urology post. The Trust has a plan in place to improve performance in SBA delivery and a meeting arranged in September with the Commissioner to review this in the context of the regional challenges with this specialty.

2. **Progress on prioritised recurrent Elective Investments -**  
The Trust continues to work with HSCB and SLCG to confirm capacity gaps and agree service models and associated

recurrent funding to close these gaps. Work also continues within the Trust to reform service provision to be able to provide greater productivity.

Initial areas prioritised for investment included ENT, Gynaecology, General Surgery, Cardiology and Orthopaedics. Ongoing negotiations between the HSCB and Trust in relation to financial proposals for recurrent investments for ENT, Gynaecology and General Surgery are nearing completion and the Trust is now proceeding with recruitment in these areas in the anticipation that an agreement on an acceptable level of funding is imminent.

An investment proposal for orthopaedics was submitted to HSCB on 19<sup>th</sup> September and the proposal for cardiology is nearing completion and will be submitted to HSCB within the next month.

3. **Emergency Department** – The Trust secured diagnostic expertise and training to assist with a review of unscheduled care and has developed plans to manage current and future pressures focusing on total patient flow. An element of these plans is dependent upon an increase in staffing levels and proposals have been prepared and informally discussed with the Commissioner. The Trust anticipates being able to implement proposals non-recurrently potentially utilising any additional regional funding that may be made available to manage additional pressures over the winter period while recurrent investment is formalised.
4. **Cancer 62-Day Pathway** – Whilst the Trust has experienced increased demand for cancer (red flag) referrals which has affected performance against the 62-day pathway the regional focus has been on ensuring there are no patients waiting over 85 days. The Trust is maintaining this position and is in a strong Regional position. Urology remains the area of internal focus and performance in these areas is affected by the overall manpower issues being experienced in this specialty area, which have been discussed with the commissioner.
5. **AHP** – Increasing demand and staffing issues in AHP have led to an increased volume of patients waiting beyond access times.  
  
The Trust has developed and discussed an action plan with the HSCB, to address the backlog of patients waiting beyond access times. HSCB has agreed additional non-recurrent funding for key areas to address the backlog which is reliant upon recruitment of additional temporary AHP staff. Work is also underway with HSCB to define the residual capacity gaps resulting from continually increasing demand for some AHP services and seek to secure recurrent resources to maintain the access time.
6. **Mental Health Access** – Two areas of service reported under mental health targets are challenged currently in achievement of



maximum waiting time targets. Memory/Dementia Services are experiencing a capacity gap due to increasing demand in this service area. The pathway has been reviewed and defined and the Service are preparing proposals on identified capacity gaps for discussion with Commissioner in order to secure non-recurrent funding to address the backlog and seek recurrent funding to address ongoing need.

Psychological Therapies received investment in 2012/13 to enable the service to manage an increased level of demand. Whilst this is now embedded the service requires to secure non-recurrent funding to address the accrued backlog of patients waiting in excess of 13 weeks. The issue has been raised with the SLCG and proposals are being prepared.

***Summary of SMT challenge/discussion***

- Assurance given that there is management effort to ensure that the 'no risk' specialties deliver their SABA/access targets to allow focus on areas of high risk and those where we are in discussion with Commissioner for additional resources.
- Assurance sought that strict chronological management in place.
- Agreement to develop performance recovery action plans for high risk specialties/services and assurance sought that these action plans will be closely monitored to ensure full implementation, escalation of any deviation and on-going revision to achieve expected level of access / SBA.
- Confirming that discussions with HSCB about the funding model for recurrent investments (70% of specialty costs) are at the right level of seniority to secure urgent agreement and agreement to escalate to Chief Executive level if not resolved by 27<sup>th</sup> September.
- Action sought to address long waits as quickly as possible.
- Consideration of the recommendations of the draft internal audit report on performance management and agreement to adapt this Performance Report to enhance information about actions required to address underperformance and to add in lead Director position for each target.

## **PERFORMANCE MANAGEMENT REPORT**

### **COMMISSIONING PLAN STANDARDS/TARGETS FOR 2013/2014 INCLUDING INDICATORS OF PERFORMANCE**

**September 2013 Report for  
August 2013 Performance**

## CONTENT

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| Reporting                                                       | 1    |
| Commissioning Plan Standards/Targets and Associated Performance | 2    |

## 1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance for 2013/2014 against:

- Health and Social Care Commissioning Plan Standards/Targets

A significant number of Indicators of Performance (IoP) have also been identified in year to complement the Commissioning Plan Standards and Targets. These IoPs whilst not identified as specific targets will be monitored in year to assess broader performance.

Detailed in the attached report are the Indicators of Performance that are currently reported on a monthly basis.

## 2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers;
- To develop more innovative, accessible and responsive services; promoting choice and by making more services available in the community;
- To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services;

The level of performance on a monthly basis will be assessed as follows:

|            |                                                                                                                                                                       |
|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Green (G)  | Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track                                                                       |
| Yellow (Y) | Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track |
| Amber (A)  | Standard partially achieved/limited progress towards achievement of target – Management actions required                                                              |
| Red (R)    | Standard/target not achieved/not on track to achieve – Management actions/intervention required                                                                       |
|            | Not assessed (due to lack of baseline; target; or robust data)                                                                                                        |

The performance trend will be assessed as follows and represent the typical performance profile for the identified standard/target over the period assessed and will not reflect month on month shifts in performance.

|   |                        |
|---|------------------------|
| ↑ | Performance improving  |
| ↓ | Performance decreasing |
| ↔ | Performance static     |

### 3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

**MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF SAFE, RESILIENT AND SUSTAINABLE SERVICES**
**CP 3: HIP FRACTURES: Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip fractures.**

**Baseline:** 92.7% (cumulative April 2012 – March 2013)

**TDP Assessment:** Likely to be achieved with some delay/partially achieved

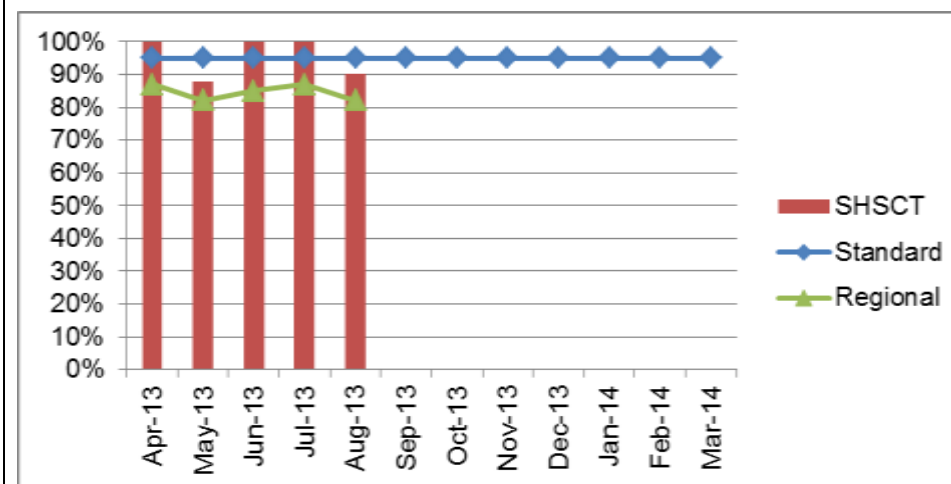
**Standard:** 95%

**Comments:**

Whilst performance against the 48-hour standard for Fracture Neck of Femur has fallen in August it remains well above the regional average, with breaches only reported in 2 out of the 5 months to date (May and August).

Performance has been maintained in part by the creation of additional in-house capacity which has been required to meet a general increase in trauma demand, which has presented both as additional inpatient and outpatient demand. The Trust met with the HSCB In August to discuss this issue and is undertaking further analysis of demand, productivity & capacity for the commissioner

The Trust has finalised investment proposals for additional Trauma & Orthopaedic capacity which will see the current service model increase from a six to ten consultant model. Proposal includes additional elective orthopaedic gap and trauma capacity to facilitate the repatriation of Newry & Mourne trauma patients to the Southern Trust.



| Site     | Monthly Position:      |                       |                        |                        |                       |      |     |     |     |     |     |     | Monthly Assess | Trend |
|----------|------------------------|-----------------------|------------------------|------------------------|-----------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|          | Apr                    | May                   | Jun                    | Jul                    | Aug                   | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Trust    | 100%<br>(30 out of 30) | 88%<br>(21 out of 24) | 100%<br>(16 out of 16) | 100%<br>(18 out of 18) | 90%<br>(26 out of 29) |      |     |     |     |     |     |     | Y              | ↓     |
| Regional | 87%                    | 82%                   | 85%                    | 87%                    | 82%                   |      |     |     |     |     |     |     |                |       |

**CP 4: CANCER CARE SERVICES: Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62-days (from date of referral).**

**Baseline:** 97.73% (cumulative April 2012 – January 2013)

**TDP Assessment:** Likely to be achieved with some delay/partially achieved

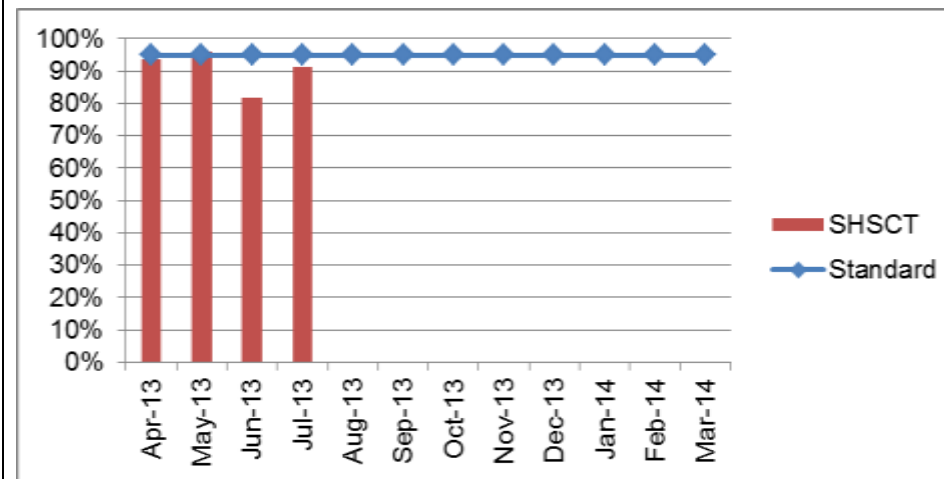
**Standard:** 95%

**Comments:** Reporting two months in arrears against the 62-day standard.

Performance against the 62-day standard in July has improved (91.4%) in comparison to the June position (81.58%). In July there were 6 patients who did not achieve the 62-day standard (2 internal and 4 external/regional).

HSCB focus is on the interim standard that no patient should be waiting in excess of 85-days. At the end of July the Trust continued to have no patients in excess of 85 days at month end.

Actions to improve the internal pathway are focused on urology with the creation of additional assessment and diagnostic capacity at the start of the patient pathway.

**Monthly Position:**

| Apr    | May    | Jun    | Jul   | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Monthly Assess | Trend |
|--------|--------|--------|-------|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| 93.75% | 95.96% | 81.58% | 91.4% |     |      |     |     |     |     |     |     | Y              | ↑     |

**CP 5: ACCIDENT AND EMERGENCY : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Departments are either treated and discharged home, or admitted, within 4 hours of their arrival in the department;**

**Baseline:** Trust – 86% (Position March 2013)  
CAH – 77%  
DHH – 92%

**Standard:** 95%

**TDP Assessment:** Likely to be achieved with some delay/partially achieved

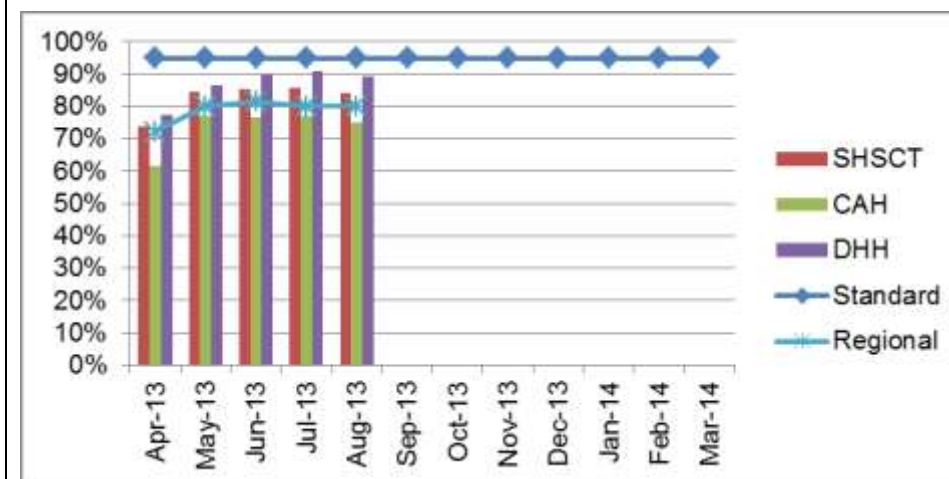
**Comments:**

Performance in August (84.2%) has remained relatively static from the July position (85.8%). The SHSCT corporate position and DHH site performance remain in excess of Regional performance with only CAH site performance falling below Regional level.

A number of improvement initiatives have been put in place including:

- Review of unscheduled care flow with development of Acute Medical Model
- Enhanced discharge management model project
- Extension of Emergency Nurse Practitioner cover into evening
- Development of dedicated laboratory facilities
- On-going works at DHH with creation of see and treat model

Investment proposals detailing resources required to support improvement in this area have been prepared and discussed with the Commissioner. It is anticipated the early impact of these initiatives will lead to a 5% increase in the CAH performance by September.



| Site  | Monthly Position:           |                               |                               |                               |                               |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------|-----------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|       | Apr                         | May                           | Jun                           | Jul                           | Aug                           | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Trust | 74%<br>(8942 out of 12080)  | 84.5%<br>(10483 out of 12409) | 85.5%<br>(10256 out of 11994) | 85.8%<br>(10840 out of 12640) | 84.2%<br>(10107 out of 12002) |      |     |     |     |     |     |     | Y              | ↔     |
| CAH   | 61.6%<br>(3776 out of 6126) | 76.9%<br>(4801 out of 6247)   | 76.8%<br>(4663 out of 6071)   | 77%<br>(4893 out of 6352)     | 75%<br>(4523 out of 6031)     |      |     |     |     |     |     |     | R              | ↔     |

| Site                   | Monthly Position:                 |                                   |                                   |                                   |                                   |      |     |     |     |     |     |     | Monthly Assess | Trend |
|------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                        | Apr                               | May                               | Jun                               | Jul                               | Aug                               | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| DHH                    | 77.4%<br>(2702<br>out of<br>3489) | 86.5%<br>(3071<br>out of<br>3551) | 90.2%<br>(3037<br>out of<br>3367) | 90.7%<br>(3334<br>out of<br>3674) | 89.2%<br>(3182<br>out of<br>3569) |      |     |     |     |     |     |     | Y              | ↔     |
| Regional Ave<br>(Peer) | 72.1%                             | 80.1%                             | 81.5%                             | 80.1%                             | 80%                               |      |     |     |     |     |     |     |                |       |



**CP 5: ACCIDENT AND EMERGENCY : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, no patient attending any emergency department should wait longer than 12 hours.**

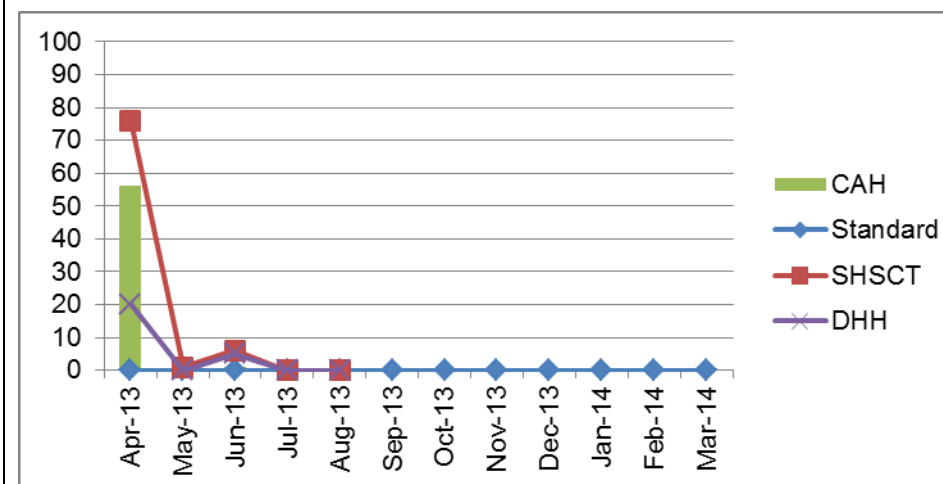
**Baseline:** 41 (cumulative April 2012 – March 2013)

**TDP Assessment:** Likely to be achieved with some delay/partially achieved

**Standard:** 0

**Comment/Actions:** In August the Trust maintained the July position with no breaches of the 12-hour standard reported.

Unvalidated July regional information estimates 196 breaches of the 12-hour target throughout the Province, with only SHSCT and BHSCT having a 0 breach position for Type 1 Emergency Departments.



| Site  | Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|       | Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Trust | 76                | 1   | 6   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |
| CAH   | 56                | 1   | 1   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |
| DHH   | 20                | 0   | 5   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |

**CP 6: HOSPITAL RE-ADMISSIONS : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**By March 2014, secure a 10% reduction in the number of emergency re-admissions within 30 days.**

**Baseline:** To be confirmed

**TDP Assessment:** Achievable dependent upon additional funding

**Target:** 10% reduction

**Comment/Actions:** The Acute Information Team are continuing with the development of the Hospital Re-Admissions report, however, due to the multiple stages of development and validation required it is anticipated that this report will not be available until at least Quarter 2.

Benchmarking data obtained from the CHKS system details the Trust re-admission rate (patients discharged from Southern Trust hospitals and re-admitted to Southern Trust hospitals (within 30 days) at 5.2% versus Peer of 6.2%.

| Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Not Available     |     |     |     |     |      |     |     |     |     |     |     |                |       |

**CP 7: ELECTIVE CARE – OUT-PATIENTS : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, at least 70% of patients wait no longer than 9-weeks for their first out-patient appointment with no-one waiting longer than 18-weeks, increasing to 80% by March 2014 and no-one waits longer than 15-weeks.**

**Baseline:** 87.9% (<9-weeks @ 31 March 2013)  
83 (>18-weeks @ 31 March 2013)

**TDP Assessment:** Achievable dependent upon additional funding

**Standard:** 70% <9-weeks and 0 >18-weeks; rising to 80% <9-weeks and 0 >16-weeks

**Comment/Actions:**

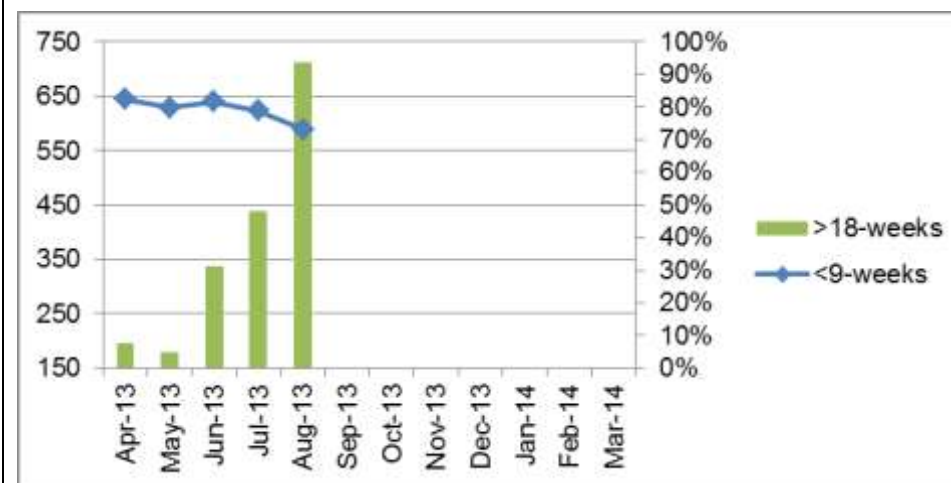
The percentage of patients waiting less than 9-weeks decreased slightly in August which demonstrates on-going variable performance against this target. In correlation the number of patients waiting over 18-weeks (713) has increased. This cohort over 18-weeks equates to 4% of the total OP waiting list.

The HSCB has asked the Trust to achieve a maximum wait of 15 weeks by September. The Trust has identified 4 internal specialties that will be in excess of 15 weeks, Dermatology, Paediatrics, Orthopaedic ICATS and Urology. All of these areas have affected by medical staffing issues except for orthopaedic ICATS which is experienced increased demand. The Trust met with the SLCG in September to discuss demand issues in ICATs and is seeking non-recurrent resources to improve capacity whilst discussions are ongoing.

The Trust has identified 2 external (visiting specialties) that will be in excess of 15 weeks; Ophthalmology (Visiting Service element) and Paediatric Cardiology

Whilst plans are in place to deliver 15-weeks for all other specialty areas risk is also associated with those specialties where capacity to achieve 15-weeks is reliant upon the Independent Sector.

In respect of patients waiting in excess of 9-weeks there are a total of 5677 patients (4595 consultant-led and 1082 ICATS). 2581 (1678 consultant-led and 903 ICATS) of these relate to specialty areas that require to achieve 9-weeks. Specialties which will not achieve 9 weeks but will achieve the 15 backstop include: ENT; Gynaecology; Neurology,



| Respiratory; Rheumatology and Orthopaedics.                                                                                                            |                   |                  |                  |                  |                  |      |     |     |     |     |     |     |                |       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|------------------|------------------|------------------|------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| All internal plans focus on the delivery of core commissioned capacity and additional capacity funded non-recurrently to achieve the best access time. |                   |                  |                  |                  |                  |      |     |     |     |     |     |     |                |       |
|                                                                                                                                                        | Monthly Position: |                  |                  |                  |                  |      |     |     |     |     |     |     | Monthly Assess | Trend |
|                                                                                                                                                        | Apr               | May              | Jun              | Jul              | Aug              | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>&lt;9-weeks</b>                                                                                                                                     | 82.3%<br>(12954)  | 79.8%<br>(13220) | 81.5%<br>(13896) | 78.8%<br>(13574) | 73.1%<br>(12495) |      |     |     |     |     |     |     | <b>G</b>       | ↓     |
| <b>&gt;18-weeks</b>                                                                                                                                    | 195               | 180              | 336              | 439              | 713              |      |     |     |     |     |     |     | <b>R</b>       | ↓     |

**CP 8: ELECTIVE CARE – DIAGNOSTICS : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, no patient waits longer than 9-weeks for a diagnostic test including endoscopy and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.**

**Baseline:** Diagnostic Testing – 254 > 9 weeks (@ 31 March 2013)  
 Endoscopy – 11 > 9 weeks (@ 31 March 2013)  
 Imaging DRTT – 90.9% < 2 days(@ 31 March 2013)  
 Non-Imaging DRTT – 88% < 2 days (@ 31 March 2013)

**TDP Assessment:** Likely to be achieved with some delay/partially achieved.

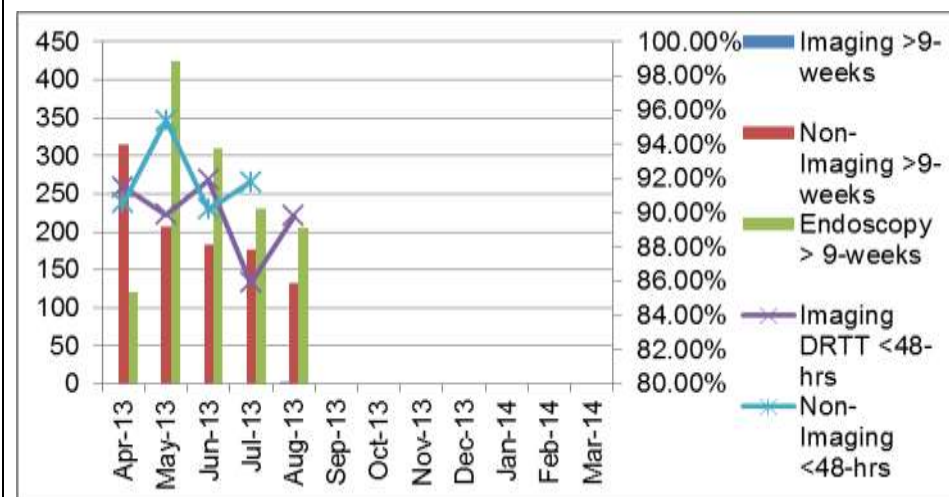
**Standard:** Diagnostic Testing – 9-weeks  
 Endoscopy – 9-weeks  
 DRTT – 2 days

**Comment/Actions:**

**Diagnostic Testing** - Waits in excess of 9-weeks has decreased in August (369) in comparison to the end of July (439).

- **Urodynamics** - 107 (29%) of the patients waiting over 9-weeks currently relate to Urodynamics (Urology) for which there has been a significant capacity shortfall creating backlog. The Trust has developed an in-house plan to create additional capacity to clear this backlog of patients by March 2014 and achieve a 9 week position. Once the backlog is cleared it is anticipated that the service will be able to maintain the 9-week access standard. The longest waiter is currently 77-weeks.
- **Cardiac Investigations** - 17 of the patients waiting over 9-weeks relate to Cardiac Investigations. The Division are currently working through this backlog to return to 9-weeks. The longest waiters are currently 19-weeks.
- **Imaging** – whilst 32 patients are reported as waiting over 9-weeks in August, Division have only 2 confirmed breaches of the 9-weeks in August and anticipate no patients will wait over 9 weeks by September 2013
- **Endoscopy** – The Trust continues to have patients waiting in excess of 9-weeks for Endoscopy, (205 patients). This is predominantly associated with increase in general demand and in particular the volumes of red flag within this.

This increased demand of approximately 1500 additional patients per annum has been recognised by HSCB, which has approved additional non-recurrent activity in year which the Trust is securing through both in-



house and independent sector activity.

The Trust is also finalising a proposal for expansion in nurse endoscopist capacity to deal with the capacity gap on a recurrent basis, as requested by HSCB.

**Diagnostic Reporting – Imaging** – Performance in August (89.8%) has increased slightly from the end of July position. Within Imaging the challenges in turnaround time for reporting remain within the modalities of MRI and Barium Enema. Performance against the 48-hour standard is affected by the timing of the examinations with timing of examination is based on the clinical need of the patient and not the ability to report within the 48-hour standard.

**Non-Imaging** – No update available for August

|                                           | Monthly Position:           |                             |                             |                             |                             |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                                           | Apr                         | May                         | Jun                         | Jul                         | Aug                         | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>Imaging &gt;9-wks*</b>                 | 23                          | 17                          | 3                           | 32                          | 32                          |      |     |     |     |     |     |     | Y              | ↓     |
| <b>Non-Imaging &gt;9-wks</b>              | 315                         | 207                         | 183                         | 176                         | 132                         |      |     |     |     |     |     |     | R              | ↑     |
| <b>Endos. &gt;9-wks</b>                   | 121                         | 425                         | 309                         | 231                         | 205                         |      |     |     |     |     |     |     | R              | ↑     |
| <b>Imaging DRTT Urgents &lt;48-hrs</b>    | 91.5%<br>(2238 out of 2441) | 89.9%<br>(2330 out of 2592) | 91.9%<br>(2333 out of 2540) | 85.9%<br>(2390 out of 2782) | 89.8%<br>(2244 out of 2499) |      |     |     |     |     |     |     | Y              | ↑     |
| <b>Non-Imaging DRTT Urgent &lt;48-hrs</b> | 90.6%<br>(126 out of 139)   | 95.4%<br>(145 out of 152)   | 90.2%<br>(120 out of 133)   | 91.8%<br>(134 out of 146)   | Not Available               |      |     |     |     |     |     |     | Y              | ↔     |

**CP 9: ELECTIVE CARE – IN-PATIENTS AND DAY CASES: Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, at least 70% of in-patients and day cases are treated within 13-weeks with no-one waiting longer than 30-weeks, increasing to 80% by March 2014, and no patient waits longer than 26-weeks for treatment.**

**Baseline:** 67.2% (<13-weeks @ 31 March 2013)  
172 (>30-weeks @ 31 March 2013)

**TDP Assessment:** Achievable dependent upon additional funding

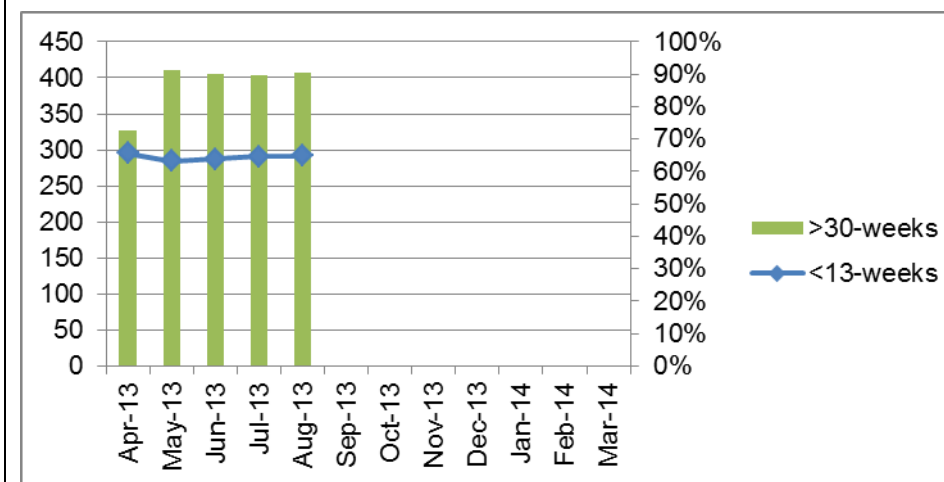
**Target:** 70% <13-weeks and 0 >30-weeks; rising to  
80% <13-weeks and 0 >26-weeks

**Comment/Actions:**

The percentage of in-patients/day cases, excluding scopes, waiting less than 13-weeks at the end of August (64.8%) remains relatively static from the July position with the number of patients waiting longer than the 30-week backstop fairly static at 407. The number waiting over 30 weeks equates to 7% of the total IP/DC waiting list.

The HSCB has asked the Trust to achieve a maximum wait of 26-weeks by September. The Trust has identified two specialties, Urology and Cardiology, where it anticipates that the maximum waiting time will be greater than 26-weeks at the end of September.

- **Urology** – staffing issues and significant volumes of urgent/red flags patients are affecting the longest waits. The Trust has secured capacity in NHSCT for a cohort of long wait patients and has secured appointment of the replacement 5<sup>th</sup> consultant post which will increase capacity in Q3/4. If the cohort of patients transferred to the NHSCT are treated in September then the longest wait at the end of September is projected to be 59-weeks. If the patients transferred to the NHSCT are not treated in September then the longest wait at the end of September is projected to be 80-weeks. The Trust has discussed challenges in securing and retaining staff with the commissioner and is developing plans to increase capacity in the short term.
- **Cardiology** – staff vacancy and regional capacity issues with specialist operators affecting the longest waits for patients waiting electrophysiology/ablation procedures. The Trust is seeking to secure capacity from IS or NHS UK hospitals to address this



regional deficit; longest wait for EP/Ablation in September projected at 52-weeks, all other non-invasive cardiology procedures will be seen within the 26 week backstop. It is also of note that waits for diagnostic angiography procedures has improved to less than 13 weeks.

In respect of patients waiting in excess of 13-weeks there are a total of 2067 patients. Specialties which will not achieve 13-weeks but will achieve the new 26 week backstop include: Breast Surgery, General Surgery; ENT; Gynaecology, Pain Management; Rheumatology; and Orthopaedics.

Whilst plans are in place to deliver 13 weeks for all other specialty areas risk is also associated with those specialties were capacity to achieve same is reliant upon the independent sector.

All internal plans focus on the delivery of core commissioned capacity and additional capacity funded non-recurrently to secure the best access time achievable.

|                     | Monthly Position (Excluding Scopes): |                 |                 |                 |                 |      |     |     |     |     |     |     | Monthly Assess | Trend |
|---------------------|--------------------------------------|-----------------|-----------------|-----------------|-----------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                     | Apr                                  | May             | Jun             | Jul             | Aug             | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>&lt;13-weeks</b> | 65.7%<br>(4443)                      | 63.2%<br>(4241) | 63.9%<br>(4230) | 64.6%<br>(4087) | 64.8%<br>(3886) |      |     |     |     |     |     |     | Y              | ↔     |
| <b>&gt;30-weeks</b> | 327                                  | 410             | 406             | 404             | 407             |      |     |     |     |     |     |     | R              | ↔     |



**CP 10: HEALTHCARE ACQUIRED INFECTIONS : Lead Director – Mr John Simpson, Medical Director**

**By March 2014, secure a reduction of 29% in MRSA and Clostridium Difficile infections compared to 2011/2012.**

**Baseline:** MRSA – 1  
C Diff – 42

**TDP Assessment:** Awaiting confirmation of targets for 2013/2014

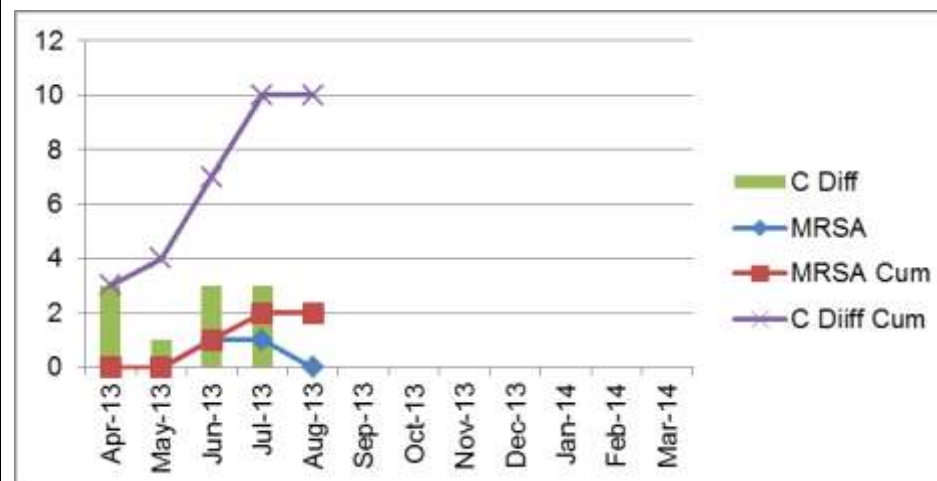
**Target:** MRSA – <3  
MRSA Case Reduction Required – -1 - +2  
C Diff – 33  
C Diff Case Reduction Required – -9

**Comment/Actions:**

**MRSA** – In August no further cases of MRSA were reported.

**C Diff** – In August no further cases of C Diff were reported.

Further information on the HCAI rates is provided within the Medical Director's Trust Board Report.



|               | Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|---------------|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|               | Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| MRSA Actual   | 0                 | 0   | 1   | 1   | 0   |      |     |     |     |     |     |     | G              | ↑     |
| MRSA Cum      | 0                 | 0   | 1   | 2   | 2   |      |     |     |     |     |     |     | Y              | ↔     |
| C Diff Actual | 3                 | 1   | 3   | 3   | 0   |      |     |     |     |     |     |     | G              | ↑     |
| C Diff Cum    | 3                 | 4   | 7   | 10  | 10  |      |     |     |     |     |     |     | Y              | ↔     |

**CP 12: SPECIALIST DRUGS: Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, no patient should wait longer than 3-months commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, and no patient should wait longer than 9-months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.**

**Baseline:** 0 Rheumatology (>3-months @ 31 March 2013)  
8 Dermatology (>9-months @ 31 December 2012)

**TDP Assessment:** Achievable dependent on additional funding

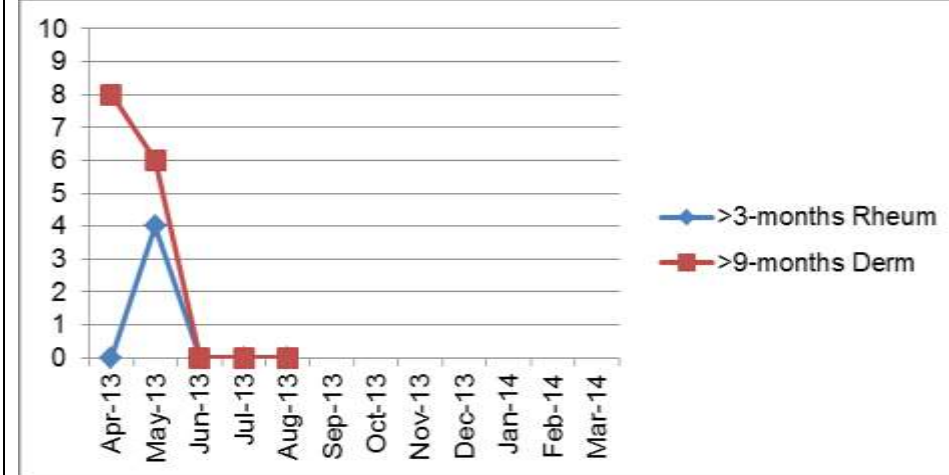
**Target:** 0 >3-months Rheumatology  
0 >9-months Dermatology; changing to  
0 >3-months by September 2013

**Comment/Actions:**

No patients are waiting more than 3-months for the commencement of NICE approved specialist therapies for rheumatoid arthritis; psoriatic arthritis; or ankylosing spondylitis.

The Trust has submitted an investment proposal to PHA/HSCB for the commencement of the additional anti-TNF therapies along with the small recurrent capacity gap within core rheumatology. Whilst funding for therapies has been agreed, capacity required for the recurrent gap to enable support and delivery of therapies has not yet been agreed. Formal commissioner response is awaited.

No patient was waiting more than 9-months for the commencement of NICE approved specialist therapies for psoriasis.

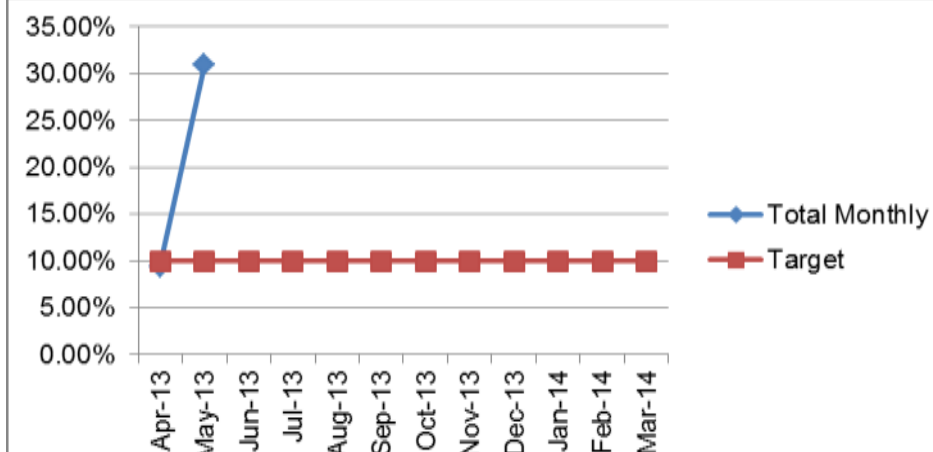


|                 | Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-----------------|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                 | Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| >3-months Rheum | 0                 | 4   | 0   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |
| >9-months Derm  | 8                 | 6   | 0   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |

**CP 13: SPECIALIST DRUGS: Lead Director – Mrs Deborah Burns, Director of Acute Services****By March 2014, ensure that at least 10% of patients with confirmed Ischaemic stroke receive thrombolysis.****Baseline:** 9.7% (cumulative April 2012 – December 2012)**TDP Assessment:** Achievable**Target:** 10%**Comment/Actions:**

In May the Trust achieved a greater than 10% of patients with confirmed ischaemic stroke having received thrombolysis (31%), with a cumulative position of 17.1%.

In respect of CAH the target was achieved in 1 out of 2 months; whilst at DHH the target was achieved in 2 out of 2 months.



| Site                    | Monthly Position: |             |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------------|-------------------|-------------|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                         | Apr               | May         | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>Trust</b>            | 9.4%              | 31.0%       |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>Trust Admissions</b> | A 53<br>T 5       | A 29<br>T 9 |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Trust Cumulative</b> | -                 | 17.1%       |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>CAH</b>              | 5.6%              | 31.6%       |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>CAH Admissions</b>   | A 36<br>T 2       | A 19<br>T 6 |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>CAH Cumulative</b>   | -                 | 14.5%       |     |     |     |      |     |     |     |     |     |     |                |       |

| Site                  | Monthly Position: |             |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-----------------------|-------------------|-------------|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                       | Apr               | May         | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>DHH</b>            | 17.6%             | 30.0%       |     |     |     |      |     |     |     |     |     |     | <b>G</b>       | ↑     |
| <b>DHH Admissions</b> | A 17<br>T 3       | A 10<br>T 3 |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>DHH Cumulative</b> | -                 | 22.2%       |     |     |     |      |     |     |     |     |     |     |                |       |

**Note:** Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

**CP 14: MEDICINES FORMULARY : Lead Director – Mrs Deborah Burns, Director of Acute Services**

**From April 2013, ensure that HSCB achieve 70% concordance with the published Medicines Formulary.**

**Baseline:** To be confirmed

**TDP Assessment:** HSCB to respond

**Target:** 70%

**Comment/Actions:** The Trust will work to support the 70% compliance target of primary care. Monitoring arrangements on drug usage levels in Trusts are being developed in conjunction with the HSCB and will be implemented once agreed. Regular prescribing audits are carried out for both in-patients and out-patients.

The Trust will establish a baseline for 2013/2014 as requested.

| Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Not Available     |     |     |     |     |      |     |     |     |     |     |     |                |       |

**CP 15: ALLIED HEALTH PROFESSIONALS: Lead Director – Mrs Angela McVeigh, Director of Older People and Primary Care Services**
**From April 2013, no patient waits longer than 9-weeks for referral to commencement of AHP treatment.**
**Baseline:** 27 Paediatric OT (>9-weeks @ 31 March 2013)

**TDP Assessment:** Achievable

**Standard:** 0

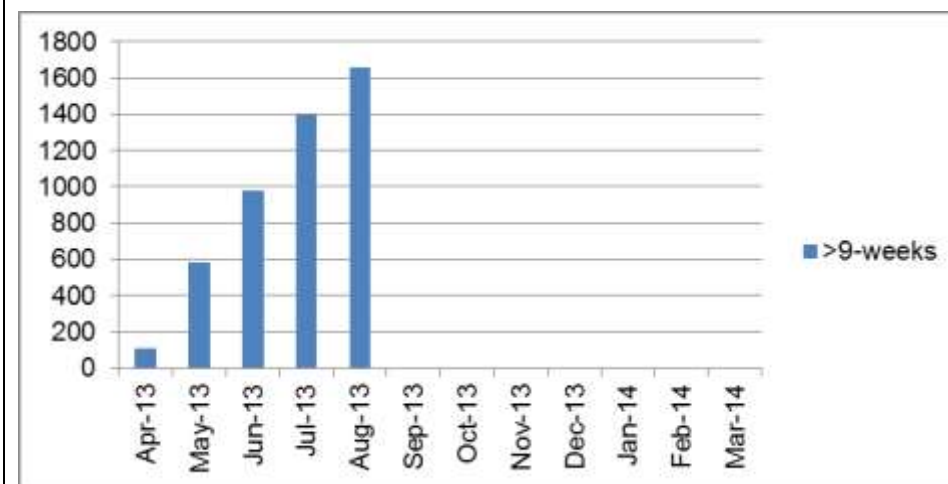
**Comments:**

The number of waiters in excess of 9-weeks has significantly increased to 1661 at the end of August. The breakdown and longest waiters are as follows: Dietetics 54 (15-weeks); Occupational Therapy 305 (28-weeks); Physiotherapy 1451 (18-weeks); Podiatry 58 (13-weeks); and Speech & Language Therapy 152 (20-weeks).

The Trust has submitted a paper to HSCB detailing performance against agreed SBA levels and has highlighted that SBA performance is on-track with some minimal underperformance. Therefore, the increasing number of breaches appears to be a demand issue.

The Trust has met with HSCB and PHA to review capacity and demand issues and has sought additional non-recurrent funding to pull-back the current level of breaching patients, with agreement reached on key priority area.

A subsequent demand and capacity exercise is required to ascertain the volume of additionality to maintain 9-weeks in Quarters 3 and 4 once the backlog has been addressed.



| Monthly Position: |     |     |      |      |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------|-----|-----|------|------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| Apr               | May | Jun | Jul  | Aug  | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| 108               | 584 | 979 | 1396 | 1661 |      |     |     |     |     |     |     | R              | ↓     |

**CP 16: TELEHEALTH: Lead Director – Mrs Angela McVeigh, Director of Older People and Primary Care**

**By March 2014, deliver 500,000 Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.**

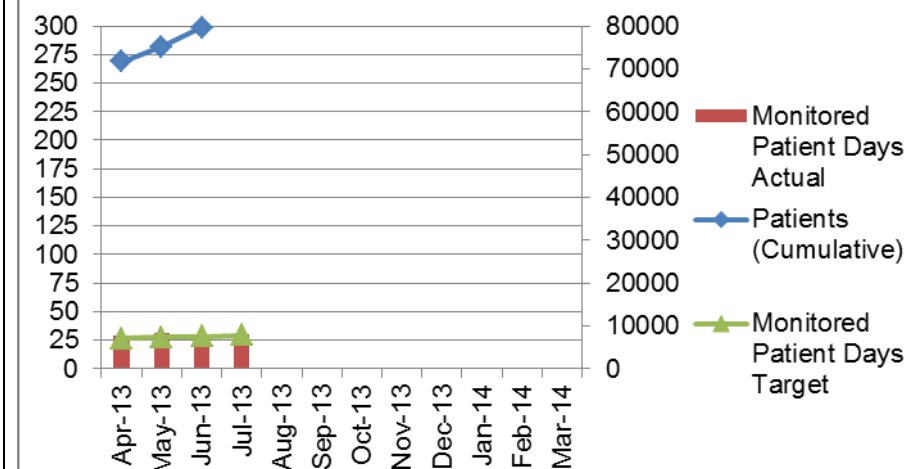
**Baseline:** To be confirmed

**TDP Assessment:** To be confirmed

**Target:** To be confirmed

**Comment/Actions: Trust baseline and Trust proportion of target to be confirmed.**

At 31 March 2013 there were 247 patients on telemonitoring. Cumulatively at the end of July there were 314 patients on telemonitoring.



|                                      | Monthly Position: |                   |                   |                   |               |      |     |     |     |     |     |     | Monthly Assess | Trend |
|--------------------------------------|-------------------|-------------------|-------------------|-------------------|---------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                                      | Apr               | May               | Jun               | Jul               | Aug           | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>Patients (Cumulative)</b>         | 22<br>Cum.<br>269 | 13<br>Cum.<br>282 | 17<br>Cum.<br>299 | 16<br>Cum.<br>315 | Not Available |      |     |     |     |     |     |     |                |       |
| <b>Actual Monitored Patient Days</b> | 7780              | 8243              | 7887              | 8166              | Not Available |      |     |     |     |     |     |     |                |       |
| <b>Target Monitored Patient Days</b> | 7085              | 7299              | 7513              | 7744              | Not Available |      |     |     |     |     |     |     |                |       |

**CP 19: UNPLANNED ADMISSIONS Lead Director – Mrs Angela McVeigh, Director of Older People and Primary Care****By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long-term conditions****Baseline:** -5.7% (cumulative April 2012 to December 2012)**TDP Assessment:** Achievable**Target:** Reduce by 10%**Comment/Actions:** Reported 3-months in arrears.

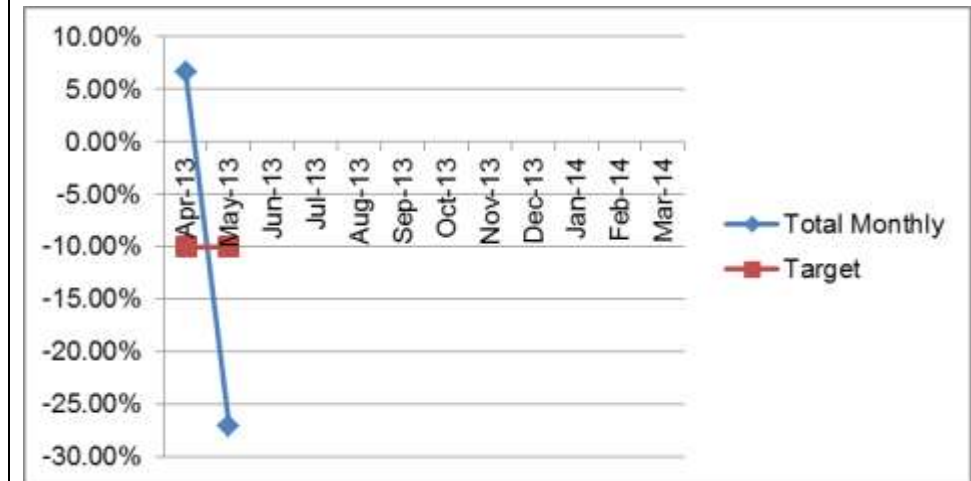
The total\* conditions specified within this target are:

- COPD;
- Diabetes;
- Heart Failure; and
- Asthma.

May activity shows that 3 out of the 4 specified long-term conditions, COPD, Diabetes and Heart Failure have achieved a higher reduction than the target of a reduction in admissions by 10%.

The baseline admissions for the 4 specified long-term conditions is listed below with the corresponding activity for the two months of 2013/2014:

- Total – Baseline 228 versus 207 actual admissions
- COPD – Baseline 125 versus 110 actual admissions
- Diabetes – Baseline 19 versus 18 actual admissions
- Heart Failure – Baseline 67 versus 53 actual admissions
- Asthma – Baseline 17 versus 26 actual admissions





|                                 | Monthly Position: |               |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|---------------------------------|-------------------|---------------|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                                 | Apr               | May           | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>Total* Monthly</b>           | 6.6%              | -27.1%        |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>Total Admissions*</b>        | B 121<br>A 129    | B 107<br>A 78 |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Total* Cumulative</b>        | -                 | -9.2%         |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>COPD</b>                     | 11.1%             | -35.5%        |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>COPD Admissions</b>          | B 63<br>A 70      | B 62<br>A 40  |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>COPD Cumulative</b>          | -                 | -12.0%        |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Diabetes</b>                 | 0%                | -11.1%        |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>Diabetes Admissions</b>      | B 10<br>A 10      | B 9<br>A 8    |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Diabetes Cumulative</b>      | -                 | -5.3%         |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Heart Failure</b>            | -18.4%            | -24.1%        |     |     |     |      |     |     |     |     |     |     | G              | ↑     |
| <b>Heart Failure Admissions</b> | B 38<br>A 31      | B 29<br>A 22  |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Heart Failure Cum</b>        | -                 | -20.9%        |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Asthma</b>                   | 80%               | 14.3%         |     |     |     |      |     |     |     |     |     |     | R              | ↑     |
| <b>Asthma Admissions</b>        | B 10<br>A 18      | B 7<br>A 8    |     |     |     |      |     |     |     |     |     |     |                |       |
| <b>Asthma Cumulative</b>        | -                 | 52.9%         |     |     |     |      |     |     |     |     |     |     |                |       |

**Note:** Long-term conditions admissions figures: B = Baseline / A = Actual In-Year

**CP 21: UNNECESSARY HOSPITAL STAYS: Lead Director – Mrs Deborah Burns, Director of Acute Services**

**By March 2014, reduce the number of excess beddays for the Acute Programme of Care by 10%.**

**Baseline:** To be confirmed

**TDP Assessment:** To be confirmed

**Target:** Reduce by 10%

**Comment/Actions:** Clarification on definition of 'excess beddays' to be provided by HSCB.

Benchmarking data obtained from the CHKS system details the Trust excess beddays at 9.2% versus Peer Average of 11.9%, with 25<sup>th</sup> percentile at 13.5% and 75<sup>th</sup> percentile at 8.5% (2012/2013).

| Monthly Position:                                             |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|---------------------------------------------------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| Apr                                                           | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Not Available – Awaiting Definitional Clarification from HSCB |     |     |     |     |      |     |     |     |     |     |     |                |       |

**MINISTERIAL PRIORITY: TO IMPROVE PRODUCTIVITY BY ENSURING EFFECTIVE AND EFFICIENT ALLOCATION AND UTILISATION OF ALL AVAILABLE RESOURCES, IN LINE WITH PRIORITIES**

**CP 22: PATIENT DISCHARGE : Lead Director – Mr Francis Rice, Director of Mental Health & Disability**

**From April 2013, ensure that all learning disability and mental health discharges take place within 7-days of the patient being assessed as medically fit for discharge.**

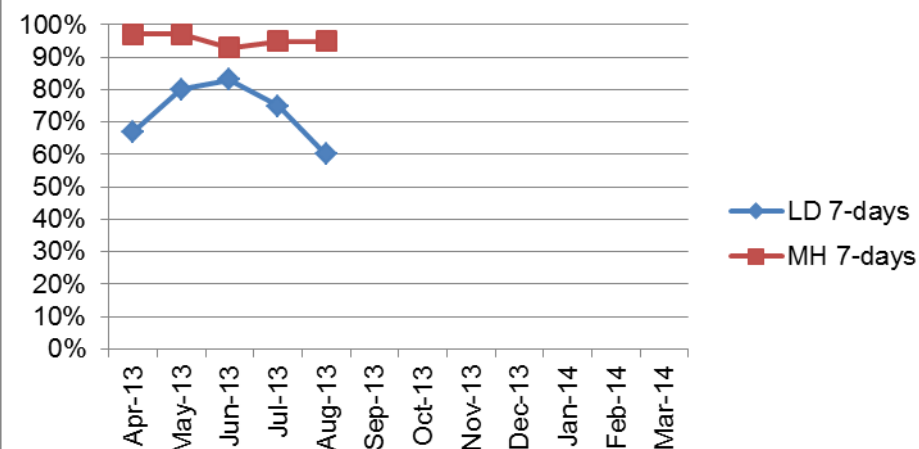
**Baseline:** LD 84% (cumulative April 2012 – March 2013)  
MH 98% (cumulative April 2012 – March 2013)

**Standard:** 100% all discharges 7-days

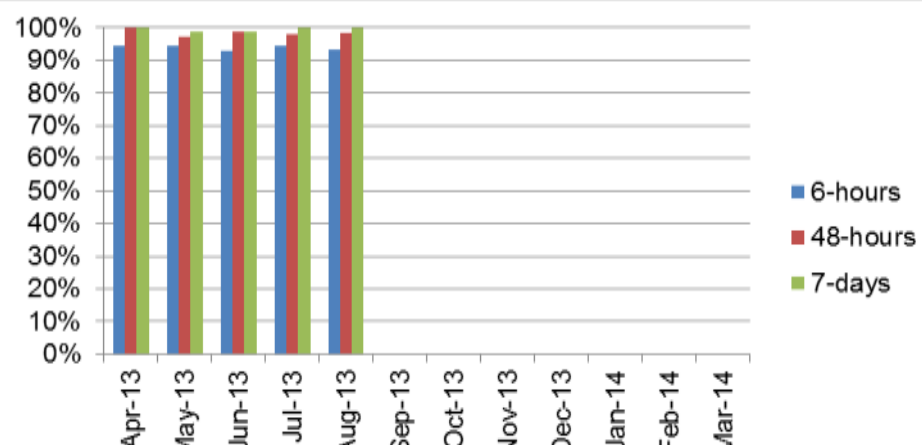
**TDP Assessment:** Achievable

**Comment/Actions:** In Learning Disability 3 out of 5 (60%) Learning Disability patients were discharged within 7-days which continues to show variable performance associated with the small cohort of patients discharged.

In Mental Health 123 out of 129 (95%) were discharged within 7-days showing a static position in comparison with July.



|                  | Monthly Position:   |                     |                     |                     |                     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                  | Apr                 | May                 | Jun                 | Jul                 | Aug                 | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>LD 7-days</b> | 67%<br>(2 out of 3) | 80%<br>(4 out of 5) | 83%<br>(5 out of 6) | 75%<br>(3 out of 4) | 60%<br>(3 out of 5) |      |     |     |     |     |     |     | <b>A</b>       | ↓     |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                   |                                    |                                   |                                   |                                   |      |     |                                                                                          |     |     |     |     |                |       |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|------|-----|------------------------------------------------------------------------------------------|-----|-----|-----|-----|----------------|-------|---|
| MH<br>7-days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 97%<br>(112<br>out of<br>115)     | 97%<br>(133<br>out of<br>137)      | 93%<br>(115<br>out of<br>123)     | 95%<br>(131<br>out of<br>138)     | 95%<br>(123<br>out of<br>129)     |      |     |                                                                                          |     |     |     |     |                | Y     | ↑ |
| CP 22: PATIENT DISCHARGE: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   |                                    |                                   |                                   |                                   |      |     |                                                                                          |     |     |     |     |                |       |   |
| From April 2013, ensure that all non-complex discharges from an Acute hospital take place within 6 hours; 90% of all complex discharges take place within 48-hours; and that all complex discharges, take place within 7-days.                                                                                                                                                                                                                                                                                                                                  |                                   |                                    |                                   |                                   |                                   |      |     |                                                                                          |     |     |     |     |                |       |   |
| Baseline: 93.9% non-complex 6-hours (cum April 2012 – March 2013)<br>97.7% complex 48-hours (cum April 2012 – March 2013)<br>99.6% all discharges 7-days (cum April 2012 – March 2013)                                                                                                                                                                                                                                                                                                                                                                          |                                   |                                    |                                   |                                   |                                   |      |     | Standard: 100% non-complex 6-hours<br>90% complex 48-hours<br>100% all discharges 7-days |     |     |     |     |                |       |   |
| TDP Assessment: Achievable                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                   |                                    |                                   |                                   |                                   |      |     |                                                                                          |     |     |     |     |                |       |   |
| Comment/Actions:<br><br>Non-Complex Discharges – Performance against the 6-hour discharge standard has remained relatively static in August (93.1%). This equates to 2159 out of 2320 non-complex discharges being completed within 6-hours with 161 not being completed within 6-hours.<br><br>The Trust has reviewed unscheduled care and developed whole system discharge plans to seek to improve this performance.<br><br>Complex Discharges – 58 out of 59 complex discharges were completed within 48-hours with no patients waiting longer than 7-days. |                                   |                                    |                                   |                                   |                                   |      |     |      |     |     |     |     |                |       |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Monthly Position:                 |                                    |                                   |                                   |                                   |      |     |                                                                                          |     |     |     |     | Monthly Assess | Trend |   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Apr                               | May                                | Jun                               | Jul                               | Aug                               | Sept | Oct | Nov                                                                                      | Dec | Jan | Feb | Mar |                |       |   |
| 6-hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 94.5%<br>(2281<br>out of<br>2414) | 94.65%<br>(2331<br>out of<br>2463) | 92.9%<br>(2198<br>out of<br>2366) | 94.5%<br>(2265<br>out of<br>2397) | 93.1%<br>(2159<br>out of<br>2320) |      |     |                                                                                          |     |     |     |     |                | Y     | ↑ |
| 48-hrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 100%<br>(83 out<br>of 83)         | 97.37%<br>(79 out<br>of 81)        | 98.8%<br>(85out<br>of 86)         | 98.1%<br>(53 out<br>of 54)        | 98.3%<br>(58 out<br>of 59)        |      |     |                                                                                          |     |     |     |     |                | G     | ↔ |
| 7-days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 100%<br>(83 out                   | 98.7%<br>(80 out                   | 98.8%<br>(85 out                  | 100%<br>(54 out                   | 100%<br>(59 out                   |      |     |                                                                                          |     |     |     |     |                | G     | ↑ |

|  |        |        |        |        |        |  |  |  |  |  |  |  |  |  |
|--|--------|--------|--------|--------|--------|--|--|--|--|--|--|--|--|--|
|  | of 83) | of 81) | of 86) | of 54) | of 59) |  |  |  |  |  |  |  |  |  |
|--|--------|--------|--------|--------|--------|--|--|--|--|--|--|--|--|--|

**CP 23: LEARNING DISABILITY / MENTAL HEALTH : Lead Director – Mr Francis Rice, Director of Mental Health & Disability**

**By March 2014, 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.**

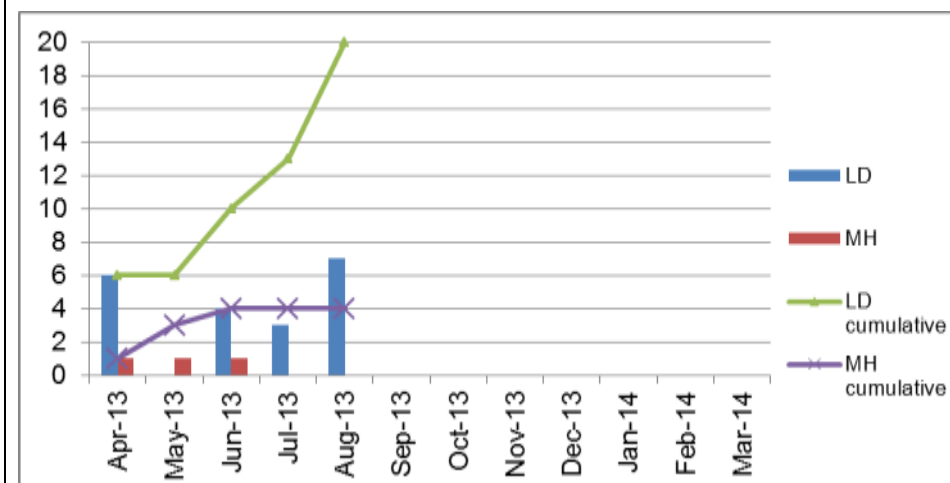
**Baseline:** Learning Disability 11 (@ 31 March 2013)  
Mental Health 3 (@ 31 March 2013)  
**TDP Assessment:** Learning Disability – Achievable  
Mental Health – Not Achievable 2013 – 2014 – Achievable 2015

**Target:** Learning Disability – 12  
Mental Health – 17

**Comment/Actions:**

**Mental Health** – Resettlement plans for the remaining long stay population in St Luke's remain dependent upon a number of Supported Living schemes which should be available providing sufficient places to resettle the remaining population by 2015. In the interim the Division is exploring all other potential opportunities for resettlement in year within existing facilities as well new places in the Independent Sector. Discussion is underway with Commissioner regarding an in-year target versus a final target for all patients to be resettled by no later than March 2015.

**Learning Disability** – The Granville scheme is due to open in 2013/2014 and remains on target. 20 patients have been resettled achieving the in-year target



|               | Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|---------------|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|               | Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| LD            | 6                 | 0   | 4   | 3   | 7   |      |     |     |     |     |     |     | G              | ↑     |
| LD Cumulative | 6                 | 6   | 10  | 13  | 20  |      |     |     |     |     |     |     |                |       |
| MH            | 2                 | 1   | 1   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |
| MH Cumulative | 2                 | 3   | 4   | 4   | 4   |      |     |     |     |     |     |     |                |       |

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

**From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%**

**Baseline:** To be confirmed

**TDP Assessment:** To be confirmed

**Standard:** Increase to 85%

**Comment/Actions:** Further work is required to establish the Trust's baseline.

| Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| Not Available     |     |     |     |     |      |     |     |     |     |     |     |                |       |

| CP 25: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services |     |     |     |     |      |     |     |                                     |     |     |     |                |       |
|--------------------------------------------------------------------------------------------------------|-----|-----|-----|-----|------|-----|-----|-------------------------------------|-----|-----|-----|----------------|-------|
| From April 2013, ensure a 3-year time frame for 90% of all children to be adopted from care.           |     |     |     |     |      |     |     |                                     |     |     |     |                |       |
| Baseline: To be confirmed<br>TDP Assessment: To be confirmed                                           |     |     |     |     |      |     |     | Standard: 3-year time frame for 90% |     |     |     |                |       |
| Comment/Actions: Awaiting HSCB guidance to enable establishment of the Trust’s baseline.               |     |     |     |     |      |     |     |                                     |     |     |     |                |       |
| Monthly Position:                                                                                      |     |     |     |     |      |     |     |                                     |     |     |     | Monthly Assess | Trend |
| Apr                                                                                                    | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec                                 | Jan | Feb | Mar |                |       |
| Not Available                                                                                          |     |     |     |     |      |     |     |                                     |     |     |     |                |       |



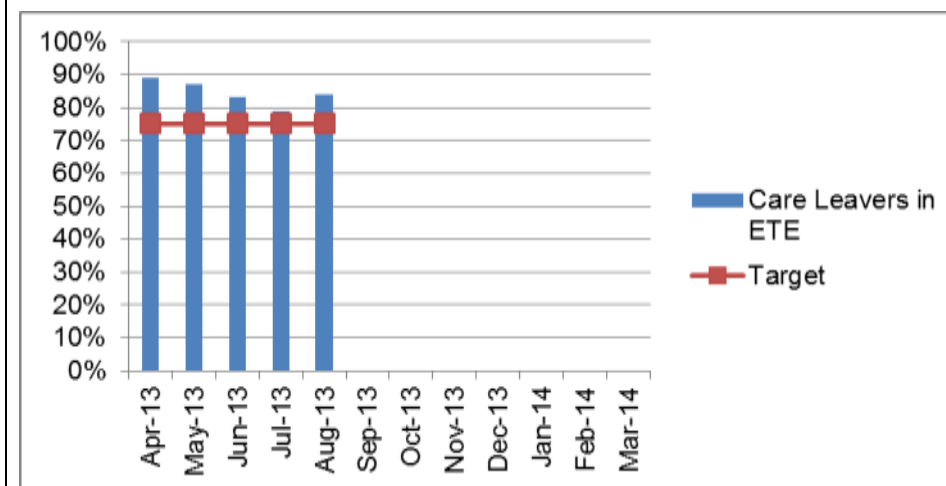
**CP 26: CHILDREN IN CARE: Lead Director – Mr Paul Morgan, Director of Children & Young Peoples Services****By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%.****Baseline:** 76% (@ 31 March 2013)**TDP Assessment:** Partially Achievable**Target:** 75%**Comment/Actions:**

Performance continues to be in excess of the target with 84% of care leavers in education, training or employment at the end of August. This equates to 26 out of 33 care leavers.

Reasons for the trends in this performance are associated with:

- Young people, who despite the teams vigorous efforts, have refused to engage with the 16 Plus Service.
- Young people, who have not engaged in ETE but who have been offered 'Give and Take' and have not attended their various appointments with the employability worker.

Discussions have been held Regionally in respect of not counting those young people who refuse our service. Staff continue to try and engage all these young people in ETE.

**Monthly Position:**

| Apr                   | May                   | Jun                   | Jul                   | Aug                   | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Monthly Assess | Trend |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
| 89%<br>(25 out of 28) | 87%<br>(26 out of 30) | 83%<br>(25 out of 30) | 79%<br>(26 out of 33) | 84%<br>(26 out of 31) |      |     |     |     |     |     |     | G              | ↓     |

**CP 27: MENTAL HEALTH: Lead Director – Mr Francis Rice, Director of Mental Health & Disability**

**From April 2013, no patient waits longer than 9-weeks to assess child and adolescent services (CAMHS) or adult mental health (AMH) services, and 13- weeks for psychological therapies (PT) (any age).**

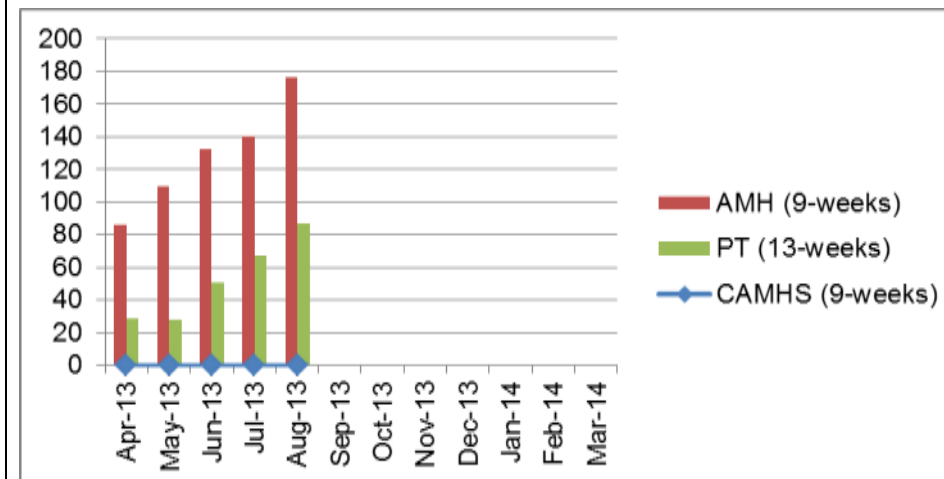
**Baseline:** 0 CAMHS (@ 31 March 2013)  
72 Adult Mental Health (30 PMHC & 42 Memory)  
(@ 31 March 2013)  
67 Psychological Therapies (@ 31 March 2013)  
**TDP Assessment:** CAMHS – Achievable  
Adult Mental Health and Psychological Therapies – Achievable but remains at risk 2013/2014

**Standard:** 0 >9-weeks – CAMHS and Adult Mental Health  
0 >13-weeks – Psychological Therapies

**Comment/Actions:**

**Adult Mental Health Services** – The number of patients waiting in excess of 9-weeks in August (176) continues to increase with the breakdown as follows: Primary Mental Health Care 6 and Memory 170.

- **Primary Mental Health Care** – The service continues to roll forward with its recovery plan, phasing in as appropriate, the appointment of the new staff along with any additional in-house capacity sourced. Current longest waiting patients are 12-weeks
- **Memory/Dementia Services** – The total number of patients waiting in excess of 9-weeks has further increased in August (170) in comparison to end of April position (71). As part of the Divisions' Recovery Plan analysis of the patient pathway through this service, and its subsequent reporting against the access standards is required before a definitive demand and capacity analysis can be undertaken to establish if a recurrent capacity gap exists. Current longest waiting patients are 34-weeks. In order to give sufficient time to recover this position for March 2014 this recovery plan requires to be completed in the early part of Quarter 3.



**Psychological Therapies** – The number of patients waiting in excess of 13-weeks has increased further in August (87), with the longest wait for this service 25-weeks.

The approval and appointment of 2.70 WTE practitioners within Psychological Therapies continues to assist with the recurrent capacity shortfall within the service with the service continuing with its recovery plan which phases in as appropriate, the appointment of the new staff along with any additional in-house capacity sourced.

|                                                | Monthly Position: |     |     |     |     |      |     |     |     |     |     |     | Monthly Assess | Trend |
|------------------------------------------------|-------------------|-----|-----|-----|-----|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                                                | Apr               | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>CAMHS</b>                                   | 0                 | 0   | 0   | 0   | 0   |      |     |     |     |     |     |     | G              | ↔     |
| <b>AMH</b><br>Including<br>Memory/<br>Dementia | 86                | 110 | 132 | 140 | 176 |      |     |     |     |     |     |     | R              | ↓     |
| <b>PT</b>                                      | 29                | 28  | 51  | 67  | 87  |      |     |     |     |     |     |     | R              | ↓     |

**CP 28: COMMUNITY CARE: Lead Director – Mrs Angela McVeigh, Director of Older People and Primary Care**

From April 2013, people with continuing care needs wait no longer than 5-weeks for assessment to be completed, and have the main components of their care needs met within a further 8-weeks.

**Baseline:** 96% 5-weeks (@ 31 December 2012)  
100% 8-weeks (@ 31 March 2013)

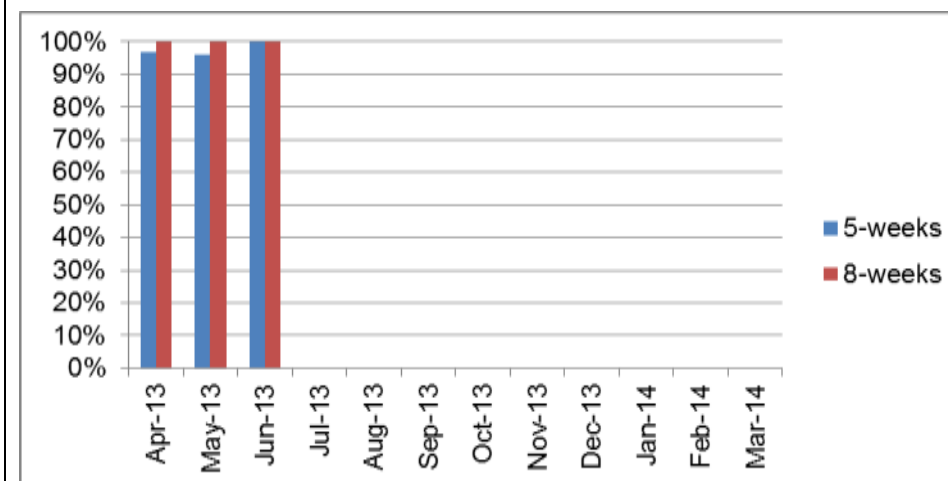
**TDP Assessment:** Achievable

**Standard:** 100% 5-weeks  
100% 8-weeks

**Comment/Actions:**

The Trust met the target completely for assessment and delivery of care needs within 5 and 8-weeks in June.

No update is available at 18 September 2013.



|                | Monthly Position:     |                       |                        |               |               |      |     |     |     |     |     |     | Monthly Assess | Trend |
|----------------|-----------------------|-----------------------|------------------------|---------------|---------------|------|-----|-----|-----|-----|-----|-----|----------------|-------|
|                | Apr                   | May                   | Jun                    | Jul           | Aug           | Sept | Oct | Nov | Dec | Jan | Feb | Mar |                |       |
| <b>5-weeks</b> | 97%<br>(74 out of 76) | 96%<br>(82 out of 85) | 100%<br>(75 out of 75) | Not Available | Not Available |      |     |     |     |     |     |     | <b>G</b>       | ↑     |
| <b>8-weeks</b> | 100%<br>(0 out of 0)  | 100%<br>(0 out of 0)  | 100%<br>(0 out of 0)   | Not Available | Not Available |      |     |     |     |     |     |     | <b>G</b>       | ↑     |

**MINISTERIAL PRIORITY: TO IMPROVE AND PROTECT HEALTH AND WELL-BEING AND REDUCE INEQUALITIES; THROUGH A FOCUS ON PREVENTION, HEALTH PROMOTION AND EARLIER INTERVENTION**

**CP 1: BOWEL SCREENING: Lead Director – Mrs Deborah Burns, Director of Acute Services**

The HSC will extend the bowel cancer screening programme to invite in 2013/2014 50% of all eligible men and women aged 60 – 71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60 – 74 from April 2014.

| Update Position:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Monthly Assess | Trend |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------|
| <b>Comment:</b> <ul style="list-style-type: none"> <li>Bowel cancer screening sessions are now being provided – 1.5 sessions weekly – but SABA has increased by 80 so there is a requirement to undertake 2 sessions weekly.</li> <li>The Specialist Screening Practitioner (SSP) sessions are now seeing 8 patients weekly.</li> <li>JAG accreditation for remaining endoscopy sites being considered through the endoscopy users group and prioritised</li> <li>The rate of repeat colonoscopies after 1-year is 13% which is higher than anticipated and has been highlight to PHA.</li> </ul> | G              | ↔     |

**MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF SAFE, RESILIENT AND SUSTAINABLE SERVICES**
**CP 18: LONG-TERM CONDITIONS: Lead Director – Mrs Angela McVeigh, Director of Older People & Primary Care**
**By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively.**

| Update Position:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Monthly Assess | Trend      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|------------|
| <b>Comment:</b><br><br>The Trust has a number of programmes in place for patients to manage their long-term conditions effectively.<br><br>It has commissioned a series of “Challenging Your Condition” generic self-management programmes for people with long-term conditions and these are provided by Arthritis Care and CHS.<br><br>A number of education programmes are available for people with both Type 1 and Type 2 Diabetes: SHAIRE, SET 2, BERTIE, X-PERT, CHOICE and DAY.<br><br>Education is provided at pulmonary rehabilitation and maintenance programmes provided by the COPD team and is also an integral part of the Cardiac Rehabilitation programme. |                | <b>N/A</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>G</b>       |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                |            |

**CP 20: INTEGRATED CARE PARTNERSHIPS**

**During 2013/2014, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care**

| Update Position:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Monthly Assess | Trend |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------|
| <p><b>Comment: HSCB Target – Trust update on contribution to the process:</b></p> <p>Responsibility and leadership for implementing Integrated Care Partnerships across NI sits with the Integrated Care Director in HSCB. A regional project structure is in place and staff have been appointed to support the establishments of 3 ICPs in the southern area. This includes a lead GP (not yet appointed in the south) and 3 locality lead GPs. The intention is to have an initial meeting of these 3 partnership committees before the end of June 2013.</p> <p>The Trust, as one provider partner within the structures, has nominated senior staff to be representatives on these 3 local ICPs. These Trust representatives will ensure that a 2 way communication process is in place to bring updates into the Trust on ICP plans and to represent the Trust objectives at the ICP meetings. An initial area of discussion within the ICPs will be how the collective partners/providers intend to work together to deliver against regionally issued commissioning specifications for a range of long-term conditions and what associated investment of transitional funding will be required to support this delivery. The Trust has signalled the criticality of the ICPs and the development of alternative primary and community care based services to the achievement of its TYC and QICR plans.</p> <p>The Trust had worked with the Southern LCG and 9 local GP practices during 2012/13 to develop a pilot phase of integrated care working. HSCB recently advised that as at the end of June 2013, this pilot would cease to be funded and the learning and approaches would be merged into the new ICP structures and processes.</p> <p>As the pilot has now ceased the responsibility for reporting on this target has moved from the Trust to the ICP.</p> | N/A            | N/A   |

Southern Health &  
Social Care Trust

# **Corporate Risk Register**

**June 2010**

**(Version with new updates 21 June 2010)**

**Governance Committee Meeting  
7 September 2010**



## Contents

| <b>Section one</b>   | <b>High level Corporate Risks</b>                                                                                                                                                           | <b>Status</b> |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|
| CR1                  | Maintenance and development of Trust estate (facilities, equipment, ICT, etc) to support service delivery and improvement Sufficient funding to fully close baseline gaps                   | Unchanged     |
| CR2                  | Achieving the year two BCBV plans (including productivity line)                                                                                                                             | Unchanged     |
| CR3                  | Impact of demand on Trust Domiciliary Care expenditure                                                                                                                                      | Unchanged     |
| CR4                  | Protection of Vulnerable Adults                                                                                                                                                             | Unchanged     |
| CR5                  | Level of unallocated child care cases in FSS teams.                                                                                                                                         | Unchanged     |
| CR6                  | Issues relating to release from prison of LD /Mental Health clients into the community including those on probation. Communications between PBNi and HSC. Person Specific.                  | Unchanged     |
| CR7                  | Compliance with Standards and Guidelines                                                                                                                                                    | Unchanged     |
| CR8                  | Lack of comprehensive systems of assessment and assurance in relation to safety and quality of Trust services, including morbidity and mortality and other indicators of safety and quality | Unchanged     |
| <b>Section Two</b>   | <b>Moderate Level Corporate risks</b>                                                                                                                                                       | <b>Status</b> |
| CR9                  | Risk of non compliance with European Working Time Directive (EWTD)                                                                                                                          | Unchanged     |
| CR10                 | RQIA recommendations on maternity services Updated 28 April 2010                                                                                                                            | Unchanged     |
| CR11                 | Ongoing achievement of Access Targets and review appointments                                                                                                                               | Unchanged     |
| CR12                 | Decontamination of Dental Instruments                                                                                                                                                       | Unchanged     |
| CR13                 | Carrying out of annual reviews of care plans (Statutory Requirement) for domiciliary placements and care home placements.                                                                   | Unchanged     |
| <b>Section Three</b> | <b>Low Level Corporate risks</b>                                                                                                                                                            | <b>Status</b> |
| CR 14                | Prevention and management of HCAI within the Trust                                                                                                                                          | Unchanged     |

### Issues downgraded for removal from Corporate Risk Register

Placement of 16 and 17 year olds in unaccredited facilities (B Doran request to remove) No longer a Corporate Risk Issue will be managed as Directorate risk issue.

## Section One High level Corporate Risks

There are a number of corporate risks which the Trust is currently seeking to managing successfully, these risk areas are of high concern to the Senior Management Team due to their potential impact and the current restraints on the Trust in seeking to reduce the level of risk in these areas.

| Risk ID                          | Title / Description                                                                                                              | Link to Corporate Objective / Value              | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Corporate/Cross Programme</b> |                                                                                                                                  |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Rating High</b>               | <b>Maintenance and development of Trust estate (facilities, equipment, ICT, etc) to support service delivery and improvement</b> | 1. Provide Safe, High Quality and Effective Care | <ul style="list-style-type: none"> <li>• Maintaining Existing Service capital priorities submitted to DHSSPS and some funding secured to address critical risks</li> <li>• Capital priorities funded where possible from CRL and business cases prepared for major schemes awaiting funding</li> <li>• HCAI risks funded in 08/09 and ongoing</li> <li>• Bi monthly meetings with DHSSPS (Strategic Investment Group) at which capital investment issues are discussed.</li> <li>• CRL report to SMT bi-monthly.</li> </ul> |
|                                  |                                                                                                                                  |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                  |                                                                                                                                  |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Control Strength | Action Plan                                                                                                                                        | Nominated Lead for Actions         | Review Date | Monitoring                                              |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------|---------------------------------------------------------|
| Strong           | <ul style="list-style-type: none"> <li>• Ongoing prioritization and bidding process in place</li> <li>• CRL management process in place</li> </ul> | Director of Performance and Reform | Bi monthly  | CRL Monitoring group SIG meeting bi-monthly with DHSSPS |

CR1

| Risk ID                          | Title / Description                                                    | Link to Corporate Objective / Value | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------|------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Corporate/Cross Programme</b> |                                                                        |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                  | <b>Achieving the year two BCBV plans (including productivity line)</b> | Making best use of resources.       | <ul style="list-style-type: none"> <li>Contingency Plans to address the potential gaps have been drawn up and are being implemented</li> <li>Efforts to identify recurring savings are being given new momentum and additional capacity to identify and drive forward schemes has been created with the appointment of Best Care Best Value (BCBV) senior posts in operational directorates. BCBV Programme Board and project structure is in place including Directorate specific BCBV performance management meetings.</li> <li>Trust Board report (finance paper)</li> <li>Weekly review by SMT</li> <li>BCBV Programme Board and project structure in place</li> </ul> |
| <b>Rating High</b>               | <b>Sufficient funding to fully close baseline gaps</b>                 |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                  |                                                                        |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                  |                                                                        |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Control Strength | Action Plan                                                                                                                             | Nominated Lead for Actions                      | Review Date                                | Monitoring |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------|------------|
| Strong           | <ul style="list-style-type: none"> <li>Ongoing review of controls</li> <li>BCBV Project Plan</li> <li>Trust contingency plan</li> </ul> | Directors of Finance and Performance and Reform | Ongoing Review within specified timescales | Ongoing    |

| Risk ID                          | Title / Description                                                    | Link to Corporate Objective / Value            | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------|------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Corporate/Cross Programme</b> |                                                                        |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                  | <b>Impact of demand patterns on Trust Domiciliary Care Expenditure</b> | Provide safe, high quality and effective care. | <ol style="list-style-type: none"> <li>1. Services and staff made aware of SH&amp;SSB Access to Domiciliary Care Criteria.</li> <li>2. Development of OPPC Access to Domiciliary Care sub eligibility Criteria (ie. access criteria and sub criteria agreed for provision of specific services (meals services, personal care, toileting, back to bed and night sit services).</li> <li>3. Raising of authority for Dom Care Package approval to Heads of Services.</li> <li>4. Financial contingency plan in place since Nov '08 and revised in April 2010.</li> <li>5. Agreed content of a training package and the training package has been produced, along with delivery of multi-disciplinary training for staff who assess for services, to ensure consistent roll-out and application of the various access criteria and sub eligibility criteria. and</li> <li>6. Ongoing development of Domiciliary Care access criteria and control measures in discussion with Commissioner</li> </ol> |
| <b>Rating</b>                    |                                                                        |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Moderate</b>                  |                                                                        |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Control Strength | Action Plan                                                                                     | Nominated Lead for Actions                              | Review Date | Monitoring |
|------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------|------------|
| Some Weaknesses  | Domiciliary Help Group established to consider issues, develop and implement an action plan.    | Director of OPPC in conjunction with Assistant Director | Quarterly   | Ongoing    |
|                  | Care Management RPE Group established to consider issues, develop and implement an action plan. | Director of OPPC in conjunction with Assistant Director | Quarterly   | Ongoing    |

| Control Strength | Action Plan                                                                                                                | Nominated Lead for Actions                           | Review Date | Monitoring       |
|------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------|------------------|
|                  | Development of Directorate Financial Contingency Plans to address over expenditure<br>2010/11 Plan now agreed in April '10 | Director of OPPC                                     | Feb '11     | Ongoing via BCBV |
|                  | Defining level of access criteria which can be met within budget available: last reviewed April '10                        | Director and Assistant Director                      | June '10    | Ongoing          |
|                  | Working towards devolving budget responsibility and accountability to HOS and Team Levels                                  | Director and Assistant Director and Finance Officers | April '10   | Ongoing          |

| Risk ID                                       | Title / Description                    | Link to Corporate Objective / Value | Potential for Harm                                                                                                                                                   | Control Measures                                            |
|-----------------------------------------------|----------------------------------------|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Children and Young Peoples Directorate</b> |                                        |                                     |                                                                                                                                                                      |                                                             |
| <b>1866</b>                                   | <b>Protection of Vulnerable Adults</b> | 1 provide safe, high quality care.  | There are inconsistencies in practice and limited specialist expertise available for the protection of vulnerable adults. Systems and processes need to be reviewed. | Lead director and lead professional reviewing arrangements. |
| <b>Rating High</b>                            |                                        |                                     |                                                                                                                                                                      |                                                             |
|                                               |                                        |                                     |                                                                                                                                                                      |                                                             |

| Control Strength | Action Plan                                                                                                                                                                                                           | Nominated Lead for Actions                                      | Review Date                                                                                      | Monitoring                                                                                                                                                                                                                                       |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Moderate         | <p>Proposal for change to arrangements and appointment of co-ordinator. Awaiting funding from HWIP.</p> <p>DHSSPSNI identified additional monies for protection arrangements.</p> <p>Increased targeted training.</p> | Directors CYP (Ex Dir SW) & OPPC Trust Vulnerable Adults Forum. | <p>June 2010</p> <p>Commissioning Plan to clarify development funding and priorities 2010/11</p> | <p>(I) Reports to Director, SHSSB and Trust Board of Directors.</p> <p>(I) Trust reporting arrangements via vulnerable adults forum.</p> <p>(I) Audit programme.</p> <p>(E) RQIA reviews.</p> <p>(E) HSCB monitoring of statutory functions.</p> |

| Risk ID                                       | Title / Description                                        | Link to Corporate Objective / Value | Potential for Harm                                                                                                                                                                                                                                                  | Control Measures                                                                                                                                                                               |
|-----------------------------------------------|------------------------------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Children and Young Peoples Directorate</b> |                                                            |                                     |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                |
| <b>1909</b>                                   | <b>Level of unallocated child care cases in FSS teams.</b> | 1 provide safe, high quality care.  | There has been insufficient capacity in family support teams to allow allocation of all cases transferred from Gateway. Retention of social work staff in FST has been difficult resulting in significant numbers of relatively inexperienced AYE's in these teams. | Weekly monitoring of numbers of unallocated cases.<br><br>Workforce strategy group for family support and safeguarding teams.<br><br>Social work supervision and line management arrangements. |
| <b>Rating High</b>                            |                                                            |                                     |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                |
| <b>Ref No 1909</b>                            |                                                            |                                     |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                |
|                                               |                                                            |                                     |                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                |

| Control Strength | Action Plan                                                                                                                                                                                                                                                                     | Nominated Lead for Actions | Review Date | Monitoring                                                                                                                                                                               |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Strong           | Independent child care consultant commissioned to review unallocated child care referrals April – June 2009.<br><br>RQIA Action plans in place and being implemented<br><br>Case management review report action plans.<br><br>Further development of workforce strategy paper. | Director of C&YP           | Monthly     | Weekly HSCB reports.<br><br>Monthly DHSSPSNI reports.<br><br>Performance report to Trust Board and reporting to Governance Committee<br><br>Annual Delegated Statutory Functions Report. |

| Risk ID                                                    | Title / Description                                                                                                                                                               | Link to Corporate Objective / Value           | Control Measures                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Learning Disability &amp; Mental Health Directorate</b> |                                                                                                                                                                                   |                                               |                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Forensic Services</b>                                   | <b>Issues relating to release from prison of LD /Mental Health clients into the community including those on probation. Communications between PBNI and HSC. Person Specific.</b> | Provide Safe, High Quality and Effective Care | <ul style="list-style-type: none"> <li>• Encourage client engagement with services.</li> <li>• Provisions of the Criminal Justice (N.Ireland) Order 2008.</li> <li>• Individual client specific control measures.</li> <li>• Mental Health Order(where applicable).</li> <li>• Ongoing liaison with PBNI and PPS</li> <li>• Issued raised with DHSSPS and NIO (letter from CX 10/9/09)</li> </ul> |
| <b>Rating High</b>                                         |                                                                                                                                                                                   |                                               |                                                                                                                                                                                                                                                                                                                                                                                                   |

| Control Strength | Action Plan                                                                                                                    | Nominated Lead for Actions               | Review Date | Monitoring |
|------------------|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------|------------|
| Moderate         | Issues to be taken forward by SHSCT Forensics services and also ongoing liaison between Trust and HSC Board, DHSSPSNI and NIO. | Director of Mental Health and Disability | Monthly     | Ongoing    |



| <i>Risk ID</i>               | <i>Title / Description</i>                                                                                                                                                                                                                                                                                 | <i>Link to Corporate Objective / Value</i>    | <i>Control Measures</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Corporate/Cross Directorates |                                                                                                                                                                                                                                                                                                            |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Medical Directorate          | Compliance with Standards and Guidelines                                                                                                                                                                                                                                                                   | Provide Safe, High Quality and Effective Care | <ol style="list-style-type: none"><li>1. Information on Standards and Guidelines disseminated via chief executives office to Medical Director and Lead Director.</li><li>2. SABS system in place for the issue and response to Safety Action Bulletins</li><li>3. Effectiveness and Evaluation Unit monitoring progress with a small number of clinical guidelines in line with national and regional projects</li><li>4. Review of C&amp;SC Governance operation systems and processes underway to report in July 2010</li></ol> |
| Rating High                  | Lack of assessment of Trust performance against national and regional clinical and social care guidelines endorsed and issued by DHSSPS and commissioner, resulting in lack of assurance and potential failure to identify where the Trust is not providing clinical and social care to endorsed standards |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                              |                                                                                                                                                                                                                                                                                                            |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| <i>Control Strength</i> | <i>Action Plan</i>                                                                                                                                                                                                                                                           | <i>Nominated Lead for Actions</i> | <i>Review Date</i> | <i>Monitoring</i>              |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------|--------------------------------|
| Some weaknesses         | Reallocation of resources within the medical directorate to ensure work is taken forward to ensure cataloguing of standards, monitoring of progress with implementation and provision of assurances to SMT and Trust Board that the Trust is compliant with these standards. | Medical Director                  | July 2010          | At each SMT Governance meeting |

| Risk ID                      | Title / Description                                                                                                                                                                         | Link to Corporate Objective / Value     | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                 |  |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--|
| Corporate/Cross Directorates |                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |  |
| <b>Medical Directorate</b>   | Lack of comprehensive systems of assessment and assurance in relation to safety and quality of Trust services, including morbidity and mortality and other indicators of safety and quality | <b>Provision of Safe Effective Care</b> | <ul style="list-style-type: none"> <li>Governance Committee and SMT Governance Group in place</li> <li>Directorate and Division-specific governance groups in place with regular review of information emerging from SAls, AIs, complaints, etc.</li> <li>System of Root Cause Analysis in place for SAls and HCAls.</li> <li>Limited range of quality and safety indicators in place and reported monthly to Trust Board</li> <li>Staff training in reporting of incidents ongoing</li> <li>The Patient Safety initiative suite of interventions as per the Regional Patient Safety Forum is well established.</li> <li>Effectiveness and evaluation unit have a defined programme of activity.</li> <li>Reallocation of resources in medical directorate to ensure standards and guidelines workload is taken forward.</li> <li>Rolling programme of specialty-specific information to Trust Board from April 2010</li> </ul> |                                                                                 |  |
| <b>Rating High</b>           |                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |  |
|                              |                                                                                                                                                                                             |                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                 |  |
| Control Strength             | Action Plan                                                                                                                                                                                 | Nominated Lead for Actions              | Review Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Monitoring                                                                      |  |
|                              | Review of C&SC Governance operational systems and processes underway, including assessment against recommendations of Mid Staffordshire                                                     | Chief Executive                         | July 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Monthly progress report to SMT Governance                                       |  |
|                              | Development of benchmarked clinical indicators via CHKS.                                                                                                                                    | DP&R/Medical Director                   | June 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Monthly progress update to SMT Governance and bimonthly to Governance Committee |  |
|                              | Review of Specialty M&M system underway to ensure assurance in relation to service quality and safety                                                                                       | Medical Director                        | June 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Recommendations for SMT approval by June 2010                                   |  |
|                              | Improvement Plan for clinical coding underway                                                                                                                                               | DP&R                                    | May 2010                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Monthly performance reported to Trust Board                                     |  |

## Section Two Moderate level Corporate Risks

There are a number of corporate risks which the Trust is currently managing successfully, however these risks need to remain in focus due to their potential impact. Examples of these are:

| Risk ID                   | Title / Description                                                 | Link to Corporate Objective / Value                                 | Control Measures                                                                                                                                                                 |
|---------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Corporate/Cross Programme |                                                                     |                                                                     |                                                                                                                                                                                  |
| Human Resources           | Risk of non compliance with European Working Time Directive (EWTD). | Making best use of resources and providing safe, high quality care. | EWTD steering group has ensured compliance in the majority of medical specialties. HR leading work to identify and address EWTD issues for other service areas and staff groups. |
| Rating Moderate           |                                                                     |                                                                     |                                                                                                                                                                                  |
|                           |                                                                     |                                                                     |                                                                                                                                                                                  |

| Control Strength | Action Plan                                                                                                                                                                                                                                                                                | Nominated Lead for Actions | Review Date | Monitoring |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-------------|------------|
| Moderate         | <ul style="list-style-type: none"> <li>• Actions plans being developed to address residual areas of non-compliance.</li> <li>• Regular meetings between HR and medical management to explore alternative solutions for compliance.</li> <li>• Derrogation for some specialties.</li> </ul> | Director of HR             | Bi-monthly  | Ongoing    |

| Risk ID                    | Title / Description                                                                     | Link to Corporate Objective / Value            | Control Measures                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acute Directorate</b>   |                                                                                         |                                                |                                                                                                                                                                                                                                                                                                                                                                                                      |
| <b>IMWH</b>                | Capacity to deliver high quality standards of maternity care as defined by RQIA report. | Provide safe, high quality and effective care. | <ol style="list-style-type: none"> <li>1. Action plan for final RQIA report in progress.</li> <li>2. Temporary medical staff have been recruited to provide increased labour ward cover in DHH.</li> <li>3. Continuing discussions with commissioners, NIMDTA regarding anaesthetic cover and other matters.</li> <li>4. Monthly report to SMT.</li> <li>5. Regular update to Trust Board</li> </ol> |
| <b>Rating<br/>Moderate</b> |                                                                                         |                                                |                                                                                                                                                                                                                                                                                                                                                                                                      |
|                            |                                                                                         |                                                |                                                                                                                                                                                                                                                                                                                                                                                                      |

| Control Strength | Action Plan                                                   | Nominated Lead for Actions | Review Date                      | Monitoring |
|------------------|---------------------------------------------------------------|----------------------------|----------------------------------|------------|
| Strong           | Action Plan developed and under discussion with commissioner. | Director of Acute          | Monthly update to SMT Governance | Ongoing    |

| Risk ID                  | Title / Description                                           | Link to Corporate Objective / Value              | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------|---------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Acute Directorate</b> |                                                               |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>All Divisions</b>     | Ongoing achievement of Access Targets and review appointments | 1. Provide Safe, High Quality and Effective Care | <ul style="list-style-type: none"> <li>RVBL team established to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity.</li> <li>Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time.</li> <li>Patients waiting since 2007 have had their Patient Centre letter on PAS downloaded, and appointment given if appropriate.</li> <li>Vacant Outpatient sessions have been backfilled with Review Backlog patients, when Consultant available.</li> <li>Heads of Service are meeting with Relevant Consultants and conveying current provision on a monthly basis</li> </ul> |
| <b>Rating Moderate</b>   |                                                               |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                          |                                                               |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| Control Strength | Action Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Nominated Lead for Actions                                                                                                                                    | Review Date | Monitoring |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------|
| Some Weaknesses  | <ul style="list-style-type: none"> <li>Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation</li> <li>Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached.</li> <li>Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation.</li> </ul> | Directors of Acute Services, Performance and Reform, Older People and Primary Care, Children and Young People, Finance, Mental Health and Learning Disability | Weekly      | Weekly     |

## OPPC Podiatry issues added 28 April 2010

| Risk ID                                                            | Title / Description                     | Link to Corporate Objective / Value | Potential for Harm                                                                                                                                                                                                                                                                                | Control Measures                                                                                  |
|--------------------------------------------------------------------|-----------------------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <b>Children and Young Peoples Directorate<br/>OPPC Directorate</b> |                                         |                                     |                                                                                                                                                                                                                                                                                                   |                                                                                                   |
| <b>1467</b>                                                        | Decontamination of dental instruments   | 1 provide safe, high quality care   | Because of revised guidelines the Trust is not permitted to replace dental autoclaves. When an autoclave breaks down clinics have to be cancelled which impacts on capacity to meet targets.<br><br>Exposure of patients accessing the service and staff working within the service to infection. | Vigilance by clinicians regarding equipment efficiency and use of instruments prior to treatment. |
| <b>Rating<br/>Moderate</b>                                         | Decontamination of Podiatry instruments |                                     |                                                                                                                                                                                                                                                                                                   |                                                                                                   |
|                                                                    |                                         |                                     |                                                                                                                                                                                                                                                                                                   |                                                                                                   |
|                                                                    |                                         |                                     |                                                                                                                                                                                                                                                                                                   |                                                                                                   |

| Control Strength | Action Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Nominated Lead for Actions                       | Review Date                   | Monitoring                |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------|---------------------------|
| Strong           | Order for new autoclave stopped by DHSSPSNI. Estates have a case developed to bring servicing in house up to the required standard.<br><br><b>Use of a Central Decontamination Service for all Podiatry Re-usable Instruments</b> - This is the preferred option of choice and currently the only option that would enable the service to eliminate all decontamination and other potential risks. It is not possible to implement a change from local to central decontamination due to funding shortfalls and CSSD capacity constraints at this time. | Michelle Oliver<br><br>Head of Podiatry Services | 1 <sup>st</sup> December 2009 | Decontamination Committee |

| Risk ID                   | Title / Description                                                                                                       | Link to Corporate Objective / Value            | Control Measures |
|---------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------|
| Corporate/Cross Programme |                                                                                                                           |                                                |                  |
|                           | Carrying out of annual reviews of care plans (Statutory Requirement) for domiciliary placements and care home placements. | Provide safe, high quality and effective care. |                  |
| <b>Rating</b>             |                                                                                                                           |                                                |                  |
| <b>Moderate</b>           |                                                                                                                           |                                                |                  |
|                           |                                                                                                                           |                                                |                  |
|                           |                                                                                                                           |                                                |                  |

| Control Strength | Action Plan                                                                                                                                                                     | Nominated Lead for Actions             | Review Date | Monitoring |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------|------------|
| Some Weaknesses  | Group constituted to examine operational management of the annual review process. Group has met and given attention to those longest outstanding reviews in the first instance. | Assistant Director & Heads of Services | April 09    | June 09    |
|                  | Consideration being given to the establishment of a Permanent Placement Team.                                                                                                   | Assistant Director & HOS               | May '10     | Sept '10   |

### Section Three      Low Level Corporate risks

There are a number of corporate risks which the Trust is currently managing successfully, these risks are categorised as low with a plan to reallocate to Directorate risk registers. Examples of these are:

| Risk ID                          | Title / Description                                | Link to Corporate Objective / Value              | Control Measures                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------|----------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Corporate/Cross Programme</b> |                                                    |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                  | Prevention and management of HCAI within the Trust | 1. Provide Safe, High Quality and Effective Care | <ul style="list-style-type: none"> <li>• Project structure in place, Strategic, Operational and Clinical Teams</li> <li>• HCAI Improvement plan in place and being implemented</li> <li>• Regular monitoring and reporting to SMT, Trust Board and key staff throughout organization</li> <li>• RCAs completed for all HCAIs(C Diff, MRSA bacteraemia and MSSA bacteraemia) and process for identifying and addressing root cause.</li> <li>• Hand hygiene campaign underway</li> </ul> |
| <b>Rating Low</b>                |                                                    |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                  |                                                    |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                  |                                                    |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

| Control Strength | Action Plan           | Nominated Lead for Actions             | Review Date                                | Monitoring |
|------------------|-----------------------|----------------------------------------|--------------------------------------------|------------|
| Strong           | HCAI Improvement Plan | Medical Director/Operational Directors | Ongoing Review within specified timescales | Ongoing    |





# **CORPORATE RISK REGISTER**

**August 2015**

**to Governance Committee on  
8<sup>th</sup> September 2015**

## **INTRODUCTION**

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the Trust's Corporate Objectives as detailed below:-

- 1: Provide safe, high quality care.
- 2: Maximise independence and choice for our patients and clients.
- 3: Support people and communities to live healthy lives and improve their health and wellbeing.
- 4: Be a great place to work, valuing our people.
- 5: Make the best use of resources.
- 6: Be a good social partner within our local communities.

*Note – Red font indicates the changes that have been made to the Register since May 2015*

### **OVERVIEW OF CORPORATE RISK REGISTER AS AT 19th AUGUST 2015**

| <b>LOW</b> | <b>MEDIUM</b> | <b>HIGH</b> | <b>TOTAL</b> |
|------------|---------------|-------------|--------------|
| <b>0</b>   | <b>10</b>     | <b>15</b>   | <b>25</b>    |

|                                                                          |                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| New risks identified by SMT or escalated from Directorate Risk Registers | Potential new risk 'Inability to recruit into the Medical workforce leaving gaps within the current rotas within Daisy Hill Hospital'. The Trust has in place a range of measures to mitigate the risk and full risk assessment will be brought to SMT when Corporate Risk Register is next being reviewed. |
| Risks removed from the Register                                          | None                                                                                                                                                                                                                                                                                                        |
| Merged risks                                                             | None                                                                                                                                                                                                                                                                                                        |
| Risks where overall rating has been reduced                              | Whilst rating has not been reduced, the focus of the risk regarding the HRPTS system (Risk No.22) is now on Payroll and Travel payments.                                                                                                                                                                    |
| Risks where overall rating has been increased                            | None                                                                                                                                                                                                                                                                                                        |

Summary of Corporate Risks as at **August 2015**

| Risk No. | HIGH RISKS                                                                                                                                | * Corporate Objective | Risk Rating | Change to Status since August 2014             |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------|------------------------------------------------|
| 1.       | Achievement of Elective Commissioning Plan Standards and Targets                                                                          | 1                     | HIGH        | Unchanged                                      |
| 2.       | Out-Patient Reviews and Planned Treatment Backlogs                                                                                        | 1                     | HIGH        | Unchanged                                      |
| 3.       | Achievement of statutory duties/functions                                                                                                 |                       |             |                                                |
|          | - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed                                                        | 1                     | HIGH        | Unchanged                                      |
| 6.       | Medicines Management compliance in domiciliary care                                                                                       | 1                     | HIGH        | Unchanged                                      |
| 7.       | Inability to recruit/retain Consultant medical staff for specific specialties                                                             | 1                     | HIGH        | Unchanged                                      |
| 8.       | Increasing inability to recruit registered nursing staff                                                                                  | 1                     | HIGH        | New risk added on 22.4.15                      |
| 10.      | Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement         | 1                     | HIGH        | Unchanged                                      |
| 12.      | High Voltage capacity limit on electrical supply to Craigavon Hospital                                                                    | 1                     | HIGH        | Unchanged                                      |
| 13.      | The lack of capacity, due to staff shortages within Estate services, to provide and maintain a safe and efficient healthcare environment. | 1                     | HIGH        | New risk added on 1 <sup>st</sup> October 2014 |
| 14.      | Pharmacy Aseptic Suite, CAH                                                                                                               | 1                     | HIGH        | Unchanged                                      |

| 17.                     | Accreditation status of Laboratory, Craigavon Area Hospital                                                                             | 1           | HIGH     | Unchanged                          |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------|----------|------------------------------------|
| 23.                     | GP Out of Hours Service - inability to attract adequate cover for GP shifts                                                             | 1           | HIGH     | Unchanged                          |
| 24.                     | Health Visiting Service – impact on families due to decreased staffing levels                                                           | 1           | HIGH     | Unchanged                          |
| 25.                     | Safeguarding of Residents within HH/BC                                                                                                  | 1           | HIGH     | New risk added on 14.1.15          |
| 19.                     | Implementation of NMC's revised revalidation arrangements for Registered Nurses, Midwives and Specialist Community Public Health Nurses | 4           | HIGH     | New risk added on 18.2.15          |
| Risk No. MODERATE RISKS |                                                                                                                                         | Risk Rating |          | Change to Status Since August 2014 |
| 4.                      | Achievement of statutory duties/functions:<br>Robust Care Management processes                                                          | 1           | MODERATE | Unchanged                          |
| 5.                      | Systems of assessment and assurance in relation to quality of Trust services                                                            | 1           | MODERATE | Unchanged                          |
| 11.                     | Fire Safety                                                                                                                             | 1           | MODERATE | Unchanged                          |

|     |                                                                                                                                                    |   |                 |                                          |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------|---|-----------------|------------------------------------------|
| 9.  | Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health | 1 | <b>MODERATE</b> | Unchanged                                |
| 15. | HCAI                                                                                                                                               | 1 | <b>MODERATE</b> | Unchanged                                |
| 16. | Risk of harm to patients from water borne pathogens                                                                                                | 1 | <b>MODERATE</b> | Unchanged                                |
| 18. | Fully embedded Appraisal system                                                                                                                    | 4 | <b>MODERATE</b> | Unchanged                                |
| 20. | Financial Balance – risk in 2015/16 that the Trust will not achieve Financial balance in year                                                      | 5 | <b>MODERATE</b> | Downgraded from high risk 19.11.14       |
| 21. | Management and monitoring of procurement and contracts                                                                                             | 5 | <b>MODERATE</b> | Unchanged                                |
| 22. | HRPTS Payroll and Travel Payments                                                                                                                  | 5 | <b>MODERATE</b> | Separated out from BSTP risk on 15.10.14 |

## Southern Health & Social Care Trust: Summary of Corporate Risks as at **August 2015**

| CORPORATE OBJECTIVE 1: PROVIDE SAFE, HIGH QUALITY CARE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                  |        |
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| No                                                     | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | Status |
| 1                                                      | <p><b>Achievement of Elective Commissioning Plan Standards and Targets</b></p> <ul style="list-style-type: none"> <li>Waiting times in excess of Commissioning Plan Standards / Targets across Out-Patients; Diagnostics (including Endoscopy); In-Patients; and Day Cases (Acute; CYPS; Mental Health; and OPPC areas)</li> <li>Waiting times in excess of Commissioning Plan Standards / Targets across AHP professions</li> <li>Plain film reporting only maintained at current level, which excludes films that have been categorised as IRMER'ised (Ionizing Radiation Medical Exposure Regulations) with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations</li> </ul> | <ul style="list-style-type: none"> <li>Monthly reporting to Senior Management Team</li> <li>Monthly reporting to Trust Board</li> <li>Monthly exception reporting to Operational Directorate In-Year Assurance meetings</li> <li>Fortnightly Operational Performance meetings within the Acute Services Directorate and the Children &amp; Young Person's Services Directorate</li> <li>Monthly Operational Performance meetings with the Mental Health &amp; Disability Directorate</li> <li>Quarterly Operational Performance meetings with the Older Persons and Primary Care Directorate</li> <li>Monthly Operational AHP Performance meetings cross-directorate</li> <li>Implementation plans in place for reductions in access times, where demand remains static, associated with submitted and approved IPTs</li> <li>Monthly Elective and Unscheduled Performance meetings with Health and Social Care Board</li> <li>Non-recurrent allocation of available funding from HSCB for elective access periodically</li> </ul> | <p><b>Access Times</b></p> <ul style="list-style-type: none"> <li>Focus on SBA remains as first priority within Operational Directorates, where robust SBA volumes exist, into 2015/2016. Delivery of access times will follow SBA delivery on the priority list.</li> </ul> <p>Recurrent capacity gaps prioritised with SLCG, in line with early indication of available recurrent funding, for 2015/2016 as Symptomatic Breast Clinic and Haematology. <b>IPT was submitted and formal allocation received for recurrent funding for symptomatic breast services (July 2015)</b></p> <ul style="list-style-type: none"> <li>Non-recurrent allocation received for Diagnostics (including Endoscopy) for Quarter 1 and 2 2015/2016.</li> </ul> <p>Volumes allocated are insufficient to reduce access times to required 9-week wait. No allocations received for Out-Patients; In-Patients; or Day Cases.</p> <p>IS Providers have been given permission to undertake the treatment of the paused patients, from 2014/2015, in Quarter 1 of 2015/2016.</p> | Performance and Reform and Operational Directors | HIGH   |

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|  |  | <ul style="list-style-type: none"> <li>Operational plans under development to maintain red flag waiting time standards and reduce urgent waiting times to the acceptable clinical timescale. However, routine waiting times will increase as a consequence of the management of the red flag and urgent waiting times.</li> <li>Operational workshop undertaken to review and implement the required processes for the monitoring; escalation; and actioning of the urgent waiting times that have been clinically agreed and communicated with the Consultants.</li> </ul> | <ul style="list-style-type: none"> <li>SMT permission had been given, for the month of April, for additionality to be continued in previously identified risk areas. Where non-recurrent allocations have been received from HSCB the April Trust spend will be recouped from this allocation.</li> <li>Key areas of risk identified within the Acute Services Directorate around . Symptomatic Breast Clinic Services, CT and Endoscopy have been partially addressed with non recurrent funding and part year effect recurrent investments. Remaining areas of risk highlighted to Health and Social Care Board formally include:- <ul style="list-style-type: none"> <li>Haematology (NOP)</li> <li>Urology (OP Review Backlog)</li> <li>General Surgery (OP Review Backlog)</li> <li>Cardiology (OP Review Backlog)</li> <li>Dermatology (OP Review Backlog)</li> <li>Trauma (NOP and IP)</li> </ul> </li> </ul> <p>The Trust will continue to re-direct internal resources to areas of greatest risk as funding becomes available or as operationally feasible.</p> <p><b>Plain Film X Ray</b></p> <ul style="list-style-type: none"> <li>A non-recurrent allocation for plain film reporting has been received for Quarter 1 &amp; 2 2015/2016. This non-recurrent funding will be utilised for the Independent Sector provision.</li> </ul> |  |  |
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|  |  |  | <p>It should be noted that the IS provider is now working to full capacity with no further options for additional plain film reporting to be undertaken.</p> <ul style="list-style-type: none"> <li>• With the IS provider at full capacity and with the loss of internal additional reporting capacity the Trust is facing further pressure for plain film reporting.</li> </ul> <p>The CCS Division has therefore undertaken a mini-competitive tender off the Regional Eligible Providers List and anticipate ability to award a contract for additional capacity in August 2015.</p> <ul style="list-style-type: none"> <li>• An operational plan is being developed, in the first instance, to return chest x-ray plain film reporting to within the 28-day standard.</li> <li>• HSCB have provided recurrent funding for the implementation of plain film reporting by radiographers for ED films.</li> </ul> <p>HSCB have provided recurrent funding for plain film reporting of the remaining in-patient IRMER'ised patients.</p> <ul style="list-style-type: none"> <li>• A training programme is in place to increase the scope of Plain Film reporting that is carried out by Radiographers.</li> </ul> |  |  |
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|   |                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                   | <b>AHP Access Times</b><br><br>No non-recurrent funding has been allocated in Quarter 1 & 2 2015/2016 as the outcome of the PHA demand and capacity exercise remains outstanding. No non-recurrent resources from HSCB were provided in 2014/2015 either.<br><br>The Trust had agreed to retain a level of additionality until the end of April 2015.<br><br>The Trust, in parallel with the PHA/HSCB review, is undertaking a capacity and demand exercise to calculate available capacity within the AHP professions which will inform future capacity gaps and investment priorities. This work should be completed in Q3 2015/16. |                      |               |
|   | <b>Risk Area and Principal Risks</b>                                                                                                                                                                                                                                                                                     | <b>Key Controls</b>                                                                                                                                                                                                                                                                                                                                                                               | <b>Action Planned/Progress update</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Lead Director</b> | <b>Status</b> |
| 2 | <b>Out-Patient Review and Planned Treatment Backlogs</b><br><br>Out-Patient Review Waiting List Backlogs (Acute; CYPS; MHD; and OPPC Directorate) and Planned Treatment Backlogs (Acute only), are on-going with a significant volume of patients waiting past their clinically indicated review timescale (OP and AHPs) | <ul style="list-style-type: none"> <li>• Monthly reporting to Senior Management Team</li> <li>• Monthly reporting to Trust Board</li> <li>• Monthly exception reporting to Operational Directorate In-Year Assurance meetings</li> <li>• Fortnightly Operational Performance meetings within the Acute Services Directorate and the Children &amp; Young Person's Services Directorate</li> </ul> | <ul style="list-style-type: none"> <li>• At 1 August 2015, there were a total of 23,423 patients waiting in excess of their clinically indicated timescale for review out-patient appointment (Dr-led services only, including Visiting Specialties).<br/><br/>           37% of these patients (8,750) are waiting in excess of 6-months past their clinically indicated timescale; 21% (4,830) are waiting between 3 – 6-months past their clinically indicated timescale; with 42% (9,839) waiting less than 3-months past their clinically indicated timescale.</li> </ul>                                                        |                      |               |

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|  |  | <ul style="list-style-type: none"> <li>• Monthly Operational Performance meetings with the Mental Health &amp; Disability Directorate</li> <li>• Quarterly Operational Performance meetings with the Older Persons and Primary Care Directorate</li> <li>• Monthly Operational AHP Performance meetings cross-directorate</li> <li>• Short-term validation exercise undertaken in Quarter 4 2014/15 within a limited number of Acute Services Directorate specialties</li> <li>• Operational workshop undertaken to review the ability to identify red flag and urgent reviews on the out-patient review waiting list and the processes for monitoring; escalation; and actioning of these reviews, that have been clinically agreed and communicated with the Consultants.</li> </ul> | <p>The longest waiting dates back to June 2011.</p> <p>No non-recurrent funding has been received from HSCB in Quarter 1 and 2 2015/2016 for the out-patient review backlog.</p> <p>The Acute Services Directorate has identified a number of areas of clinical risk within their review backlog and these were contained within the clinical risk paper to SMT on 29 April 2015. This paper details potential contingency options for discussion and approval in order to minimise the clinical risk associated with this backlog.</p> <ul style="list-style-type: none"> <li>• As at 1 August 2015, there are a total of 1,303 patients on the planned treatment backlog. The longest waiting patient dates back to November 2013.</li> </ul> <p>63% (819) of the planned treatment backlog relates to endoscopy. The non-recurrent allocation for Endoscopy in Quarter 1 &amp; 2 will only facilitate the maintenance of planned scopes at 8-months past their clinically indicated timescale. Endoscopy, in totality, has been identified as a clinical risk within the clinical risk paper to SMT on 29 April 2015. . In line with JAG accreditation requirements the planned treatment backlog should not exceed 6-months.</p> |  |  |
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|   |                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>AHP review backlogs are not as readily quantifiable, however, manual information indicates significant review backlog volumes within Podiatry; Speech &amp; Language Therapy; Dietetics; and Occupational Therapy.</li> <li>The Trust will continue to re-direct internally resources to areas of greatest risk as funding becomes available.</li> </ul>                                                                                                                                                                                                                                                                                                                                                            |                               |             |
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|   | Risk Area and Principal Risks                                                                                                                                                                                              | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Lead Director                 | Status      |
| 3 | <p>Achievement of statutory functions/duties:</p> <ul style="list-style-type: none"> <li>Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed.</li> </ul> | <ul style="list-style-type: none"> <li>Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors</li> <li>Group established to examine operational management of the annual review process</li> <li>Delegated Statutory Functions Report</li> <li>Monthly reporting to Trust Board (from August 2013)</li> <li>Annual meeting with Heath &amp; Social Care Board Director of Social Care/Children's Services and follow up of action plan</li> </ul> | <p>Older People and Primary Care Directorate has undertaken a Domiciliary Care review and has a process in place to implement the recommendations to achieve compliance.</p> <p><b>Compliance with Review Target</b></p> <ul style="list-style-type: none"> <li>Overall % within 12 months for commissioned packages is 87.8%</li> <li>Overall % within 12 months for Domiciliary Care packages is 83.3%</li> <li>Overall % within 12 months for Nursing Home packages is 97.5%</li> <li>Overall % within 12 months for Residential Home packages is 96.5%</li> </ul> <p>Substantial validation is ongoing with teams regarding the recording of OPPC reviews as currently two systems are being used, but this will not affect the % compliance rate.</p> | Older People and Primary Care | <b>HIGH</b> |

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|  |  |  | <p>Those clients whose reviews are outstanding are subject to a desktop risk assessment to ensure that the delay in having their review carried out is not detrimental to their care.</p> <p><b>Care Home Support Team</b></p> <p>An assurance process is embedded to ensure all residents in a Care Home with a Failure to Comply Notice in place or Vulnerable Adult investigation ongoing has an up to date review in place.</p> <p>40 permanently placed clients require to be reviewed and transferred into CHST in Craigavon/Banbridge area from ICT and Memory Teams.</p> <p><b>Adult Safeguarding Team</b></p> <ul style="list-style-type: none"> <li>- Further targeted vulnerable adults training for those staff in care management and involved in annual reviews.</li> <li>- April 2015 Caseload Analysis being led by Social Work Governance Team, supported by Executive Director of Social Work</li> </ul> |  |  |
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| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Key Controls                                                                         | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                             | Lead Director                                              | Status          |
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| 4   | <p>Achievement of statutory functions/duties:</p> <p>The Trust should have robust case management communication processes in place and an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Case Management process.</p> | <ul style="list-style-type: none"> <li>New Trust Case Management Guidance</li> </ul> | <ul style="list-style-type: none"> <li>Mental Health, Learning/Physical Disability and Older People and Primary Care training completed.</li> <li>Internal Audit of Case Management being planned.</li> <li>Restructuring process by Heads of Service is in progress within the Disability Division of the Mental Health &amp; Learning Disability Directorate.</li> </ul> | Mental Health and Disability/Older People and Primary Care | <b>MODERATE</b> |

| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Lead Director   | Status          |
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| 5   | <p>Systems of assessment and assurance in relation to quality of Trust services</p> <p>Specific risks include:-</p> <ol style="list-style-type: none"> <li>1. Lack of compliance with Standards and Guidelines (DHSSPS/HSCB/other)</li> <li>2. Lack of agreed indicators/measures of quality to provide assurance across some Trust services</li> <li>3. Effectiveness of systemic process to review all intelligence from incidents, complaints, litigation and user feedback to identify and address service safety and quality issues</li> <li>4. Effectiveness of process for learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning</li> </ol> | <ul style="list-style-type: none"> <li>Standards and Guidelines report on compliance to Governance Committee and DHSSPS Accountability Review meetings</li> <li>Standards and Guidelines Risk Assessment and Prioritisation Group</li> <li>Web-based incident reporting (on Datix) rolled out across the Trust</li> <li>Clinical and Social Care Governance Review completed and new structures/processes embedded</li> <li>Governance Committee, Senior Management Team and Governance Working Body in place</li> <li>Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee</li> <li>Quality Sub Group</li> <li>Morbidity and Mortality Group</li> <li>Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information</li> <li>Review of Specialty Mortality and Morbidity system completed.</li> </ul> | <ul style="list-style-type: none"> <li>New I.T. system to capture Standards and Guidelines has not been progressed. The Quality 2020 workstream focusing on Standards &amp; Guidelines has proposed a regional approach to developing an IT system to the Quality 2020 Steering Group.</li> <li>Q2020 Strategy Regional Workstreams continue to develop and strengthen regional quality indicators for reporting via Trust Quality Report</li> <li>The Trust is presently evaluating the effectiveness of its governance arrangements - <b>due to report by end October 2015</b></li> <li>The Trust has commenced the development and implementation of a Quality Framework. The role and remit of the Clinical and Social Care Governance Working Body will be reviewed within this work</li> </ul> | Chief Executive | <b>MODERATE</b> |

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|  |  | <ul style="list-style-type: none"> <li>• Mortality Reports to Governance Committee</li> <li>• Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chair and Chief Executive</li> <li>• Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs)</li> <li>• Medical Director Report to Trust Board and Governance Committee includes Quality and Safety Indicators</li> <li>• Serious Adverse Incident/Adverse Incident reporting system in place</li> <li>• Trust Annual Quality Report</li> <li>• Executive Director Social Work has established an internal group to progress implementation of the quality indicators contained in the Social Work Strategy</li> <li>• Director, Children and Young People's Services, reports to Trust Board and Governance Committee including Roles and Responsibilities on all Looked After Children and Child Protection services</li> <li>• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve</li> </ul> |  |  |  |
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|  |  | <p>recommendations/actions and ensure shared learning</p> <ul style="list-style-type: none"><li>• Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning</li><li>• Complaints assessed/screened for adverse incident review</li><li>• Litigation process now embedded to ensure early alert to operational Directors</li></ul> |  |  |  |
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| No. | Risk Area and Principal Risks                                                                  | Key Controls                                                                                                                                                                                                                                                                                                                                                                                          | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Lead Director                                              | Status |
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| 6   | Lack of compliance with RQIA Standards in relation to medicines management in domiciliary care | <ul style="list-style-type: none"> <li>Trust Medicines Management policy</li> <li>Review of operational procedures</li> <li>Incident reporting system in place</li> <li>Interim procedure on prescribing</li> <li>Trust Medicines Steering Group</li> <li>Trust representatives on regional group</li> <li>Themed Domiciliary Care Forum (IS) focused on safe administration of medication</li> </ul> | <ul style="list-style-type: none"> <li>Annual Competency based training re medicines management for domiciliary care workers completed for all staff.</li> <li>A registered nurse has been seconded in the Newry and Mourne area for a pilot of one year since August 2014, dedicated to progressing medicines review and safer systems. A report has been shared on progress / issues to date. <b>This pilot has now been extended to the Armagh and Dungannon areas with core teams supporting the work in Newry/Mourne areas.</b></li> <li>As part of this, single patient medication files are being tested across providers to minimise risk of error.</li> <li>Following a Regional Medication workshop held by the HSCB, a business case is being developed to secure funding to deliver an interim system which includes a specialist medicines assessment and provision of appropriate solutions for service users who are identified as potentially requiring domiciliary care support in the area of medicines management.</li> <li>Interim funding is required to allow time to fully evaluate and determine the impact of the assessment process on service delivery in the redesigned Medicines Management Pathway.</li> </ul> | Older People and Primary Care/Mental Health and Disability | HIGH   |

| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                | Key Controls                                                                                                                                                                                                                             | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Lead Director                                                  | Status      |
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| 7   | <p>Inability to recruit/retain Consultant medical staff for specific specialties</p> <ul style="list-style-type: none"> <li><u>Consultant Medical Staff</u> in Dermatology, Emergency Medicine, Orthodontics, T&amp;O, Haematology, Psychiatry Old Age and Radiology</li> <li><u>SAS Medical Staff</u> in Anaesthetics, GP Out of Hours, Urology, Dermatology, Emergency Medicine and Paediatrics</li> </ul> | <ul style="list-style-type: none"> <li>Recruitment campaigns</li> <li>Use of Locum agencies</li> <li>Risk Assessment highlighting controls/action in place</li> <li>Detailed Action Plan is held within the HROD Directorate.</li> </ul> | <p><b>Dermatology:</b> There is a recognised UK shortage of consultant posts in Dermatology and therefore a new model to attract GPs has been introduced. From late November 2014, 4 part-time GPs have started in post so this has proved successful. <b>Two retired consultants were engaged to undertake some WLI clinics however this arrangement ceased at the end of June 2015.</b></p> <p><b>An application was submitted to the Royal College of Physicians in 2014 for International Medical Graduates (IMGs) under the Medical Training Initiative (MTI) scheme, but was unsuccessful. One local doctor will reach her CCT date in July 2015, so would now be eligible to apply for a consultant post in the Trust. An IPT is currently being developed.</b></p> <p><b>T&amp;O:</b> Two consultants have been appointed to T&amp;O during 2015. One commenced in post at the start of January, however the other is not able to take up post until August. In addition, 2 Temporary Specialty Doctors have also been appointed. The following posts are currently advertised (closing date 13/8/15) 1 permanent Specialty Doctor, 3 Temporary Specialty Doctors, 1 Temporary Consultant and 2 Clinical fellows.</p> <p><b>Emergency Medicine:</b> A permanent Consultant commenced in Craigavon Area Hospital on 1<sup>st</sup> May 2015. Two Specialty Doctors were recently</p> | Human Resources & Organisational Development/ Medical Director | <b>HIGH</b> |

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|  |  |  | <p>interviewed and appointed to ED in DHH, however despite these appointments it still proves very difficult to recruit to Consultant and Specialty Doctor positions within ED</p> <p>The Trust has recently advertised for Consultant and Specialty Doctor posts in DHH. The adverts also featured in the ROI and stated that enhanced rates of pay and a full relocation package would be considered, however these campaigns were unsuccessful.</p> <p>The Trust has recently embarked on a recruitment campaign for middle grade doctors in ED with M3 Creating Connections. This company undertakes medical recruitment project work with Trusts and Health Boards on behalf of doctors.net.uk. The campaign will be live on the doctors.net.uk web site for 4 weeks.</p> <p>The Trust has also introduced a Clinical fellowship programme for ED. One appointment has been made – starting in August 2015.</p> <p><b>Anaesthetics:</b> It is planned to develop a training programme with the aim of “growing our own” specialty doctors. A proposal has been drafted and is currently under consideration by the service.</p> <p><b>Radiology:</b> There is a recognized gap in Consultant Radiologist numbers and Clinical Radiology has recently been included in the Government approved shortage occupation list. The Trust has</p> |  |  |
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|     |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                            | successfully appointed a number of Consultant Radiologists over the past few years; however some of these have left to take up other posts. The position remains unstable. In February 2015, the Trust successfully appointed 4 permanent Consultant Radiologists. One person has since withdrawn, however the other 3 will take up post in August 2015.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |
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| No. | Risk Area and Principal Risks                            | Key Controls                                                                                                                                                                                                                                                                                                                                                                                               | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Lead Director                 | Status |
| 8   | Increasing inability to recruit registered nursing staff | <ul style="list-style-type: none"> <li>• Ward Sister/Charge Nurse management of available staff on a shift by shift basis</li> <li>• Assistant Director/Head of Service (Operational) oversight regarding availability with possible redeployment of staff to respond to prioritised need</li> <li>• Escalation to Operational Director as required</li> <li>• Open registration for Nurse Bank</li> </ul> | <ul style="list-style-type: none"> <li>• All opportunities to secure permanent staff continue to be progressed</li> <li>• Regular recruitment drives ongoing</li> <li>• Introduction of Rotational Programmes within and across Directorates.</li> <li>• Targeted recruitment of current nursing students for bank Band 3 roles ongoing with a view to introducing them to the Southern Trust for their Band 5 career.</li> <li>• Six staff have secured places on the funded Open University Pre-registration Nursing Programme commencing September 2015. A further ten staff were successful at interview. SHSCT has offered these ten deferred places for the OU PRNP commencing September 2016.</li> <li>• A Trust Nursing Workforce Planning Group has been established to seek to address current and future anticipated challenges regarding the demand for and supply of</li> </ul> | Executive Director of Nursing | HIGH   |

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|   |                                                                                                                                                    |                                                                                                                                                                              | <p>Registered Nurses across all programmes of care.</p> <ul style="list-style-type: none"> <li>A regional Nursing Workforce Planning Group is being established at the request of the CNO and will be chaired by Mr F Rice, Executive Director of Nursing</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |                 |
| 9 | Long term placements for clients with challenging behaviour resulting in delayed discharge from hospital – specifically Dementia and Mental Health | <ul style="list-style-type: none"> <li>Multidisciplinary Team Assessments</li> <li>Monthly Delayed Discharge meeting for all Mental Health Wards including Gillis</li> </ul> | <ul style="list-style-type: none"> <li>The Multidisciplinary team in Gillis now use the definition of “Multidisciplinary Fit” for discharge when deciding when a patient is fit for discharge. Patient level detailed delayed discharge information is circulated to the Multidisciplinary team in Gillis and the relevant staff in the Community Memory Teams on a monthly basis.</li> <li>Continuing to explore the potential for existing homes to manage cases with an individualised bespoke package</li> <li>Discussions with Commissioners have highlighted the need to enhance community services to better support individuals in their own homes or independent sector homes to manage more challenging behaviours. Currently no funding has been made available to enhance memory services or procure a specialist home for people with dementia and challenging behaviours. Consequently individuals whose discharge is delayed remain in Gillis much longer.</li> <li>Discussions with regional and local Commissioners have sought to bring to the fore the current gap in</li> </ul> | Mental Health and Disability/Older People and Primary Care | <b>MODERATE</b> |

|     |                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Commissioning plans for inpatient dementia services, including multi-disciplinary input from pharmacy, social work and psychology. Some in year non recurrent allocations have helped with the overspend in bank nursing hours to meet need but will not enhance multi-disciplinary input. The absence of a commissioning strategy for inpatient dementia care is constantly raised at every available opportunity. The Trust is currently developing proposals for the future management of all dementia services into one Directorate and will continue to make the case with Commissioners for the additional resources required to meet the complex needs of the inpatient population. |                        |        |
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| No. | Risk Area and Principal Risks                                                                         | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Lead Director          | Status |
| 10  | Insufficient capital to maintain and develop Trust estate to support service delivery and improvement | <ul style="list-style-type: none"> <li>Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department</li> <li>Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk</li> <li>Strategic development plans in place for major projects and business cases submitted for highest risk areas<br/>Specific examples:</li> </ul> | <ul style="list-style-type: none"> <li>On-going prioritisation and bidding process for capital in place</li> <li>Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment</li> <li>Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available</li> <li>Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment &gt; £500k<br/>Business cases for High</li> </ul>                                                                                                                          | Performance and Reform | HIGH   |

|  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |  |
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|  |  | <ul style="list-style-type: none"> <li>• Fire Safety Action Plan in place (see below)</li> <li>• High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below)</li> <li>• Aging High Pressure Hot Water system (HPHW) at Craigavon Area Hospital has now been replaced with new Low Pressure Hot Water system.</li> <li>• £2.9m secured to complete structural works to tower block at South Tyrone Hospital</li> <li>• Completion of Theatre development CAH</li> </ul> | <p>Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2015/16. Phase 1 of Mechanical Infrastructure complete.</p> <ul style="list-style-type: none"> <li>• Strategic Outline Case submitted for major redevelopment at CAH site. Work is now being progressed on the main business case for submission in 2015/16.</li> <li>• New negative pressure isolation room at CAH approved for construction 2015/16.</li> <li>• Provision of new negative pressure isolation room at DHH awaiting decision on preferred option from Acute Services. Thereafter proposals to be incorporated in Business Case for consideration by SMT/Trust Board.</li> <li>• The sewage system serving the wards at CAH has reached a critical point with frequent blockages leading to bursts and subsequent contamination of patient and support areas. This presents a serious infection control risk; causes disruption to services; and has been reported in the press potentially damaging service user confidence. Whilst various efforts have been made to mitigate the risk it is clear that the system must be replaced urgently. As areas will need to be decanted during works a carefully coordinated phased programme will be implemented over the next few months.</li> </ul> |  |  |
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| No. | Risk Area and Principal Risks                                     | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Lead Director                                | Status   |
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| 11  | Fire Safety and compliance with Fire Safety Regulations (NI) 2010 | <ul style="list-style-type: none"> <li>• Fire Safety Action Plan in place</li> <li>• Local Fire Safety Management Arrangements in place</li> <li>• Funding to resolve deficiencies – prioritised within Maintaining Existing Services</li> <li>• Approximately £110k was invested for 2014/15 for swing arm door closers in residential homes; new fire alarm systems in Shanlieve, Oaklands and Burnside and alterations to fire alarm systems in Lurgan Hospital, Dromore clinic, Oakdale and South Tyrone Hospital and providing/upgrading fire alarm zone maps throughout the Trust.</li> </ul> | <ul style="list-style-type: none"> <li>• Staff training on-going</li> <li>• New methods for delivering mandatory fire training agreed, implemented and tested</li> <li>• Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out</li> <li>• Firecode funding allocation from Maintaining Existing Services for 2015/16 is for £160k. Proposed works are as follows:<br/>Additional fire alarm detection for DHH Phase 2; upgrade fire alarm cause and effect for CAH; additional fire alarm panels for South Tyrone Hospital; update fire alarm system for St Luke's Hospital site; remedial works to fire compartments for Bluestone, South Tyrone Hospital and Crozier House, Elms and Appleby Day Centre.</li> <li>• Approximately 95% completion of baseline fire risk assessments for high risk facilities/buildings – full completion is anticipated in mid-September. Approximately 95% baseline fire risk assessment completed for all other buildings. Programme is set for review of Fire Risk Assessments.</li> <li>• The most recent Fire Safety Report shows 70% of staff are up to date with their Fire Safety Training</li> <li>• Staff can now avail of Face to Face or E-Learning in order to complete Fire Safety Training</li> </ul> | Human Resources & Organisational Development | MODERATE |

|     |                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <ul style="list-style-type: none"> <li>A rolling programme is currently in place for General Fire Safety, Ski Sheet Pad and Evacuation Chair Training</li> <li>The Trust is currently in the process of tendering for the new Fire Safety Contract. This process is expected to be completed in August 2015. The new contract will be from 1<sup>st</sup> September 2015 to 31<sup>st</sup> August 2018 with the provision for 2 x 1 year extensions.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                              |                                              |        |
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| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                            | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Lead Director                                | Status |
| 12  | <p>High Voltage capacity limit on electrical supply to Craigavon Area Hospital</p> <ul style="list-style-type: none"> <li>Identified under Maintaining Existing Services scheme</li> <li>Possible limit to expansion of service provision on the Craigavon Area Hospital site</li> <li>Increased electrical demand on existing limited supply may exceed capability of supply</li> </ul> | <ul style="list-style-type: none"> <li>All future development/ expansion of the estates is to be notified to Estate Services</li> <li>Generator backup</li> <li>Load shedding</li> <li>Monitoring current demand</li> <li>Business Continuity Plans for restabilising electrical service in the event of unplanned interruption</li> <li>Peak Lopping installed and completed following agreement with Northern Ireland Electricity</li> <li>Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.</li> </ul> | <ul style="list-style-type: none"> <li>Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing.</li> <li>Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure</li> <li>Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the risk.</li> <li>Installation of new Combined Heat and Power plant is completed and G59 approval from NIE (to permit parallel generation) in place.</li> </ul> | Human Resources & Organisational Development | HIGH   |

|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Contract for operation and maintenance of plant being finalised with PALS. This will provide additional source of supply for the site. At this point, this risk will be re-assessed and may reduce to moderate risk.</p> <ul style="list-style-type: none"> <li>CAH site High Voltage infrastructure works, together with the new NIE High Voltage supply, anticipated completion April 2016</li> </ul>                                                                                                                                                                                                                                                      |                                              |        |
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| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Lead Director                                | Status |
| 13  | <p>The lack of capacity, due to staff shortages, to provide and maintain a safe and efficient healthcare environment.</p> <p>Specific risks include:-</p> <ul style="list-style-type: none"> <li>Failure to deliver capital works programme to quality, cost and/or time</li> <li>Limited ability to develop and implement processes to meet Internal Audit requirements</li> <li>Limited ability to comply with procurement regulations</li> <li>Failure to meet departmental requirements for PPEs, Peer Review processes etc.</li> </ul> | <ul style="list-style-type: none"> <li>Extensive reorganisation/restructuring of Estates Services. However, failure to fully implement restructuring through non replacement of posts removed resilience and hampered ability to effectively carry out the Estates function.</li> <li>Reduction in Capital projects from c 60pa to 24pa based on priority</li> <li>Heads of Service covering for vacancies within their areas</li> <li>Staff redirected to higher priority areas</li> </ul> | <ul style="list-style-type: none"> <li>Composite Estates Works Improvement Plan developed and monitored fortnightly by Assistant Director Estate Services. SMT approval given to commence recruitment of key posts (12/11/14) – recruitment of additional resource as follows:-</li> </ul> <p>Estate Development Team – 2 x replacement posts filled</p> <p>Estates Operations Team – critical Estates Officers and Directly Employed Labour being recruited.</p> <p>Structure discussions to be finalised to enable remaining posts (at 8a etc) to be filled; Specialist Estates</p> <p>Property Manager appointed</p> <p>Procurement team to be recruited</p> | Human Resources & Organisational Development | HIGH   |

|     | <ul style="list-style-type: none"> <li>• Risk to long term Estates service due to absence of resilience/succession</li> <li>• Limited ability to deliver effective operational service</li> <li>• Failure to manage property effectively</li> </ul>                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |        |
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| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                      | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Lead Director              | Status |
| 14  | <p>The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified several issues:</p> <ul style="list-style-type: none"> <li>• The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding).</li> <li>• Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding)</li> </ul> | <ul style="list-style-type: none"> <li>• Increased environmental monitoring to check for failures of sterility in the unit</li> <li>• Expiry dates of all products prepared has been reduced to a maximum of 24 hours.</li> <li>• A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented</li> <li>• Additional activity will not be accepted by the aseptic</li> </ul> | <ul style="list-style-type: none"> <li>• The queries received in relation to the business case for a new build aseptic suite co-located with the Mandeville Unit have been addressed and the OBC was submitted to the DHSSPSNI on 1<sup>st</sup> July 2015. A letter of Commissioner Support will also be submitted once received from the HSCB.</li> <li>• The Capita Model for chemotherapy/cytotoxic dispensing has been applied to the current workload in the unit. This has identified a staffing deficit of 3.6wte pharmacists. Using the capacity plan as a</li> </ul> | Director of Acute Services | HIGH   |

|    | <ul style="list-style-type: none"> <li>The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)</li> </ul>                                                                                                                                                                                                                                  | <p>unit until the staffing issue is resolved</p> <ul style="list-style-type: none"> <li>Additional environmental and function testing is being performed on both isolators to identify any sterility failures.</li> </ul>                                                                                                                                                                                                                                                                                                                    | <p>model the unit is short 2 pharmacists for the current workload. At a meeting with HSCB in December they agreed to fund the 2 additional band 7 pharmacists required. <b>The IPT was received in May 2015 and the recruitment process is underway.</b></p> <ul style="list-style-type: none"> <li>The first replacement isolator is now fully operational. The second isolator was installed in November 2014. However various problems with the isolators are still to be resolved. BSO PaLS are liaising with the supplier.</li> </ul>                     |                  |          |
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|    | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                                                                                | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Lead Director    | Status   |
| 15 | <p>HCAI</p> <ul style="list-style-type: none"> <li>Risk to achievement of Priorities for Action target identified</li> <li>Risk to patient safety</li> <li>Lack of automated HCAI surveillance system linked to Trust laboratory system</li> <li>Lack of appropriate isolation facilities (including negative pressure facilities) within the Trust hospital network</li> <li>Emerging infections (CPE/VHF/ebola)</li> </ul> | <ul style="list-style-type: none"> <li>Comprehensive isolation policy in place and strictly adhered to</li> <li>On-going mandatory and tailored IPC training</li> <li>Manual surveillance systems in place. Independent and self-audit programme</li> <li>Comprehensive governance structure in place, including bi-monthly Strategic Forum and monthly Clinical Forum meetings</li> <li>Outbreak /incident management plan in place</li> <li>Establishment of antimicrobial management team to oversee antimicrobial stewardship</li> </ul> | <ul style="list-style-type: none"> <li>On-going measurement of compliance against DHSSPS Communiqués</li> <li>Ongoing self and independent audit using the RQIA Augmented Care Audit tools.</li> <li>Learning outcomes from RCAs being shared with senior and junior medical staff.</li> <li>Engagement meeting with HSCB regarding GP and Primary Care involvement in C.difficile RCA cases</li> <li>Embedding Urinary Catheter project to target E-coli infections and promote safer clinical practice when dealing with urinary catheters across</li> </ul> | Medical Director | MODERATE |

|  |                                                                                                                                               |                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |  |
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|  | <ul style="list-style-type: none"> <li>HCAI outbreaks in tertiary services (BHSCT)</li> <li>Increasing emergence of CPE infections</li> </ul> | <ul style="list-style-type: none"> <li>HCAI Root Cause Analysis process in place</li> <li>Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI</li> </ul> | <p>community and acute sites.</p> <ul style="list-style-type: none"> <li>Engagement with PHA on Regional Surveillance system funding and procurement to recommence</li> <li>Enhancement communication to front line clinical staff via HCAI e-Alert</li> <li>Suite of procedures and guidelines to support the prevention, management and control of CPE.</li> <li>Completed Ebola Management Plan</li> <li>CPE Outbreak/Incident Management</li> <li>Enhanced HCAI RCA information management system and system developed to further improve meta-analysis of C Difficile cases</li> <li>Renewed focus on isolation and screening of transferred patients, including planning of negative pressure isolation facilities on CAH site</li> <li>Re-launch of IV Programme in Acute sites to address increasing MRSA/MSSA</li> </ul> |  |  |
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| No. | Risk Area and Principal Risks                                                      | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Lead Director                                                                 | Status   |
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| 16  | Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas) | <ul style="list-style-type: none"> <li>Water Safety Group in place</li> <li>Water Safety Plan</li> <li>Revised Legionella policy and procedures in place</li> <li>Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems</li> <li>Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA &amp; HEIG), results analysed, appropriate action taken as required</li> <li>Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care</li> <li>IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.)</li> <li>Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address emerging risks</li> <li>Infection prevention and control audit programme and implementation of appropriate actions based on findings</li> <li>On-going staff education programme highlighting risks of water borne pathogens</li> <li>Design of water systems within care facility/environment; attention</li> </ul> | <ul style="list-style-type: none"> <li>Consideration of opportunities to increase automated water temperature and flow monitoring</li> <li>Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013)</li> <li>Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013)</li> <li>£200k MES General Capital funding secured for priority works identified through risk assessments</li> <li>New sampling regime approved by Trust Board and new monitoring regime now in place with bi-monthly monitoring. This will continue until September 2014 at which point testing will go to quarterly (subject to satisfactory reduction in legionella positives. As at November 2014 this has not happened due to a number of positive Legionella counts being detected as part of the sampling regime. (see note below under Copper Silver Ionisation).</li> <li>Second Independent Review of Water Management arrangements expected end February 2015.</li> </ul> | Director of Human Resources & Organisational Development/<br>Medical Director | MODERATE |

|     |                                                                                                      | is given to designing system that will reduce the likelihood of propagation of water borne pathogens                                                                 | <ul style="list-style-type: none"> <li>New Trust wide contract for the control of water systems to be tendered by PALs (estimated start date of contract – March 2015)</li> <li>Following installation of Copper-Silver ionisation systems in CAH, a representative team from the Trust Water Safety Group continues to meet weekly to monitor the performance of the system. The initial 12 weeks trial period was extended to 20 weeks (end of August 2015) to ensure sufficient data will have been gathered to enable recommendations to be made regarding the overall water sampling programme for CAH and further application of this technology to other sites including Loane House etc. Early indications are encouraging and preparations are underway for deployment to other sites.</li> </ul> |               |        |
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| No. | Risk Area and Principal Risks                                                                        | Key Controls                                                                                                                                                         | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Lead Director | Status |
| 17  | Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status | <ul style="list-style-type: none"> <li>Action Plan in place to address non-conformances</li> <li>External Quality Assurance and Internal Quality controls</li> </ul> | <ul style="list-style-type: none"> <li>The Trust has submitted its application for re-accreditation and is awaiting a new date. A pre-assessment visit is planned for 8<sup>th</sup> October 2015. This visit will assess the Laboratory's state of readiness for a full UKAS 151189 inspection.</li> <li>Action Plan updated as progress is made.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                              |               | HIGH   |



| CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE |                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                              |                 |
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| No.                                                                 | Risk Area and Principal Risks                                    | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Lead Director                                                                | Status          |
| 18                                                                  | Fully embedded appraisal system – lack of evidence of compliance | <p>There are a variety of mechanisms in place to ensure appraisal takes place:-</p> <ul style="list-style-type: none"> <li>• Consultant Appraisal</li> <li>• Professional Supervision</li> <li>• Knowledge and Skills Framework (KSF) policy and monitoring system in place</li> <li>• KSF is a standing item on the agenda of the Education, Training and Workforce Development Committee and SMT meetings</li> <li>• Action Plan in place and reviewed quarterly</li> <li>• Staff Attitude Survey results provide staff view</li> <li>• Working Group established by Vocational Workforce Assessment Centre to further embed KSF throughout the organisation.</li> </ul> | <p><b><u>Consultant / Medical Appraisal</u></b></p> <p>The 2013 appraisal round is 100% complete (288 medical staff).</p> <p>Work commenced on the January to December 2014 Appraisal Round at the start of April 2015 as key information became available to issue to medical staff (e.g. CLIP reports, complaints/incidents information). Currently 33% of 315 eligible doctors have completed their 2014 appraisal with the remaining expected to complete by Autumn 2015.</p> <p><b><u>Knowledge and Skills Framework</u></b></p> <p>A KSF steering group continues to meet quarterly.</p> <p>Work is ongoing with individual Directors and Heads of Services to support staff and managers when completing their KSF Documentation, and therefore to increase uptake within each Directorate</p> <p>KSF reports continue to be collated monthly and forwarded to Directors. Regular reports regarding uptake levels across the Trust continue to be presented to SMT</p> <p>PDP's are now being recorded on HRPTS as a qualification.</p> <p>As a result of all of the above, there has been an increase in the extent to which KSF is being implemented across the Trust.</p> | <p>Medical Director</p> <p>Director of HR and Organisational Development</p> | <b>MODERATE</b> |

| No. | Risk Area and Principal Risks                                                                              | Key Controls                                                                                                                                                                                                                                                           | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Lead Director                 | Status |
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| 19  | Implementation of the Nursing Midwifery Council's (NMC) revised revalidation arrangements in December 2015 | <ul style="list-style-type: none"> <li>NI Revalidation Programme Board, attended by the Executive Director of Nursing, meets bi-monthly</li> <li>NI Revalidation Working Group attended by the Trust's Assistant Director Nursing Governance, meets monthly</li> </ul> | <p>NMC Revalidation model to be piloted in the Western HSC Trust between January – June 2015. Outcomes of all pilot sites to be considered by NMC in October 2015 and decision made as to whether or not the revalidation model will 'go live' in December 2015 across all 4 UK countries</p> <p>Organisational impact assessment for readiness to be undertaken. Assistant Director Nursing Governance has met with HR to scope out the practicalities of applying KSF/PDP appraisal processes</p> <p>Assistant Director Nursing Governance, along with Directorate Champions, will develop tools and proformas to support evidencing compliance with the core elements and to prepare nurses/midwives for their professional development discussion with their NMC colleague</p> | Executive Director of Nursing | HIGH   |

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|  |  |  | Each NMC registrant has received a copy of the revised NMC Code in the post and this has been supported by circulation of information and opportunities for open discussion. Assistant Director Nursing Governance has linked with the AND Workforce Development and Training and Clinical Education Centre to scope out planned support programmes |  |  |
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| CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES |                                                                                               |                                                                                                                                                                                                                                              |                                                                                                                                                                                                   |                                 |                 |
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| No.                                                   | Risk Area and Principal Risks                                                                 | Key Controls                                                                                                                                                                                                                                 | Action Planned/Progress update                                                                                                                                                                    | Lead Director                   | Status          |
| 20                                                    | <ul style="list-style-type: none"> <li>Achievement of financial balance in 2015/16</li> </ul> | <ul style="list-style-type: none"> <li>Contingency Plan for 2015/16 in place</li> <li>Best Care Best Value (BCBV) Project structure</li> <li>Financial monitoring systems in place</li> <li>Monthly report to SMT and Trust Board</li> </ul> | As a result of additional Health and Social Care Board allocations and Departmental approval to a number of additional contingency proposals, the Trust would now expect to breakeven in 2015/16. | Finance and Procurement/<br>All | <b>MODERATE</b> |

| No. | Risk Area and Principal Risks                                                                      | Key Controls                                                                                                                                                                                                                                                                                                                                                                                 | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Lead Director                                                                                | Status          |
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| 21  | Management and monitoring of procurement and contracts – not compliant with best practice guidance | <ul style="list-style-type: none"> <li>Contracts management improvement group established and key actions formed</li> <li>New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided .</li> <li>Training on Contract Management with focus on responsibilities of Contract Owners rolled-out with follow up sessions also delivered</li> </ul> | <p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li>Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee</li> <li>Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing<br/>(Central monitoring ceased in October 2013)</li> <li>Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity.</li> <li>Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Alternative options being considered to progress these procurements.</li> <li>Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of</li> </ul> | Director of Performance and Reform/<br>Director of Finance and Procurement/<br>All Directors | <b>MODERATE</b> |

|  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
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|  |  |  | <p>Procurement Policy awaited</p> <ul style="list-style-type: none"> <li>New Structures for contract &amp; procurement management being developed as part of Management Review</li> </ul> <p><b>ESTATES</b></p> <ul style="list-style-type: none"> <li>Proposed models brought forward by PALS and Trusts on regional basis to address procurement deficit for Estates services agreed by Directors of Finance. Regional Steering and Working Groups established. Recruitment of PALS team underway. Recruitment of Trust Team being taken forward under newly appointed Head of Service.</li> <li>Measured Term Contract (MTC) in place for 2015/16 which mitigates risks to procurement for schemes &lt;£30k</li> <li>Estates Works Management Improvement Action Plan (incorporating all IA recommendations) established and 95% implemented during 14/15. Internal Audit undertook a follow-up audit (reported March 2015) and verified that the majority of recommendations had been either partially or fully implemented. Further IA work to be undertaken third quarter of 2015/16.</li> </ul> |  |  |
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|  |  |  | <ul style="list-style-type: none"> <li>Two replacement Estates Officers appointed and volume of works being undertaken balanced against resources to facilitate compliance.</li> </ul> <p><b>SOCIAL CARE PROCUREMENT</b></p> <ul style="list-style-type: none"> <li>Regional Procurement Board via Social Care Procurement Group developing approach to social care procurement. No agreed regional way forward for procurement capacity gaps at Trust and COPE level . Issues continue to be raised with DHSSPS and Regional Procurement Board</li> <li>Capacity sought via IPT for social care procurement of key projects including (Learning disability Day Opportunities/Respite and Domiciliary Care) under influence of CoPE. Bid approved, however recruitment has been suspended due to financial pressures. Internal resource diverted to provide procurement support to key mental health directorate projects enabling change</li> <li>Impact of 2015 Public Contract Regulations on social care procurement assessed and key actions agreed to scope demand and capacity requirements</li> </ul> |  |  |
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| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                    | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                               | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Lead Director                 | Status          |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------|
| 22  | <p>Payroll &amp; Travel - HRPTS System &amp; Shared Services</p> <ul style="list-style-type: none"> <li>Payroll &amp; Travel Payments - potential for inaccurate and/or late payments. Negative media publicity and impact on Trust's reputation as a good employer.</li> <li>Transfer to Payroll Shared Services and maintenance of service delivery</li> </ul> | <ul style="list-style-type: none"> <li>Customer Forums are in place for monitoring the performance of services in Shared Services Centres</li> <li>Progress updates to Audit Committee</li> <li>3 weekly performance monitoring meetings between the Trust's Head of Resourcing and Shared Services Centre Head of Recruitment &amp; Selection</li> </ul>                                                                                                  | <ul style="list-style-type: none"> <li>Ongoing communication/engagement with Managers as regards timely completion of paperwork</li> <li>Weekly, Fortnightly and Monthly staff transferred to the Payroll Shared Service Centre.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                     | Finance Director              | <b>MODERATE</b> |
| No. | Risk Area and Principal Risks                                                                                                                                                                                                                                                                                                                                    | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                               | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Lead Director                 | Status          |
| 23  | GP Out of Hours Service – Reduced ability to maintain adequate service provision and patient safety due to vacant GP shifts                                                                                                                                                                                                                                      | <ul style="list-style-type: none"> <li>Recruitment process for vacant posts</li> <li>Business Continuity Plan</li> <li>Medical Managers with medical responsibility for the service</li> <li>Call Centre Co-ordinator</li> <li>Call Manager system</li> <li>Late availability payment</li> <li>Flexibility re shift patterns offered</li> <li>Daily monitoring of rotas and appropriate contingency plans deployed based on resources available</li> </ul> | <ul style="list-style-type: none"> <li>Advertisement on HSC recruit for sessional GPs closed with 11 applicants. 9 have been interviewed, 1 is pending interview and 1 withdrew.</li> <li>2 GPs have come forward in July 2015 seeking employment in GP OoHs</li> <li>SMT agreed a paper in February 2015 offering payment towards sessional GPs indemnity cover. This ended on 31<sup>st</sup> March 2015.</li> <li>The Health &amp; Social Care Board has commenced additional cost pilot from July 2015 to encourage GPs to book additional shifts and this will result in an additional payment.</li> </ul> | Older People and Primary Care |                 |

|  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |  |
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|  |  |  | <ul style="list-style-type: none"> <li>From 13<sup>th</sup> February 2015, [REDACTED], on occasions there has only been 1 GP to cover the Trustwide service from midnight to 8.00 a.m. There have been further occasions when there has been only 1 GP, however, Nurse Practitioners are providing some cover into the red eye shifts. There is a risk if GP scheduled to work is unable to work leaving no GP cover</li> <li>Additional salaried shifts were offered to GPs within the service in February 2015. 8 GPs have expressed an interest in 21 shifts amounting to 123 hours in a 4 week rota period. HR processes are being worked through with the aim to commence in June 2015 rota. There has been a further trawl sent to GPs with a list of available salaried shifts, with a return date of 31<sup>st</sup> July 2015.</li> <li>Regular updates to HSCB/Integrated Care Department regarding vacant shifts. Escalation to HSCB when GP cover is significantly reduced.</li> <li>When clinical cover reduced to less than 50% or 1 red eye doctor, early alert sent to HSCB by 2.00 p.m.</li> <li>A weekly email of vacant shifts is being sent on a Monday to all clinicians. Daily text messages and phone calls to GPs and Nurses in attempts to cover shifts.</li> <li>Small team of nurses in GP Out of Hours Service working extra</li> </ul> |  |  |
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|  |  |  | <p>hours, where possible to assist in covering gaps</p> <ul style="list-style-type: none"> <li>• IPT submitted to appoint 50 Nurse Triage staff. Trust proceeded at risk to commence the recruitment process. Interviews have been completed. Nurse Advisors – 25 are competent and able to work. A further 9 have received telephone triage training and are being shadowed to be deemed competent</li> <li>• As and when bank Nurse Practitioners have been recruited and are working within the service.</li> <li>• Recruitment of 8A service improvement role to the end of April 2015 to review the service model. Report will be presented by end July2015.</li> <li>• Review of workload of clinicians ongoing by Clinical Lead</li> <li>• KPIs continue to be monitored hourly. Weekly triage KPIs sent to HSCB</li> <li>• Working with Integrated Care Dept to address capacity issues and use of locum GPs. Locum agencies had been contacted and no doctors available.</li> <li>• Locally Enhanced Service pilot commissioned by the Health and Social Care Board ended on 31 March 2015. An evaluation is being undertaken.</li> <li>• Working with other OoH providers to secure additional capacity</li> <li>• The Pharmacy Pilot commenced on 28.2.2015 with 8 Pharmacists recruited to provide cover from 11</li> </ul> |  |  |
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|     |                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <p>a.m. – 4 p.m. Saturday and Sunday and Bank Holidays. Pharmacists have also provided additional cover outside these hours to increase capacity. <b>An evaluation has commenced.</b></p> <ul style="list-style-type: none"> <li>• <b>Twice daily operational meetings to review cover and actions required.</b></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     |        |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------|
| No. | Risk Area and Principal Risks                                                                                                                            | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Lead Director                                       | Status |
| 24  | Health Visiting Service – Impact on children/families due to reduced ability to deliver services as a result of decreased staffing levels in the service | <ul style="list-style-type: none"> <li>• Control measures in place include step down i.e. universal contacts to non-vulnerable families have been reduced;</li> <li>• Utilisation of bank (limited supply) and additional hours of existing health visiting staff;</li> <li>• Drop in clinics available to ensure rapid access to HV if parent worried or concerned about an infant / child;</li> <li>• Rota system is in place to equitably allocate clinic cover, new births, movement in visits and new safeguarding cases;</li> <li>• Team managers to notify HoS and Named Nurse for Safeguarding Children if they are unable to allocate a child protection case.</li> <li>• Provision of universal contacts is being monitored across service/teams on a quarterly basis through IoP report and this information is sent to Director/DHSSPS/HSCB/PHA</li> </ul> | <ul style="list-style-type: none"> <li>• The Health Visiting workforce position demonstrates that Staff in Post equate to the Funded Staffing Levels. The reality is that there are <b>16.54 wte</b> unavailable to deliver the service (due to planned and unplanned absence), which equates to <b>20%</b> of this workforce not available at a given time. This demonstrates a worsening position from that of May 2015 when 14% of the HV workforce was unavailable.</li> </ul> <p><b>This staffing deficit means that all 7 Health Visiting Teams are in step down:</b></p> <p><b>Armagh</b> currently has a <b>20%</b> step-down to core service in place;</p> <p><b>Dungannon</b> currently has a <b>20%</b> step-down to core service in place;</p> <p><b>Portadown</b> currently has a <b>30%</b> step-down to core service in place;</p> <p><b>Lurgan/Brownlow</b> HV Team</p> | Executive Director of Nursing/<br>Director of C&YPS |        |

|  |  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
|--|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
|  |  |  | <p>currently has a 20% step-down to core service in place;<br/> <b>Banbridge</b> HV team has a 20% Step-down in place;<br/> <b>N&amp;M</b> (Team 1) currently has a 10% step-down to core service in Place;<br/> <b>N&amp;M</b> (Team 2) has a 20% step-down in place.</p> <ul style="list-style-type: none"> <li>• There are currently 8 permanent vacancies, 7 maternity leaves and 8 staff on long-term sick leave.</li> <li>• Due to the regional shortage of Health Visitors, the amount of temporary staff the SH&amp;SCT is able to secure through the bank is insufficient to meet the deficit.</li> <li>• Eleven Health Visiting students are currently completing their management placements which releases some of the Practice Teachers time to work into some of the vacant caseloads.</li> <li>• In communications with the HSCB and PHA regarding the Health Visiting workforce, assurance has been given that SHSCT are proactively processing vacancies in order to appoint staff as soon as possible. SHSCT has also articulated the need for additional funding to meet the particular needs of the population within this area.</li> <li>• Sixty-one Health Visiting places were approved regionally for 14/15 and SHSCT is facilitating 11 students. These students will finish</li> </ul> |  |  |
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|     |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <p>in September 2015. 5 of the permanent vacancies have been offered and accepted by the students, with e-requisitions in progress for the remaining vacancies. We continue to await additional investment agreed with the PHA.</p> <p>This situation is exacerbated by the reduced capacity of the Family Nurse Partnership team (detailed on the CYP Directorate Risk Register).</p>                                                                                                                                                                                                                                                             |                            |        |
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| No. | Risk Area and Principal Risks                                                                                   | Key Controls                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Action Planned/Progress update                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Lead Director              | Status |
| 25  | Safeguarding of residents within HH/BC - Historical and ongoing risk to residents of potential financial abuse. | <ul style="list-style-type: none"> <li>Review of Residents within the Care Management process. Residents' reviews are held more frequently if required.</li> <li>Families were given choice regarding continuing with placement or seeking an alternative following the outcome of the initial investigation – 4 out of 5 moved</li> <li>Liaison with the residents, relatives/families where appropriate.</li> <li>Weekly Trust meetings to review status &amp; regular updates provided to Trust Board / SMT.</li> <li>Regular updates from Trust HHBC group provided to</li> </ul> | <ul style="list-style-type: none"> <li>Ongoing liaison with the residents, relatives/families where appropriate.</li> <li>Suspension of new admissions/respite beds was last reviewed at HHBC Steering group on 7/8/2015. Current controls to remain as agreed by SMT and Trust Board.</li> <li>Public Prosecution Service has determined no prosecution of the Home Owners regarding one client</li> <li>RQIA is currently pursuing a prosecution of the Home Owners under Article 42 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA Court date was last held on</li> </ul> | Mental Health & Disability |        |

|  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
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|  |  | <p>DHSS/HSCB/RQIA/Other Trusts</p> <ul style="list-style-type: none"> <li>• Within Disability Services potential placements are discussed and prioritised at Trust Accommodation Panel.</li> <li>• Regular advice/support/direction by Trust Legal Advisers</li> <li>• Contract Review Meetings with HHBC and quarterly operational meetings with HHBC as part of the contract compliance process.</li> <li>• Trust addresses in writing any identified concerns/queries as they arise with the Home Owners and their Legal representatives.</li> <li>• Trust addresses any identified concerns/queries raised by resident/relatives and Trust staff.</li> <li>• Trust addresses any identified concerns/queries raised by DHSSPSNI/RQIA.</li> <li>• Adult Safeguarding Process. Remaining residents have care and protection plans which have been put in place and updated as required.</li> <li>• Contacts with RQIA</li> <li>• Trust "Procedure for Responding to RQIA Alerts &amp; Other Performance</li> </ul> | <p>3/7/15. Next Court date is 30/9/15.</p> <ul style="list-style-type: none"> <li>• Formal Court Order regarding disclosure received by Trust. Information being reviewed by the Trust prior to sending to DLS on 6.9.2015 for presentation to the Court on 16.9.15.</li> <li>• Scoping exercise has been completed should alternative placements be required and will</li> <li>• be revisited</li> <li>• Update Report to Trust Board on 27<sup>th</sup> August 2015</li> </ul> |  |  |
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|  |  | <p>Management issues within Social Care Contracts”.</p> <ul style="list-style-type: none"><li>• Ongoing processes with OCP / RQIA / NMC / HSCB re SAI, Disclosure &amp; Barring Service (DBS)</li><li>• Trust assumed responsibility for mobility monies which are now held in PPP accounts and payment is only made on receipt of verified invoices.</li><li>• New Trust Case Management Guidance and Training Programme completed.</li></ul> |  |  |  |
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**HSC BOARD PERFORMANCE REPORT – 2015/16 End of Year Assessment****Introduction**

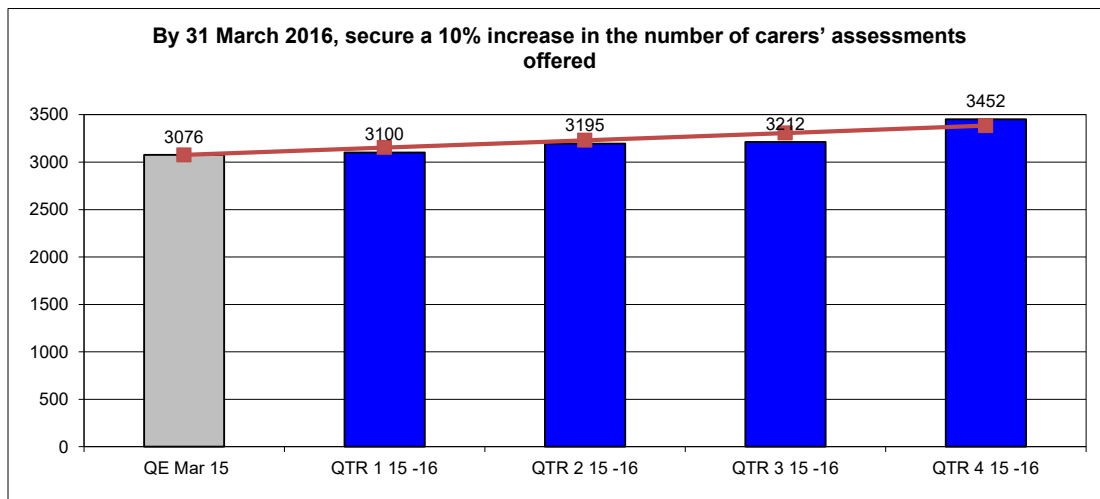
The purpose of this paper is to provide HSCB Board members with an end of year assessment of performance against the standards and targets set out in the Minister's Commissioning Plan Direction 2015/16 that the HSCB is responsible for monitoring and where end of year monitoring information is currently available.

Due to the three month period allowed to facilitate coding within Trusts, the end of year performance in relation to a small number of target areas (unplanned admissions, emergency readmissions, stroke/thrombolysis and excess bed days) is not available. Similarly, performance in relation to the two children in care standards/targets (placement change and adoption) will not be available until later in 2016/17 due to the annual reporting cycle associated with these target areas. An update on end of year performance in these areas will be provided at a future Board meeting.

Finally, an end of year assessment of Trusts' performance against the indicators set out in the Minister's Indicators of Performance Direction 2015/16 will be provided at the June Board meeting.

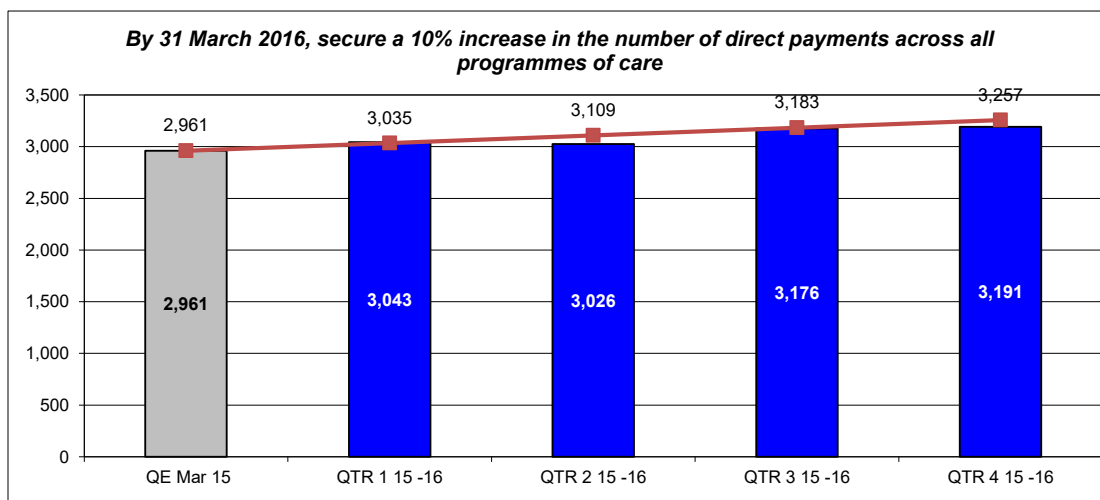
**Year-end Performance by Priority Area****PRIORITY AREA: TO PROVIDE HIGH QUALITY, SAFE AND EFFECTIVE CARE; TO LISTEN TO AND LEARN FROM PATIENT AND CLIENT EXPERIENCES; AND TO ENSURE HIGH LEVELS OF PATIENT AND CLIENT SATISFACTION**

- *Carers' assessments* – in order achieve the target to secure a 10% increase in the number of carers' assessments offered by March 2016 (compared to the position at the end of March 2015), Trusts were required to have offered 3,384 assessments – regionally at the end of March 2016, 3,452 carers' assessments had been offered.



| Trust         | Carers' assessments - 10% increase by March 2016 |                        |                      |                             |                               |
|---------------|--------------------------------------------------|------------------------|----------------------|-----------------------------|-------------------------------|
|               | Baseline (March 2015)                            | Target (by March 2016) | Actual at March 2016 | Variance (Actual vs Target) | % Variance (Actual vs Target) |
| Belfast       | 649                                              | 714                    | 805                  | 91                          | 13%                           |
| Northern      | 723                                              | 795                    | 626                  | -169                        | -21%                          |
| South Eastern | 585                                              | 644                    | 778                  | 135                         | 21%                           |
| Southern      | 762                                              | 838                    | 926                  | 88                          | 10%                           |
| Western       | 357                                              | 393                    | 317                  | -76                         | -19%                          |
| <b>Region</b> | <b>3,076</b>                                     | <b>3,384</b>           | <b>3,452</b>         | <b>68</b>                   | <b>2%</b>                     |

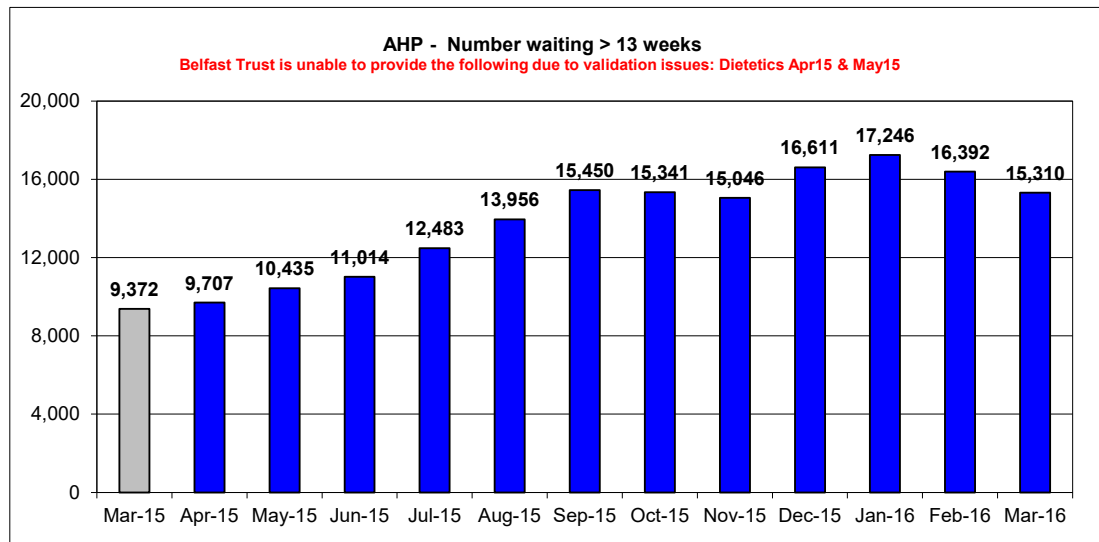
- **Direct Payments** – regionally at the end of March 2016, 3,191 direct payments were in place across all programmes of care. This represents an 8% increase on the position at the end of March 2015 (target: 10% increase)



| Trust         | Direct Payments - 10% increase by March 2016 |                        |                      |                             |                               |
|---------------|----------------------------------------------|------------------------|----------------------|-----------------------------|-------------------------------|
|               | Baseline (March 2015)                        | Target (by March 2016) | Actual at March 2016 | Variance (Actual vs Target) | % Variance (Actual vs Target) |
| Belfast       | 537                                          | 591                    | 541                  | -50                         | -8%                           |
| Northern      | 624                                          | 686                    | 659                  | -27                         | -4%                           |
| South Eastern | 618                                          | 680                    | 709                  | 29                          | 4%                            |
| Southern      | 742                                          | 816                    | 748                  | -68                         | -8%                           |
| Western       | 440                                          | 484                    | 534                  | 50                          | 10%                           |
| <b>Region</b> | <b>2,961</b>                                 | <b>3,257</b>           | <b>3,191</b>         | <b>-66</b>                  | <b>-2%</b>                    |



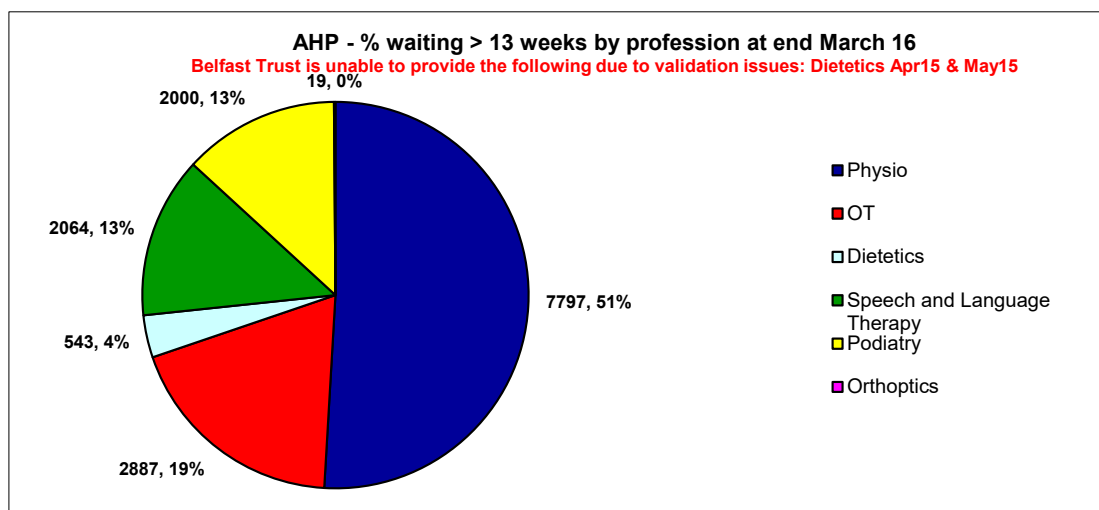
- **AHP** – at the end of March 2016, 15,310 patients were waiting longer than 13 weeks from referral to commencement of AHP treatment (standard: 13 weeks), compared with 9,372 at the end of March 2015.



| Trust         | Number of patients waiting >13wks (all AHP services) |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                                               | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 3,192                                                | 3,031  | 2,581  | 2,273  | 1,982  | 1,980  | 2,233  | 2,370  | 2,704  | 3,145  | 2,964  | 2,567  | 1,759  |
| Northern      | 2,665                                                | 2,832  | 3,384  | 4,057  | 4,966  | 5,619  | 5,792  | 5,697  | 5,664  | 6,275  | 6,817  | 6,947  | 7,214  |
| South Eastern | 156                                                  | 192    | 243    | 276    | 254    | 231    | 276    | 269    | 259    | 356    | 332    | 262    | 185    |
| Southern      | 1,436                                                | 1,636  | 2,032  | 2,173  | 2,591  | 3,043  | 3,931  | 3,840  | 3,446  | 3,627  | 3,859  | 3,629  | 3,459  |
| Western       | 1,923                                                | 2,016  | 2,195  | 2,235  | 2,690  | 3,083  | 3,218  | 3,165  | 2,973  | 3,208  | 3,274  | 2,987  | 2,693  |
| Region        | 9,372                                                | 9,707  | 10,435 | 11,014 | 12,483 | 13,956 | 15,450 | 15,341 | 15,046 | 16,611 | 17,246 | 16,392 | 15,310 |

Note 1: BHSCT figures exclude the following: dietetics - April 15 and May 15

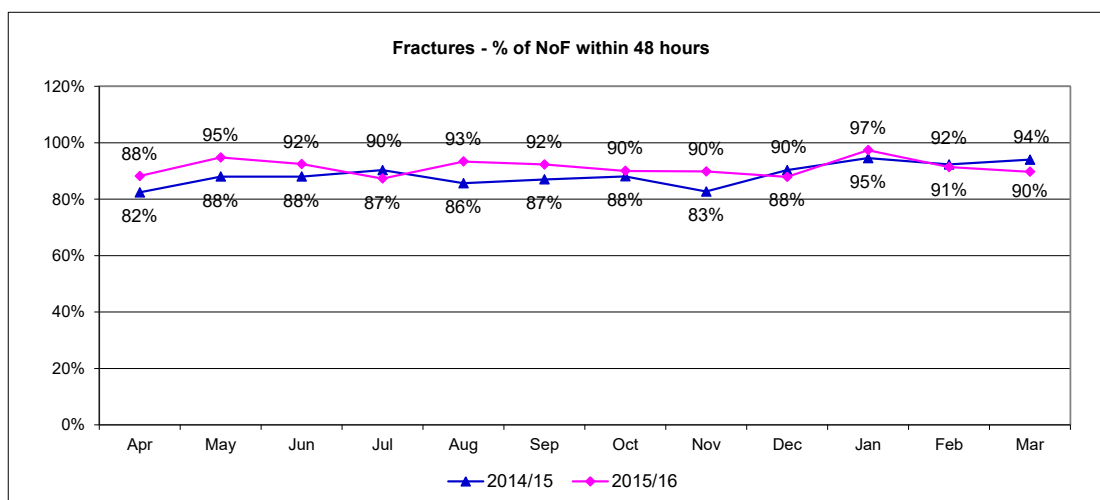
Regionally, almost 70% of the patients waiting longer than the 13-week maximum waiting time standard at the end of March 2016 continue to be in two AHP professions (physiotherapy and occupational therapy) – 7,797 and 2,887 patients were waiting longer than 13 weeks from referral to commencement of treatment for physiotherapy and occupational therapy respectively.



Over the last year, the HSCB and PHA have worked with Trusts to complete a demand and capacity exercise to ensure there is sufficient capacity in each of the AHP services to meet patient demand. This exercise has now been concluded and the HSCB and PHA will work with Trusts to agree the steps to be taken to implement the outcomes from the demand and capacity exercise and to address the waiting time position going forward, subject to the availability of funding.

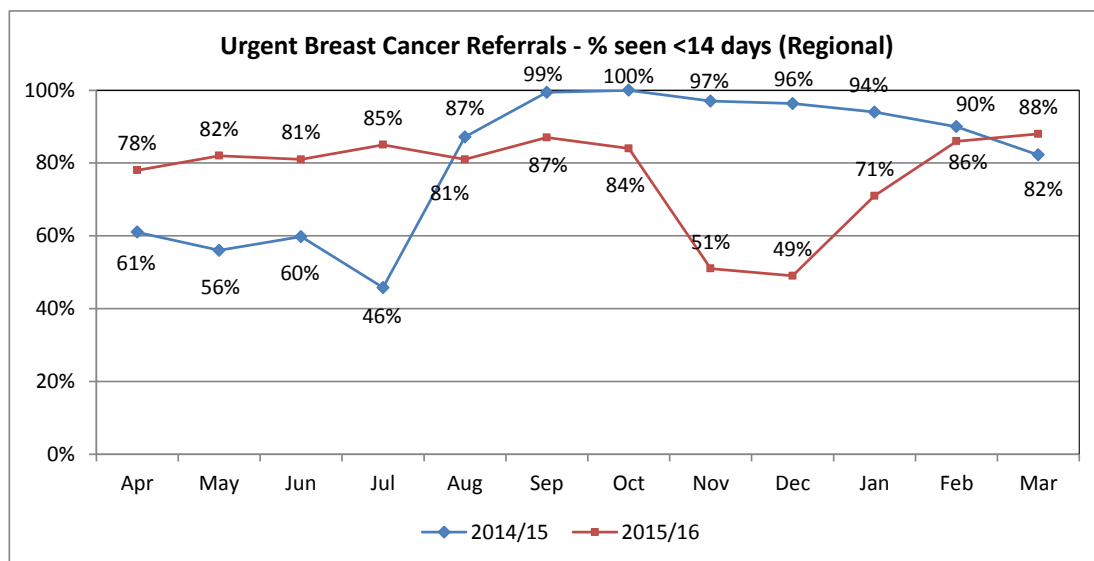
The HSCB allocated additional (non-recurrent) funding to Trusts from the November monitoring round to reduce the backlog of patients waiting for AHP services in-year. As a result of this funding, a large number of additional new and review patients received AHP treatment. If the increasing trend seen in the first ten months of 2015/16 had continued, c18,800 patients would have been waiting longer than 13 weeks at the end of March 2016. Therefore, the impact of the additionality associated with the non-recurrent funding reduced this forecast position by approximately 3,500.

- **Fractures** – during 2015/16, 91% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (standard: 95%). This represents an improvement from the position in 2014/15 (89%). The continued strong performance in Belfast Trust should be noted – 98% of patients were treated within 48 hours during 2015/16.



| Trust         | Fracture NoF- % within 48 hours |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|---------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                       | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 91%                             | 96%    | 99%    | 97%    | 96%    | 100%   | 99%    | 98%    | 100%   | 96%    | 100%   | 99%    | 94%    | 98%       |
| Northern      |                                 |        |        |        |        |        |        |        |        |        |        |        |        |           |
| South Eastern | 80%                             | 71%    | 85%    | 81%    | 68%    | 86%    | 83%    | 57%    | 64%    | 83%    | 94%    | 85%    | 81%    | 78%       |
| Southern      | 92%                             | 93%    | 88%    | 96%    | 97%    | 86%    | 93%    | 96%    | 92%    | 66%    | 95%    | 93%    | 97%    | 91%       |
| Western       | 89%                             | 85%    | 100%   | 88%    | 80%    | 96%    | 82%    | 91%    | 95%    | 97%    | 96%    | 84%    | 86%    | 89%       |
| Region        | 89%                             | 88%    | 95%    | 92%    | 87%    | 93%    | 92%    | 90%    | 90%    | 88%    | 97%    | 91%    | 90%    | 91%       |

- **Cancer (14 days)** – cumulatively during 2015/16, 76% of urgent breast cancer referrals were seen within 14 days compared to 81% during 2014/15.



| Trust         | Cancer Services (Breast) - % within 14 days |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|---------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                                   | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 83%                                         | 15%    | 20%    | 27%    | 26%    | 50%    | 80%    | 99%    | 32%    | 24%    | 37%    | 41%    | 67%    | 43%       |
| Northern      | 71%                                         | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   | 88%    | 16%    | 11%    | 58%    | 100%   | 95%    | 78%       |
| South Eastern | 68%                                         | 95%    | 81%    | 87%    | 90%    | 52%    | 43%    | 21%    | 23%    | 78%    | 99%    | 100%   | 75%    | 66%       |
| Southern      | 83%                                         | 100%   | 100%   | 100%   | 100%   | 99%    | 100%   | 100%   | 85%    | 45%    | 88%    | 100%   | 100%   | 93%       |
| Western       | 99%                                         | 100%   | 98%    | 100%   | 100%   | 100%   | 100%   | 100%   | 94%    | 100%   | 100%   | 100%   | 100%   | 99%       |
| Region        | 81%                                         | 78%    | 82%    | 81%    | 85%    | 81%    | 87%    | 84%    | 51%    | 49%    | 71%    | 86%    | 88%    | 76%       |

Regionally, performance against the 14-day breast cancer standard has continued to improve during the final quarter of 2015/16. During March 2016, 88% of urgent referrals were seen within 14 days compared to 49% in December 2015. Where patients were not seen within 14 days during March, the longest wait was 35 days in Belfast Trust.

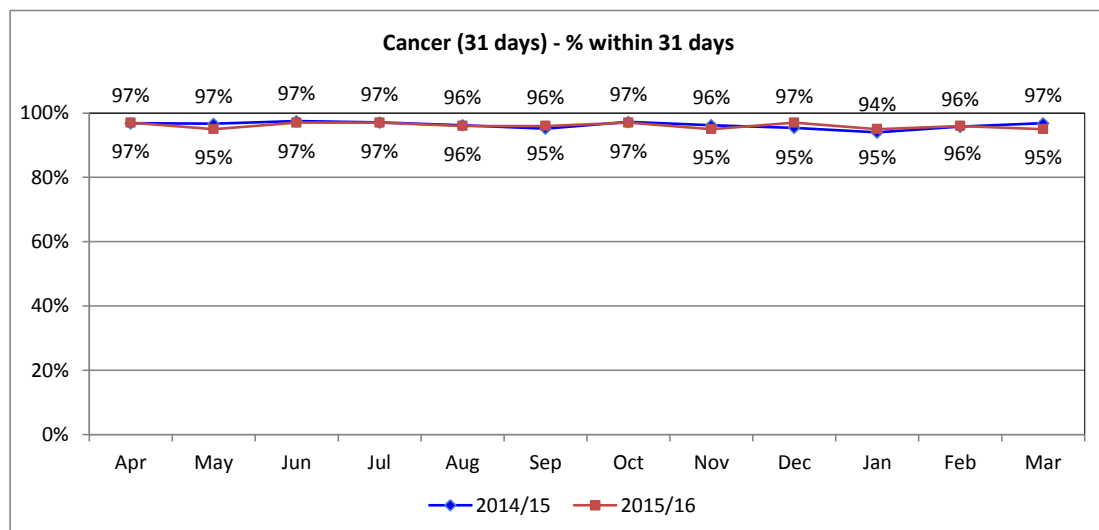
The continued strong performance in the Western Trust should be acknowledged – during 2015/16, 99% of urgent referrals were seen within 14 days.

As previously reported, the reduction in performance regionally in the second half of 2015/16 was largely due to a deterioration in performance in Belfast, Northern, South Eastern and Southern Trusts. The reasons for the deterioration and the measures put in place to improve performance have been detailed in previous reports and included staffing challenges in a number of Trusts and a significant increase in demand, in particular following breast cancer awareness month in October.

Performance returned to 100% in the Northern, South Eastern and Southern Trusts during February 2016 however, it has reduced to 95% and 75% in the Northern and South Eastern Trusts respectively in March.

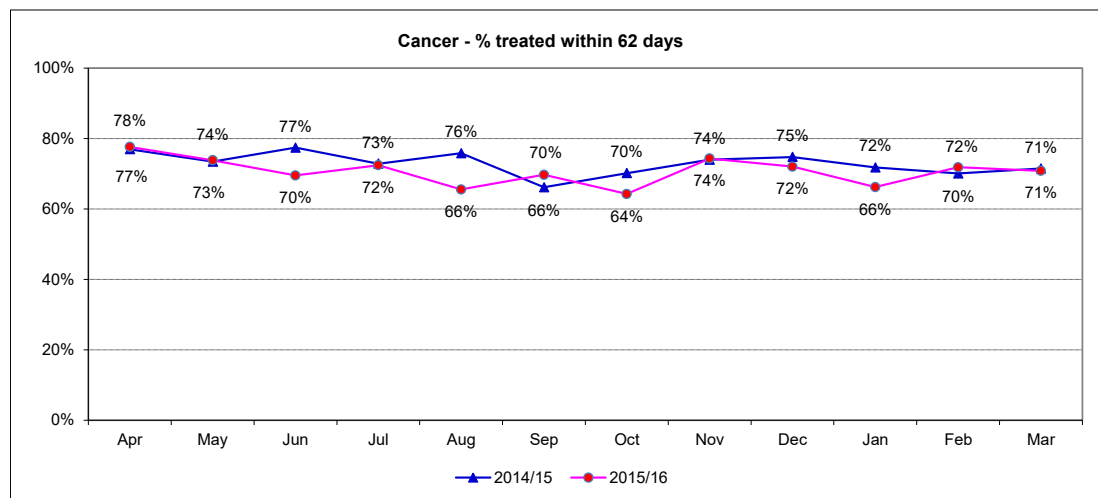
In relation to Belfast Trust, the Trust experienced a significant increase in urgent referrals following breast cancer awareness month in October and this has impacted on performance. As previously reported, the Trust has put additional clinics in place and, as a result, performance has improved to 67% in March (from 24% in December) and this improving trend is expected to continue. Furthermore, the HSCB has provided funding to the Trust for a fourth consultant breast surgeon and this will facilitate the operation of a fourth one-stop clinic from mid-April 2016. This will provide the Trust with the capacity to see a further 20 urgent or red-flag breast cancer referrals per week. The Trust has also continued the additional evening clinics throughout March and April to manage the urgent or red-flag referral demand.

- **Cancer (31 days)** – performance against the 31-day cancer access standard has continued to be strong – regionally during 2015/16, 96% of cancer patients commenced treatment within 31 days of the decision to treat (standard: 98%). This position is unchanged from 2014/15.



| Trust         | Cancer Services - % <31 days |        |        |        |        |        |        |        |        |        |        |        |        | 15/16 Cum |
|---------------|------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                    | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |           |
| Belfast       | 93%                          | 94%    | 92%    | 94%    | 94%    | 93%    | 94%    | 93%    | 92%    | 94%    | 90%    | 95%    | 90%    | 93%       |
| Northern      | 99%                          | 99%    | 99%    | 98%    | 97%    | 100%   | 99%    | 100%   | 91%    | 98%    | 96%    | 99%    | 99%    | 98%       |
| South Eastern | 97%                          | 96%    | 93%    | 96%    | 96%    | 97%    | 94%    | 100%   | 97%    | 97%    | 96%    | 92%    | 97%    | 96%       |
| Southern      | 99%                          | 100%   | 99%    | 99%    | 100%   | 99%    | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   | 100%   | 100%      |
| Western       | 100%                         | 100%   | 100%   | 100%   | 100%   | 100%   | 99%    | 99%    | 100%   | 100%   | 99%    | 100%   | 100%   | 100%      |
| Region        | 96%                          | 97%    | 95%    | 97%    | 97%    | 96%    | 96%    | 97%    | 95%    | 97%    | 95%    | 96%    | 95%    | 96%       |

- **Cancer (62 days)** – regionally during 2015/16, 71% of patients urgently referred with a suspected cancer began their first definitive treatment within 62 days (standard: 95%), compared with 73% in 2014/15.



| Trust         | Cancer Services - % <62 days |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                    | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 66%                          | 71%    | 66%    | 57%    | 65%    | 56%    | 56%    | 46%    | 63%    | 55%    | 53%    | 56%    | 58%    | 58%       |
| Northern      | 68%                          | 81%    | 72%    | 73%    | 77%    | 60%    | 63%    | 70%    | 76%    | 76%    | 62%    | 81%    | 67%    | 72%       |
| South Eastern | 64%                          | 61%    | 60%    | 62%    | 62%    | 57%    | 61%    | 57%    | 54%    | 71%    | 59%    | 54%    | 59%    | 60%       |
| Southern      | 85%                          | 91%    | 92%    | 84%    | 87%    | 82%    | 95%    | 77%    | 87%    | 91%    | 86%    | 90%    | 91%    | 88%       |
| Western       | 92%                          | 95%    | 89%    | 88%    | 87%    | 89%    | 89%    | 90%    | 95%    | 87%    | 92%    | 99%    | 89%    | 91%       |
| Region        | 73%                          | 78%    | 74%    | 70%    | 72%    | 66%    | 70%    | 64%    | 74%    | 72%    | 66%    | 72%    | 71%    | 71%       |

As previously reported, the majority of patients actively waiting longer than 62 days are on the urological, skin, lower GI and upper GI cancer pathways – at end of March 2016, 91% (443 of 486) of patients waiting more than 62 days were on a red flag pathway across these tumour groups. Given the ongoing workforce and capacity issues in these tumour sites, a number of specialty-specific regional groups involving representation from the HSCB, PHA and Trusts have been established and work is being taken forward in these fora to develop innovative long term solutions to these issues.

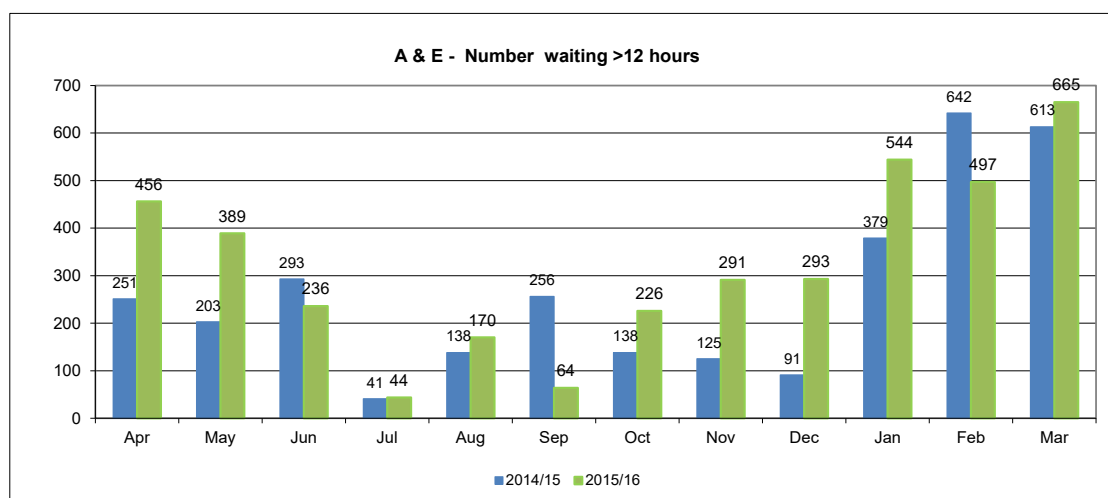
In parallel, the HSCB is continuing to meet with all Trusts on a monthly basis via the cancer service improvement and AD forum to share best practice across the region and identify opportunities for delivering improved performance pending implementation of long term solutions.

While there has been no sustainable improvement in performance against the 62-day cancer access standard in 2015/16, there have been improvements in individual parts of specific pathways. For example, the HSCB provided non-recurrent funding to the Northern Trust to target endoscopy waits in upper and lower GI. As a result, the

number of patients waiting longer than 62 days on the lower GI red flag pathway has reduced from 63 at the start of January 2016 to 30 in March and, the number waiting longer than 62 days on the upper GI red flag pathway has reduced from 44 to six during the same period.

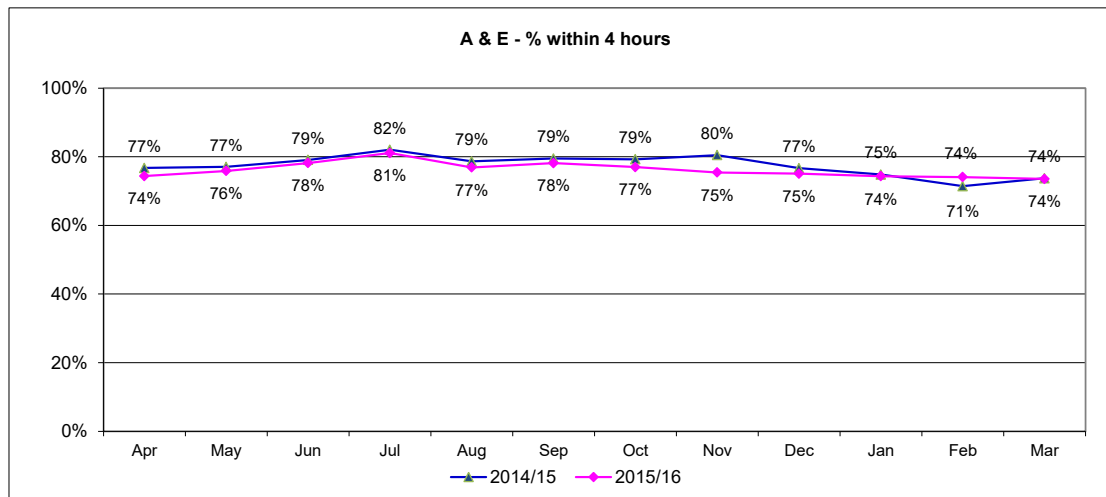
In addition, the number of patients waiting longer than 62 days on the urological cancer pathway has reduced from 227 in July 2015 to 128 at the end of March 2016. This is as a result of a number of consultants undertaking additional evening and weekend activity, predominantly in Belfast and South Eastern Trusts.

- A&E (4-hour and 12-hour standards)** – regionally during 2015/16, there has been an increase in the number of patients who waited longer than 12 hours in ED (3,875) compared to 2014/15 (3,170). During 2015/16, there has been an increase in the number of patients waiting longer than 12 hours in four of the five Trusts, with only Belfast Trust achieving a reduction in the number of patients who waited longer than 12 hours – 917 in 2015/16 compared to 1,756 in 2014/15.



| Trust         | A&E - No waiting >12 hours |        |        |        |        |        |        |        |        |        |        |        |           | 2014/15 |           |
|---------------|----------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|---------|-----------|
|               | 2015/16                    |        |        |        |        |        |        |        |        |        |        |        |           | Mar-15  | 14/15 Cum |
|               | Apr-15                     | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |         |           |
| Belfast       | 223                        | 212    | 95     | 21     | 34     | 16     | 22     | 9      | 18     | 128    | 68     | 71     | 917       | 312     | 1,756     |
| Northern      | 78                         | 75     | 5      | 0      | 10     | 1      | 85     | 179    | 89     | 124    | 144    | 297    | 1,087     | 194     | 663       |
| South Eastern | 149                        | 100    | 136    | 23     | 124    | 28     | 106    | 96     | 175    | 212    | 221    | 236    | 1,606     | 100     | 713       |
| Southern      | 1                          | 0      | 0      | 0      | 0      | 0      | 8      | 2      | 2      | 48     | 22     | 10     | 93        | 1       | 14        |
| Western       | 5                          | 2      | 0      | 0      | 2      | 19     | 5      | 5      | 9      | 32     | 42     | 51     | 172       | 6       | 24        |
| Region        | 456                        | 389    | 236    | 44     | 170    | 64     | 226    | 291    | 293    | 544    | 497    | 665    | 3,875     | 613     | 3,170     |

In relation to the 4-hour standard, regionally during 2015/16, 76% of patients were treated and discharged, or admitted within four hours compared with 78% during 2014/15.

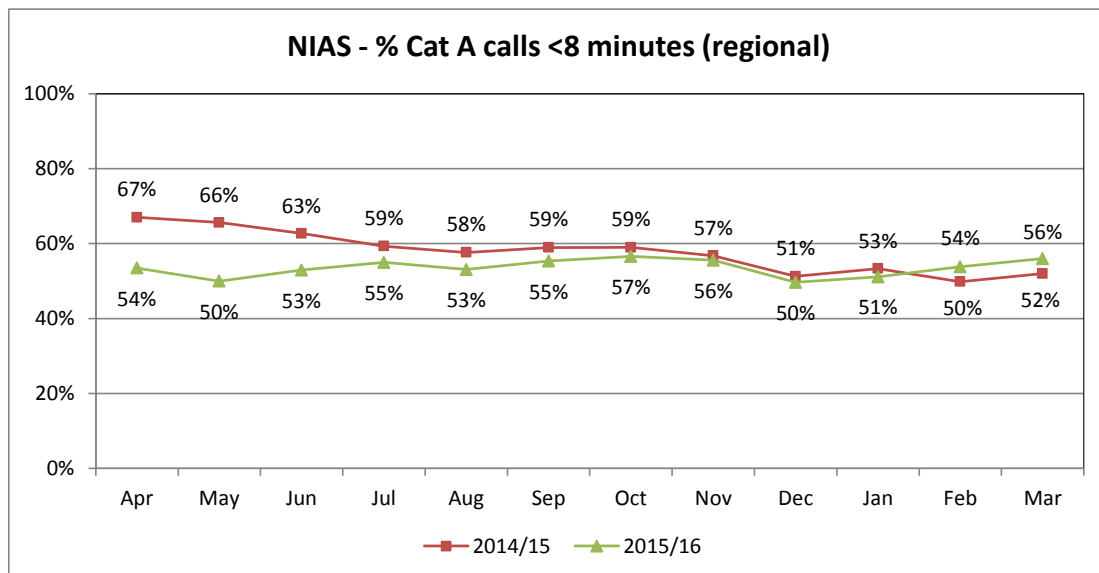


| Trust         | A&E - % <4 hours |        |        |        |        |        |        |        |        |        |        |        |           |         |           |  |
|---------------|------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|---------|-----------|--|
|               | 2015/16          |        |        |        |        |        |        |        |        |        |        |        |           | 2014/15 |           |  |
|               | Apr-15           | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum | Mar-15  | 14/15 Cum |  |
| Belfast       | 72%              | 73%    | 78%    | 81%    | 76%    | 77%    | 76%    | 76%    | 75%    | 75%    | 74%    | 73%    | 76%       | 69%     | 72%       |  |
| Northern      | 64%              | 64%    | 68%    | 69%    | 65%    | 70%    | 68%    | 65%    | 65%    | 69%    | 67%    | 65%    | 66%       | 64%     | 71%       |  |
| South Eastern | 79%              | 82%    | 81%    | 84%    | 79%    | 82%    | 81%    | 79%    | 80%    | 78%    | 78%    | 79%    | 80%       | 80%     | 81%       |  |
| Southern      | 80%              | 83%    | 81%    | 86%    | 83%    | 82%    | 80%    | 78%    | 79%    | 75%    | 77%    | 77%    | 80%       | 80%     | 84%       |  |
| Western       | 78%              | 77%    | 82%    | 85%    | 82%    | 80%    | 80%    | 78%    | 75%    | 74%    | 73%    | 73%    | 78%       | 77%     | 83%       |  |
| Region        | 74%              | 76%    | 78%    | 81%    | 77%    | 78%    | 77%    | 75%    | 75%    | 74%    | 74%    | 74%    | 76%       | 74%     | 78%       |  |

It should be noted that regionally during 2015/16 there was a 4.3% (30,350) increase in ED attendances compared with 2014/15, with a particular increase in Q4 of this year compared to last year (9% (15,282)).

Improving performance against the 4 and 12 hour standards remains a priority for the HSCB and it is continuing to work with Trusts under the new regional unscheduled care arrangements, jointly led by the HSCB and PHA, to take this work forward.

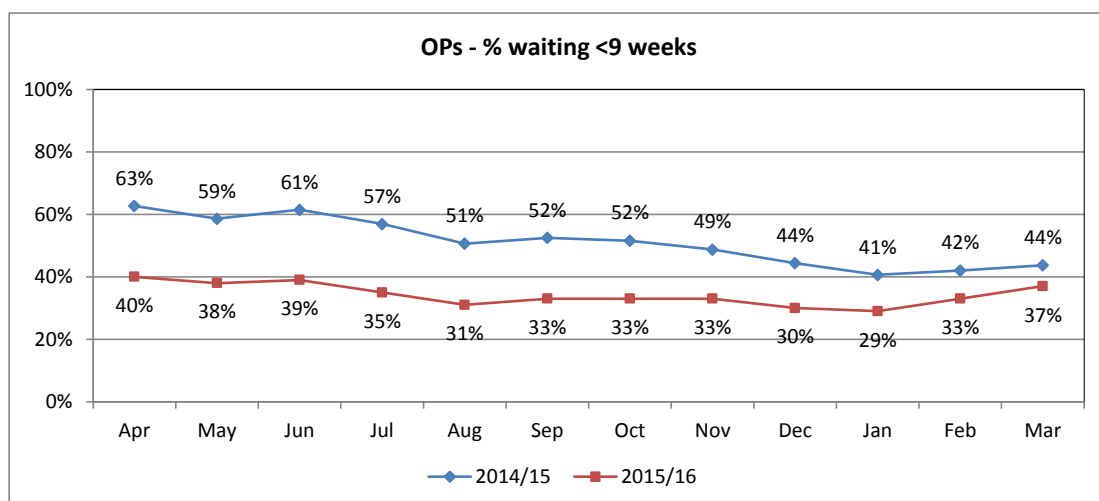
- **Ambulance Response Times** – regionally during 2015/16, 54% of Category A calls were responded to within eight minutes (target: 72.5% by March 2016 and 67.5% in each LCG area). This performance compares with 58% during 2014/15. It should however be noted that performance has improved month on month since December 2015.



| LCG           | % Cat A calls within 8 minutes |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|--------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                      | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 69%                            | 65%    | 59%    | 64%    | 67%    | 64%    | 66%    | 69%    | 65%    | 59%    | 62%    | 63%    | 68%    | 64%       |
| Northern      | 52%                            | 47%    | 42%    | 48%    | 47%    | 47%    | 47%    | 49%    | 49%    | 39%    | 44%    | 47%    | 48%    | 46%       |
| South Eastern | 53%                            | 46%    | 44%    | 43%    | 50%    | 45%    | 50%    | 54%    | 50%    | 44%    | 46%    | 49%    | 51%    | 48%       |
| Southern      | 53%                            | 49%    | 51%    | 47%    | 50%    | 49%    | 50%    | 51%    | 54%    | 46%    | 43%    | 48%    | 51%    | 49%       |
| Western       | 60%                            | 58%    | 54%    | 61%    | 60%    | 57%    | 60%    | 57%    | 59%    | 58%    | 59%    | 58%    | 58%    | 58%       |
| Region        | 58%                            | 54%    | 50%    | 53%    | 55%    | 53%    | 55%    | 57%    | 56%    | 50%    | 51%    | 54%    | 56%    | 54%       |

- Elective Care (including Diagnostics)* – there has been a significant improvement in elective care waiting times during the final quarter of 2015/16.

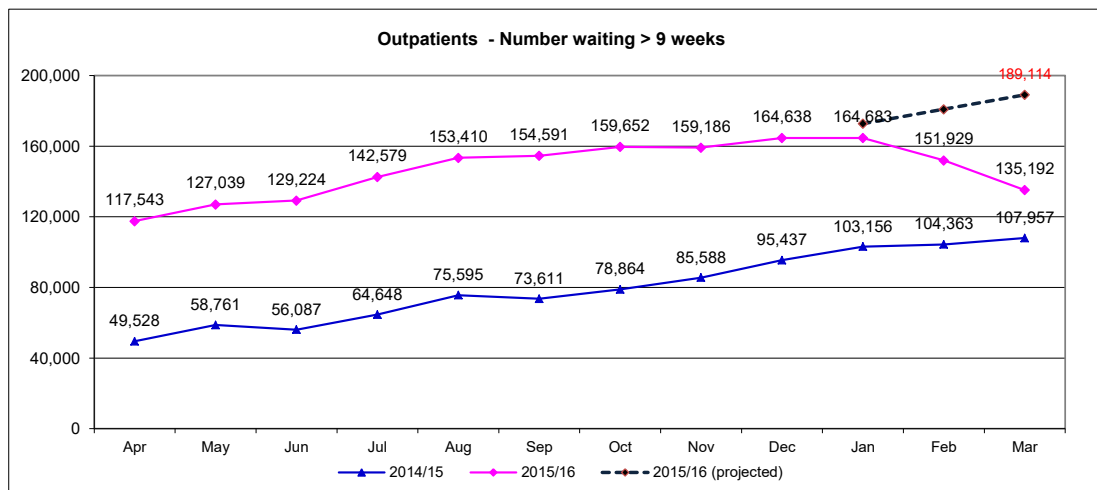
The proportion of patients waiting less than nine weeks for a first outpatient appointment has increased from 30% at the end of December 2015 to 37% at the end of March 2016. This compares with 44% at the end of March 2015.



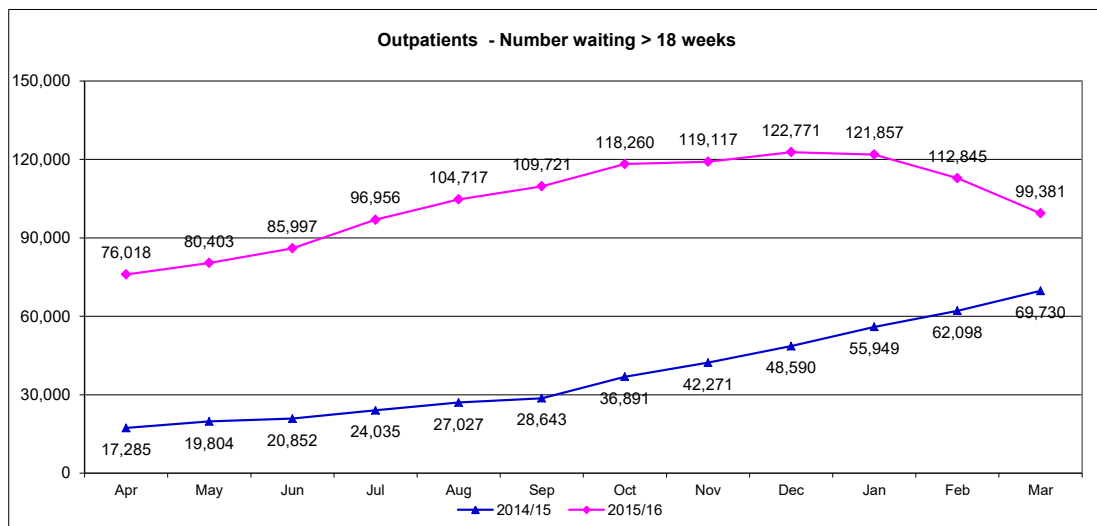
| Trust         | OP - % waiting <9 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|-------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                  | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 39%                     | 36%    | 35%    | 35%    | 31%    | 29%    | 30%    | 31%    | 31%    | 27%    | 26%    | 28%    | 32%    |
| Northern      | 46%                     | 43%    | 40%    | 41%    | 37%    | 30%    | 36%    | 35%    | 36%    | 33%    | 35%    | 41%    | 47%    |
| South Eastern | 42%                     | 39%    | 36%    | 36%    | 33%    | 26%    | 29%    | 28%    | 29%    | 26%    | 26%    | 30%    | 35%    |
| Southern      | 48%                     | 45%    | 42%    | 44%    | 40%    | 35%    | 37%    | 36%    | 38%    | 36%    | 34%    | 38%    | 40%    |
| Western       | 54%                     | 50%    | 47%    | 49%    | 45%    | 42%    | 40%    | 40%    | 40%    | 37%    | 36%    | 39%    | 43%    |
| Region        | 44%                     | 40%    | 38%    | 39%    | 35%    | 31%    | 33%    | 33%    | 33%    | 30%    | 29%    | 33%    | 37%    |



The number of patients waiting longer than nine weeks for a first outpatient appointment has reduced from 164,638 at the end of December 2015 to 135,192 at the end of March 2016 (-29,446 (19%)) and the number waiting longer than 18 weeks has reduced by 23,390 (19%) from 122,771 at the end of December to 99,381 at the end of March. The end of March 2016 position compares with 107,955 and 69,730 patients waiting longer than nine and 18 weeks respectively at the end of March 2015.

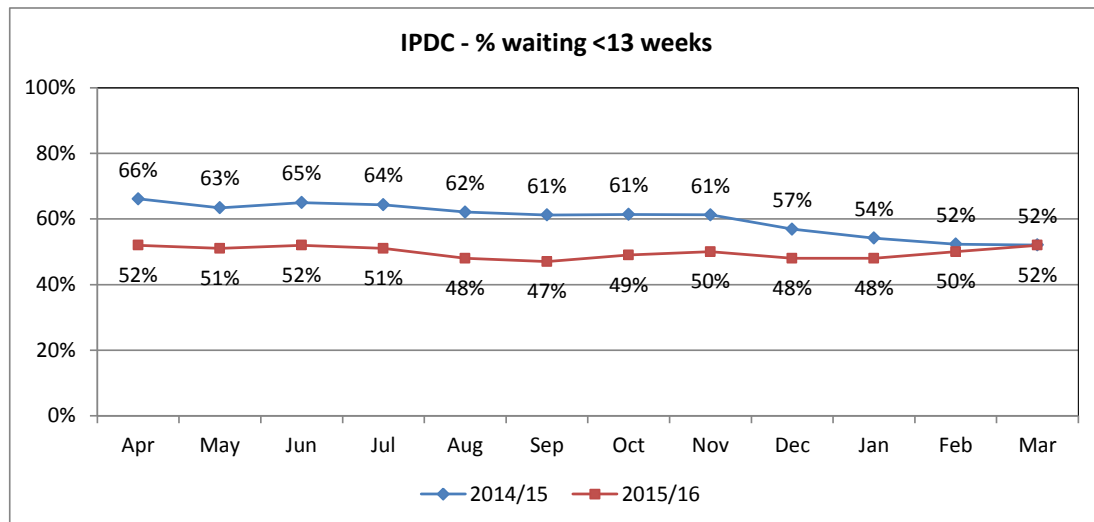


| Trust         | OP No waiting >9 weeks |                |                |                |                |                |                |                |                |                |                |                |                |
|---------------|------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
|               | Mar-15                 | Apr-15         | May-15         | Jun-15         | Jul-15         | Aug-15         | Sep-15         | Oct-15         | Nov-15         | Dec-15         | Jan-16         | Feb-16         | Mar-16         |
| Belfast       | 47,748                 | 50,833         | 53,845         | 55,352         | 60,004         | 63,461         | 63,912         | 65,560         | 66,013         | 69,180         | 69,890         | 67,392         | 59,234         |
| Northern      | 13,589                 | 15,766         | 16,845         | 16,382         | 18,196         | 20,166         | 19,079         | 20,871         | 20,840         | 20,031         | 19,291         | 15,863         | 12,597         |
| South Eastern | 20,457                 | 22,884         | 25,212         | 26,324         | 29,234         | 32,097         | 33,235         | 34,599         | 34,754         | 36,502         | 35,938         | 32,254         | 27,178         |
| Southern      | 15,950                 | 17,274         | 18,684         | 18,613         | 20,376         | 22,103         | 22,124         | 22,350         | 21,544         | 21,585         | 22,606         | 20,102         | 20,408         |
| Western       | 10,213                 | 10,786         | 12,453         | 12,553         | 14,769         | 15,583         | 16,241         | 16,272         | 16,035         | 17,340         | 16,958         | 16,318         | 15,775         |
| <b>Region</b> | <b>107,957</b>         | <b>117,543</b> | <b>127,039</b> | <b>129,224</b> | <b>142,579</b> | <b>153,410</b> | <b>154,591</b> | <b>159,652</b> | <b>159,186</b> | <b>164,638</b> | <b>164,683</b> | <b>151,929</b> | <b>135,192</b> |



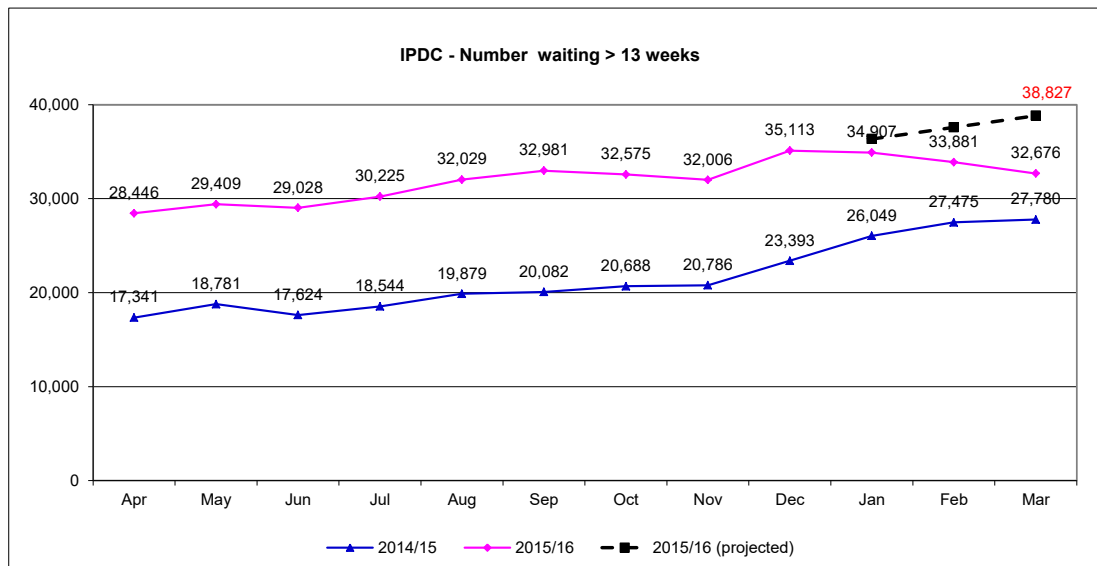
| Trust         | OP No waiting >18 weeks |               |               |               |               |                |                |                |                |                |                |                |               |
|---------------|-------------------------|---------------|---------------|---------------|---------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|---------------|
|               | Mar-15                  | Apr-15        | May-15        | Jun-15        | Jul-15        | Aug-15         | Sep-15         | Oct-15         | Nov-15         | Dec-15         | Jan-16         | Feb-16         | Mar-16        |
| Belfast       | 33,851                  | 35,426        | 37,221        | 39,958        | 43,262        | 46,232         | 48,189         | 51,147         | 51,807         | 53,839         | 54,758         | 54,285         | 47,065        |
| Northern      | 8,519                   | 10,146        | 10,545        | 10,675        | 12,331        | 13,564         | 13,357         | 15,142         | 15,301         | 14,722         | 13,661         | 10,883         | 8,370         |
| South Eastern | 13,052                  | 14,765        | 15,848        | 17,455        | 20,125        | 22,158         | 23,963         | 25,894         | 26,175         | 27,768         | 26,994         | 23,818         | 19,476        |
| Southern      | 8,309                   | 9,173         | 9,616         | 10,148        | 12,057        | 13,216         | 13,676         | 14,787         | 14,475         | 14,416         | 14,855         | 12,521         | 13,363        |
| Western       | 5,999                   | 6,508         | 7,173         | 7,761         | 9,181         | 9,547          | 10,536         | 11,290         | 11,359         | 12,026         | 11,589         | 11,338         | 11,107        |
| <b>Region</b> | <b>69,730</b>           | <b>76,018</b> | <b>80,403</b> | <b>85,997</b> | <b>96,956</b> | <b>104,717</b> | <b>109,721</b> | <b>118,260</b> | <b>119,117</b> | <b>122,771</b> | <b>121,857</b> | <b>112,845</b> | <b>99,381</b> |

The proportion of patients waiting less than 13 weeks for inpatient or daycase treatment has increased from 48% at the end of December 2015 to 52% at the end of March 2016. This is unchanged from the position at the end of March 2015.

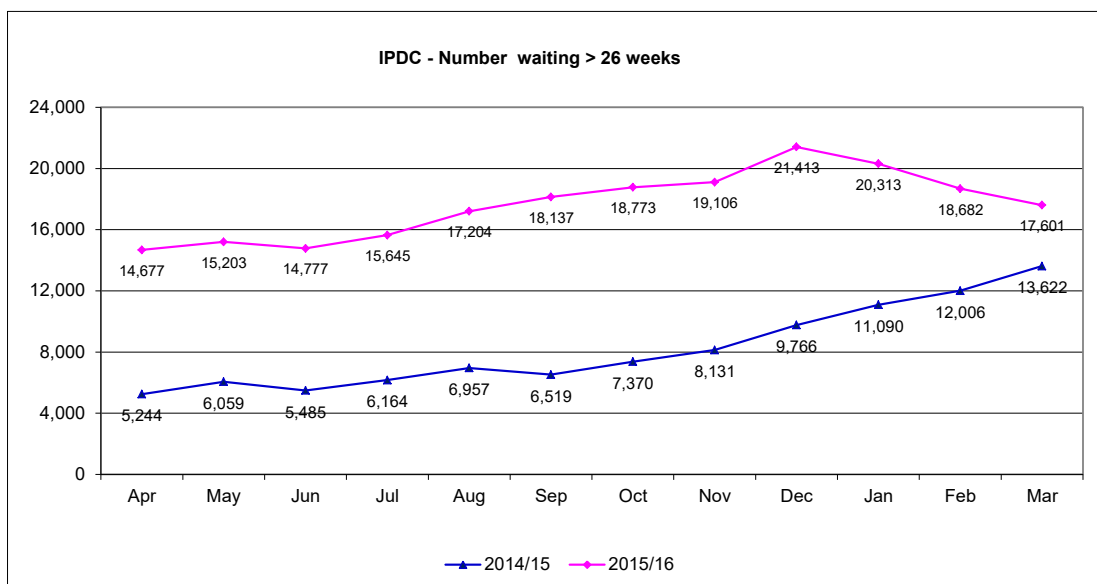


| Trust         | IPDC - % waiting <13 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|----------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                     | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 40%                        | 40%    | 39%    | 40%    | 40%    | 39%    | 37%    | 39%    | 41%    | 38%    | 38%    | 39%    | 43%    |
| Northern      | 76%                        | 78%    | 77%    | 76%    | 74%    | 73%    | 74%    | 74%    | 73%    | 70%    | 70%    | 72%    | 71%    |
| South Eastern | 57%                        | 56%    | 54%    | 54%    | 51%    | 48%    | 46%    | 46%    | 48%    | 47%    | 46%    | 49%    | 52%    |
| Southern      | 69%                        | 67%    | 63%    | 64%    | 61%    | 56%    | 56%    | 60%    | 63%    | 62%    | 61%    | 62%    | 64%    |
| Western       | 55%                        | 54%    | 54%    | 54%    | 52%    | 50%    | 49%    | 49%    | 49%    | 48%    | 49%    | 49%    | 50%    |
| Region        | 52%                        | 52%    | 51%    | 52%    | 51%    | 48%    | 47%    | 49%    | 50%    | 48%    | 48%    | 50%    | 52%    |

The number of patients waiting longer than 13 weeks for treatment has reduced from 35,113 at the end of December 2015 to 32,676 at the end of March 2016, a reduction of 2,437 (7%) and the number waiting longer than 26 weeks has reduced by 3,812 (18%) from 21,413 at the end of December to 17,601 at the end of March. This compares with 27,780 and 13,622 patients waiting longer than 13 and 26 weeks respectively at the end of March 2015.

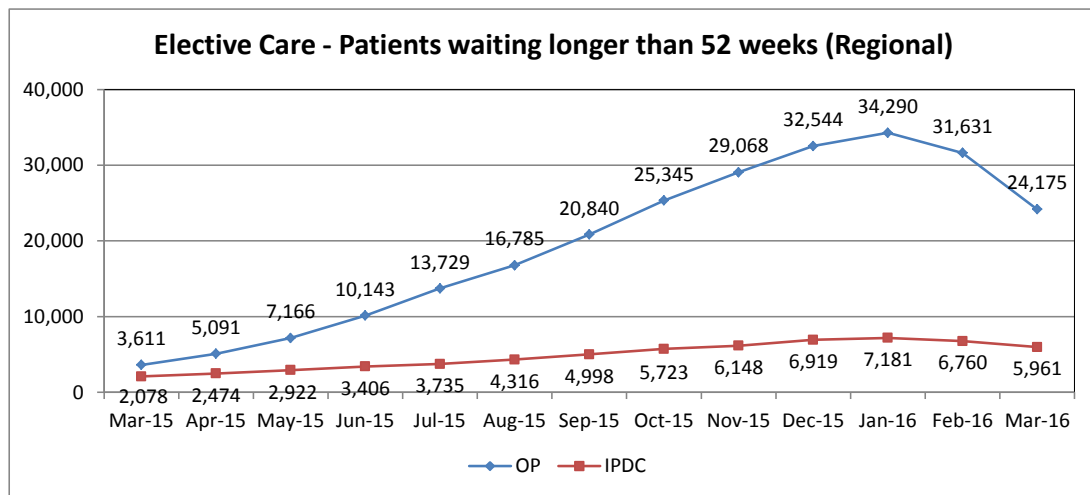


| Trust         | IPDC - No waiting >13 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|-----------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                      | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 16,448                      | 16,528 | 16,504 | 15,983 | 15,970 | 16,599 | 17,194 | 16,982 | 16,539 | 18,648 | 17,855 | 17,252 | 16,542 |
| Northern      | 1,419                       | 1,341  | 1,540  | 1,613  | 1,705  | 1,866  | 1,861  | 1,899  | 1,957  | 2,321  | 2,424  | 2,408  | 2,684  |
| South Eastern | 2,966                       | 3,215  | 3,449  | 3,577  | 3,956  | 4,210  | 4,363  | 4,442  | 4,471  | 4,685  | 5,060  | 4,733  | 4,443  |
| Southern      | 2,541                       | 2,783  | 3,191  | 3,221  | 3,597  | 3,990  | 3,991  | 3,544  | 3,265  | 3,446  | 3,496  | 3,379  | 3,154  |
| Western       | 4,406                       | 4,579  | 4,725  | 4,634  | 4,997  | 5,364  | 5,572  | 5,708  | 5,774  | 6,013  | 6,072  | 6,109  | 5,853  |
| Region        | 27,780                      | 28,446 | 29,409 | 29,028 | 30,225 | 32,029 | 32,981 | 32,575 | 32,006 | 35,113 | 34,907 | 33,881 | 32,676 |



| Trust         | IPDC - No waiting >26 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|-----------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                      | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 8,631                       | 9,192  | 9,255  | 8,738  | 8,888  | 9,588  | 10,104 | 10,350 | 10,298 | 11,954 | 10,672 | 9,810  | 9,303  |
| Northern      | 329                         | 342    | 353    | 284    | 254    | 302    | 326    | 338    | 370    | 501    | 563    | 607    | 728    |
| South Eastern | 1,380                       | 1,520  | 1,732  | 1,901  | 2,203  | 2,429  | 2,614  | 2,784  | 2,910  | 3,143  | 3,413  | 3,012  | 2,634  |
| Southern      | 1,162                       | 1,216  | 1,316  | 1,266  | 1,484  | 1,832  | 1,856  | 1,776  | 1,808  | 1,855  | 1,755  | 1,561  | 1,427  |
| Western       | 2,120                       | 2,407  | 2,547  | 2,588  | 2,816  | 3,053  | 3,237  | 3,525  | 3,720  | 3,960  | 3,910  | 3,692  | 3,509  |
| Region        | 13,622                      | 14,677 | 15,203 | 14,777 | 15,645 | 17,204 | 18,137 | 18,773 | 19,106 | 21,413 | 20,313 | 18,682 | 17,601 |

The number of patients waiting longer than 52 weeks for assessment or treatment has also reduced during Q4 – at the end of March 2016, 24,175 patients were waiting longer than 52 weeks for an outpatient assessment compared to 32,544 at the end of December (-8,369 (26%)) and 5,961 were waiting longer than a year for surgery compared with 6,919 at the end of December (-958 (14%)).



| Trust         | OP No waiting >52 weeks |              |              |               |               |               |               |               |               |               |               |               |               |
|---------------|-------------------------|--------------|--------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
|               | Mar-15                  | Apr-15       | May-15       | Jun-15        | Jul-15        | Aug-15        | Sep-15        | Oct-15        | Nov-15        | Dec-15        | Jan-16        | Feb-16        | Mar-16        |
| Belfast       | 2,808                   | 3,721        | 4,895        | 6,763         | 8,426         | 9,899         | 12,072        | 14,067        | 16,137        | 18,156        | 19,771        | 20,252        | 15,431        |
| Northern      | 125                     | 253          | 386          | 510           | 968           | 1,390         | 1,465         | 2,297         | 2,796         | 2,696         | 2,330         | 1,643         | 651           |
| South Eastern | 477                     | 676          | 862          | 1,162         | 1,851         | 2,532         | 3,414         | 4,378         | 4,924         | 5,715         | 5,960         | 5,182         | 3,850         |
| Southern      | 4                       | 93           | 408          | 745           | 1,138         | 1,470         | 1,874         | 2,270         | 2,501         | 2,883         | 3,146         | 1,377         | 1,696         |
| Western       | 197                     | 348          | 615          | 963           | 1,346         | 1,494         | 2,015         | 2,333         | 2,710         | 3,094         | 3,083         | 3,177         | 2,547         |
| <b>Region</b> | <b>3,611</b>            | <b>5,091</b> | <b>7,166</b> | <b>10,143</b> | <b>13,729</b> | <b>16,785</b> | <b>20,840</b> | <b>25,345</b> | <b>29,068</b> | <b>32,544</b> | <b>34,290</b> | <b>31,631</b> | <b>24,175</b> |

| Trust         | IPDC - No waiting >52 weeks |              |              |              |              |              |              |              |              |              |              |              |              |
|---------------|-----------------------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
|               | Mar-15                      | Apr-15       | May-15       | Jun-15       | Jul-15       | Aug-15       | Sep-15       | Oct-15       | Nov-15       | Dec-15       | Jan-16       | Feb-16       | Mar-16       |
| Belfast       | 1,633                       | 1,866        | 2,098        | 2,335        | 2,548        | 2,742        | 2,971        | 3,235        | 3,262        | 3,727        | 3,521        | 3,344        | 3,097        |
| Northern      | 4                           | 13           | 15           | 17           | 20           | 24           | 17           | 5            | 5            | 8            | 29           | 36           | 26           |
| South Eastern | 151                         | 191          | 256          | 333          | 425          | 488          | 636          | 804          | 980          | 1,127        | 1,437        | 1,308        | 1,074        |
| Southern      | 122                         | 148          | 190          | 223          | 267          | 347          | 426          | 504          | 564          | 582          | 644          | 575          | 446          |
| Western       | 168                         | 256          | 363          | 498          | 475          | 715          | 948          | 1,175        | 1,337        | 1,475        | 1,550        | 1,497        | 1,318        |
| <b>Region</b> | <b>2,078</b>                | <b>2,474</b> | <b>2,922</b> | <b>3,406</b> | <b>3,735</b> | <b>4,316</b> | <b>4,998</b> | <b>5,723</b> | <b>6,148</b> | <b>6,919</b> | <b>7,181</b> | <b>6,760</b> | <b>5,961</b> |

The increase in waiting times during the first nine months of 2015/16 was due to a combination of: a continued increase in demand for elective care services; an underdelivery of commissioned volumes of core activity by Trusts across a range of specialties; and, the unavailability of non-recurrent funding to enable Trusts to undertake additional activity to maintain waiting times in elective care specialties where there was an agreed recurrent gap between demand and funded capacity.

The reduction in the number of patients waiting longer than the maximum waiting time standards for elective care during the latter part of 2015/16 is as a result of the impact of the additional activity associated with the non-recurrent funding allocated in November 2015. As indicated previously, this funding was used by Trusts to undertake additional activity both in-house and in the Independent Sector (IS) during the final quarter of the year, with the majority of the activity being done in February and March, and was targeted at those patients who had been waiting the longest for assessment and/or treatment as evidenced by the level of reduction in the number of patients waiting longer than the maximum waiting time standards (18/26 weeks) and those waiting longer than a year.

If the increasing trend seen in the first nine months of 2015/16 had continued, c189,000 outpatients would have been waiting longer than nine weeks and c39,000 patients would have been waiting longer than 13 weeks for treatment at the end of March 2016. The additionality associated with the non-recurrent funding reduced this forecast position by c54,000 9-week waiters (OP) and c6,000 13-week waiters (IPDC) .

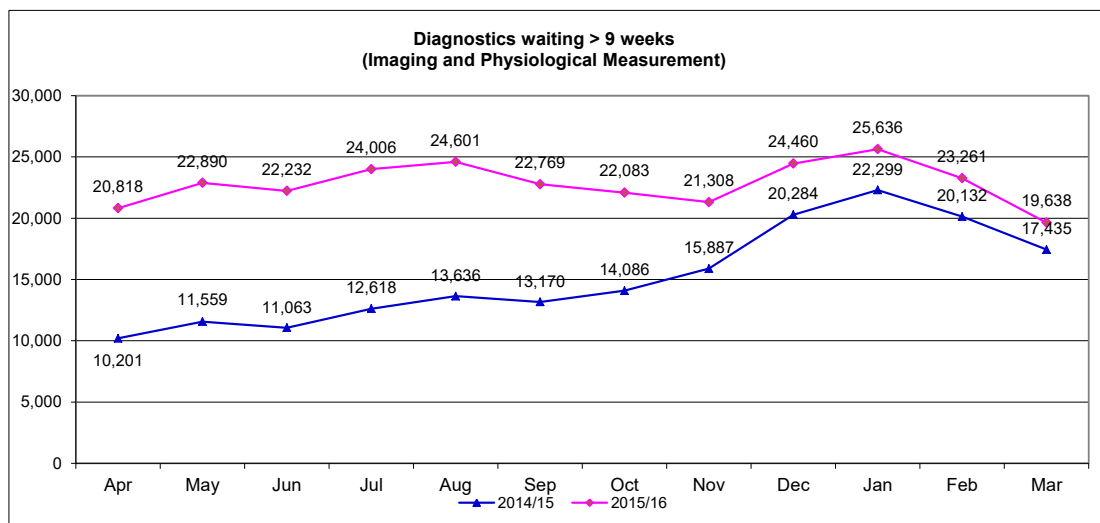
In addition, a substantial number of patients seen in 2015/16 as new outpatients and who require surgery will be treated during the first half of 2016/17. Trusts have also been asked to put arrangements in place to continue to undertake additional in-house activity during Q1 of 2016/17.

There has been a continued improvement in the delivery of commissioned volumes of core activity for new outpatient assessments – regionally during 2015/16, there has been a 6.5% (26,362) underdelivery of core activity compared to 7.0% in 2014/15. In relation to delivery of commissioned volumes of inpatient/daycase volumes, there has been a 7.9% (12,233) underdelivery of core activity in 2015/16. While this is a slight deterioration on last year (6.8%), it represents an improvement on the position earlier in the year (August 2015) when there was a 9.6% underdelivery of core.

As previously reported, the process put in place in 2015/16 where Trusts were required to submit weekly improvement plans detailing the forecast improvement in the delivery of core for specialties where there had been a continued material underdelivery of core has contributed to this improved position. The HSCB has met with all Trusts to review the delivery of core position for 2015/16 compared to 2014/15 and improvement plans have been requested for a number of specialties for the first half of 2016/17. These are currently being considered by the HSCB and, where Trusts' plans indicate a satisfactory level of improvement by the end of September 2016, performance will be monitored at the regular performance meetings with Trusts to ensure that progress is being made to deliver the agreed outcomes. In the event that Trusts' plans do not deliver an acceptable level of improvement during the first half of 2016/17, this issue will be escalated between the HSCB and the relevant Trust.

In relation to diagnostics, the number of patients waiting longer than nine weeks has continued to reduce during the final quarter of 2015/16. At the end of March 2016, 19,638 patients were waiting longer than nine weeks, a reduction of 4,822 (20%) since end of December 2015. This compares with 17,435 waiting longer than nine weeks at

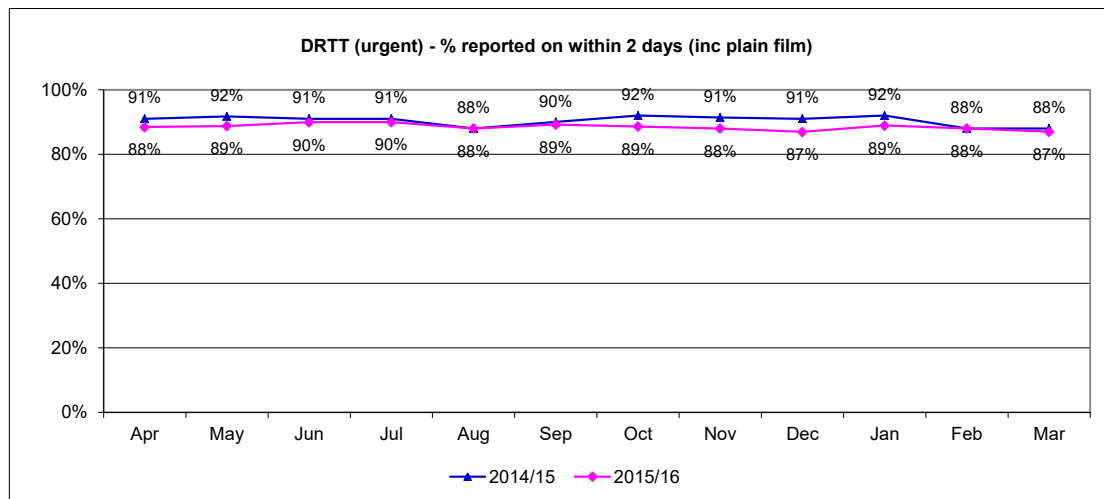
the end of March 2015. The continued strong performance in the Western Trust should also be noted – at the end of March 2016, only 200 patients were waiting longer than nine weeks.



| Trust         | Diagnostics - No waiting >9 weeks |               |               |               |               |               |               |               |               |               |               |               |               |
|---------------|-----------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
|               | Mar-15                            | Apr-15        | May-15        | Jun-15        | Jul-15        | Aug-15        | Sep-15        | Oct-15        | Nov-15        | Dec-15        | Jan-16        | Feb-16        | Mar-16        |
| Belfast       | 7,358                             | 8,891         | 9,496         | 8,536         | 9,442         | 9,452         | 8,693         | 8,902         | 9,137         | 10,332        | 10,569        | 10,330        | 8,813         |
| Northern      | 5,847                             | 6,306         | 7,035         | 7,363         | 7,628         | 7,429         | 6,939         | 6,604         | 6,209         | 6,712         | 7,167         | 6,470         | 5,334         |
| South Eastern | 1,288                             | 1,489         | 1,652         | 1,684         | 1,832         | 1,989         | 1,959         | 1,850         | 1,649         | 1,779         | 1,718         | 1,600         | 1,570         |
| Southern      | 2,673                             | 3,816         | 4,466         | 4,535         | 4,915         | 5,411         | 4,907         | 4,616         | 4,146         | 5,374         | 5,754         | 4,699         | 3,721         |
| Western       | 269                               | 316           | 241           | 114           | 189           | 320           | 271           | 111           | 167           | 263           | 428           | 162           | 200           |
| <b>Region</b> | <b>17,435</b>                     | <b>20,818</b> | <b>22,890</b> | <b>22,232</b> | <b>24,006</b> | <b>24,601</b> | <b>22,769</b> | <b>22,083</b> | <b>21,308</b> | <b>24,460</b> | <b>25,636</b> | <b>23,261</b> | <b>19,638</b> |

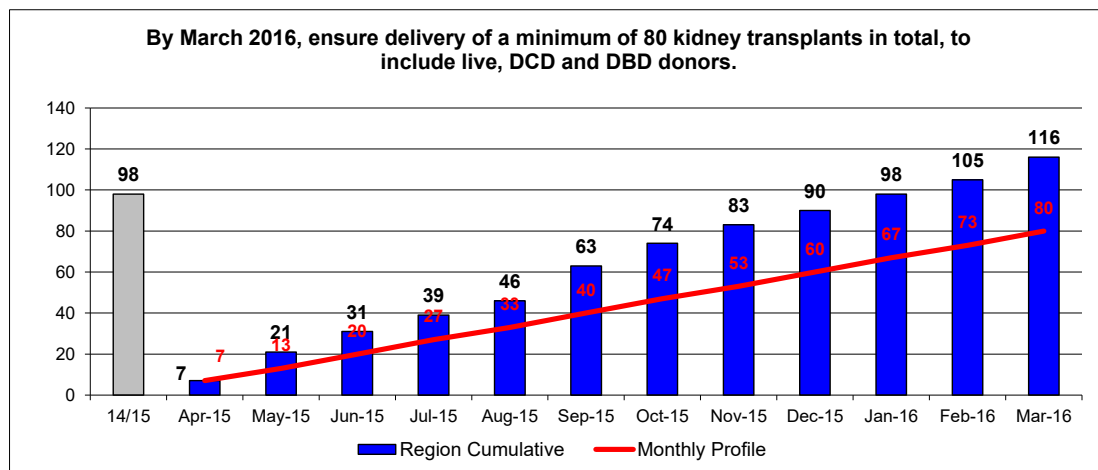
Given that diagnostics are essential in diagnosing patient conditions and enabling a treatment plan to be put in place for patients, the HSCB has recently confirmed the allocation of non-recurrent funding to Trusts to continue to undertake additional activity in Q1 and Q2 of 2016/17 to maintain and, where possible, improve upon the March 2016 waiting time position.

- **Diagnostic Reporting (Urgent)** – cumulatively during 2015/16, 88% of urgent diagnostic tests, including plain film x-rays, were reported on within two days of the test being undertaken (standard: 100%). This compares with 91% during 2014/15.



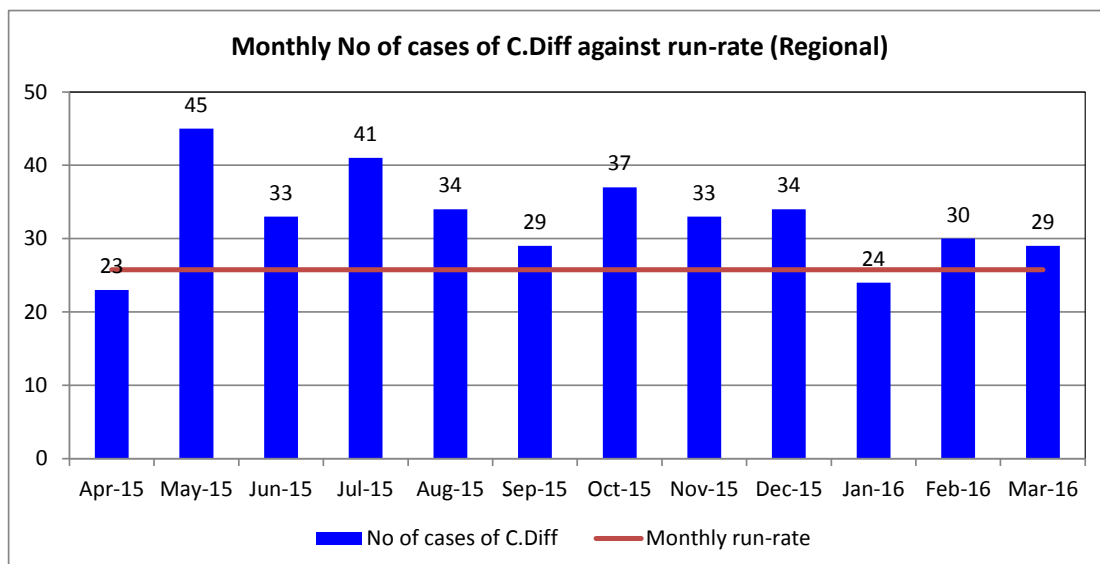
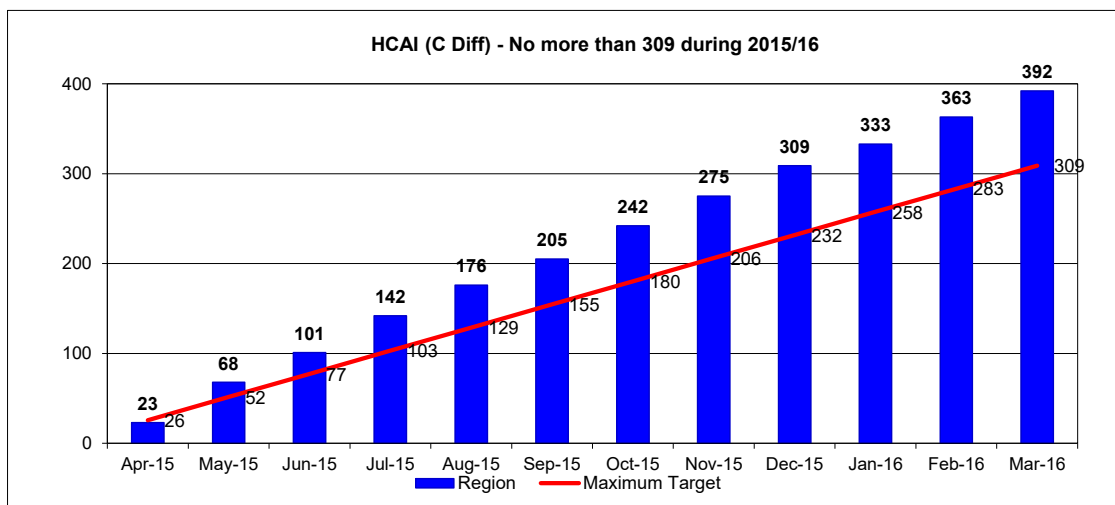
| Trust         | DRTT (urgent) - % within 2 days (inc plain film) |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|--------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                                        | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 89%                                              | 88%    | 90%    | 90%    | 88%    | 85%    | 88%    | 89%    | 88%    | 86%    | 87%    | 85%    | 87%    | 87%       |
| Northern      | 98%                                              | 97%    | 95%    | 94%    | 95%    | 95%    | 96%    | 95%    | 93%    | 94%    | 95%    | 94%    | 88%    | 94%       |
| South Eastern | 96%                                              | 97%    | 97%    | 97%    | 96%    | 97%    | 96%    | 97%    | 95%    | 96%    | 97%    | 97%    | 97%    | 96%       |
| Southern      | 84%                                              | 76%    | 76%    | 81%    | 82%    | 80%    | 78%    | 77%    | 77%    | 74%    | 78%    | 78%    | 78%    | 78%       |
| Western       | 91%                                              | 92%    | 94%    | 93%    | 94%    | 92%    | 93%    | 92%    | 93%    | 91%    | 94%    | 93%    | 93%    | 93%       |
| Region        | 91%                                              | 88%    | 89%    | 90%    | 90%    | 88%    | 89%    | 89%    | 88%    | 87%    | 89%    | 88%    | 87%    | 88%       |

- Organ Transplants** – during 2015/16, Belfast Trust delivered a total of 116 kidney transplants, including live, DCD (donation after cardiac death) and DBD (donation after brain death) donors against a target to deliver a minimum of 80 by March 2016. This is also an increase on the number of transplants delivered in 2014/15 (98).



|                        | Number of kidney transplants<br>(minimum of 80 by March 2016) |           |           |          |          |           |           |          |          |          |          |           |            |
|------------------------|---------------------------------------------------------------|-----------|-----------|----------|----------|-----------|-----------|----------|----------|----------|----------|-----------|------------|
|                        | Apr-15                                                        | May-15    | Jun-15    | Jul-15   | Aug-15   | Sep-15    | Oct-15    | Nov-15   | Dec-15   | Jan-16   | Feb-16   | Mar-16    | 15/16 Cum  |
| Live Donors            | 4                                                             | 4         | 5         | 5        | 3        | 9         | 6         | 8        | 5        | 7        | 4        | 6         | 66         |
| DCD Donors             | 2                                                             | 4         | 4         | 2        | 0        | 1         | 4         | 1        | 1        | 0        | 2        | 2         | 23         |
| DBD Donors             | 1                                                             | 6         | 1         | 1        | 4        | 7         | 1         | 0        | 1        | 1        | 1        | 3         | 27         |
| <b>Total Delivered</b> | <b>7</b>                                                      | <b>14</b> | <b>10</b> | <b>8</b> | <b>7</b> | <b>17</b> | <b>11</b> | <b>9</b> | <b>7</b> | <b>8</b> | <b>7</b> | <b>11</b> | <b>116</b> |
| <b>Profile Target</b>  | <b>7</b>                                                      | <b>6</b>  | <b>7</b>  | <b>6</b> | <b>7</b> | <b>7</b>  | <b>7</b>  | <b>6</b> | <b>7</b> | <b>7</b> | <b>6</b> | <b>7</b>  | <b>80</b>  |

- *Healthcare associated infections (C. difficile)* – regionally, the 2015/16 target to have no more than 309 cases of C. Difficile has not been achieved – during 2015/16, there have been 392 episodes of C. Difficile. This compares with 379 cases during 2014/15.

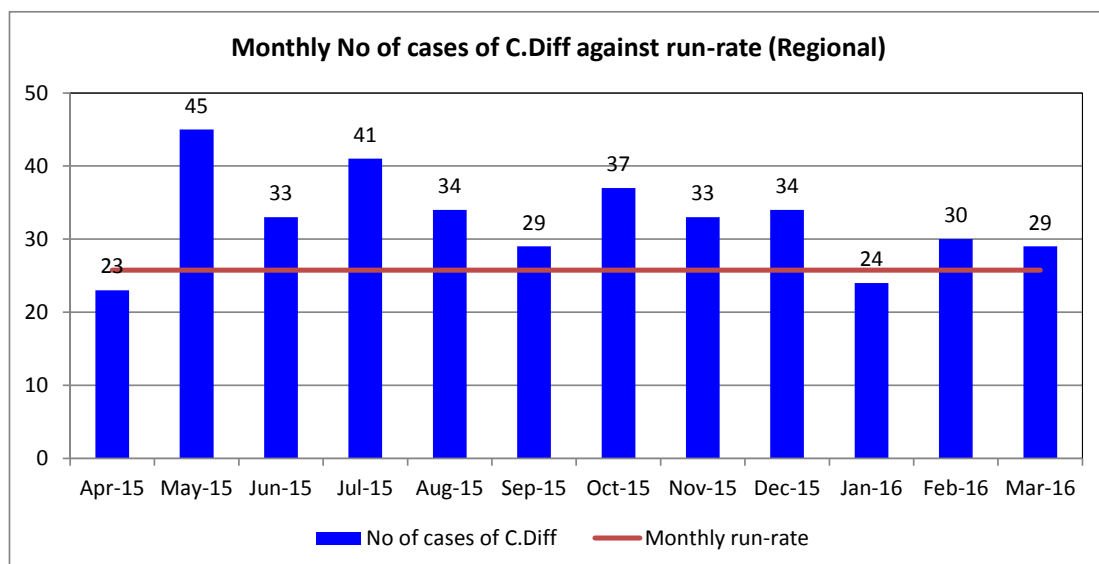
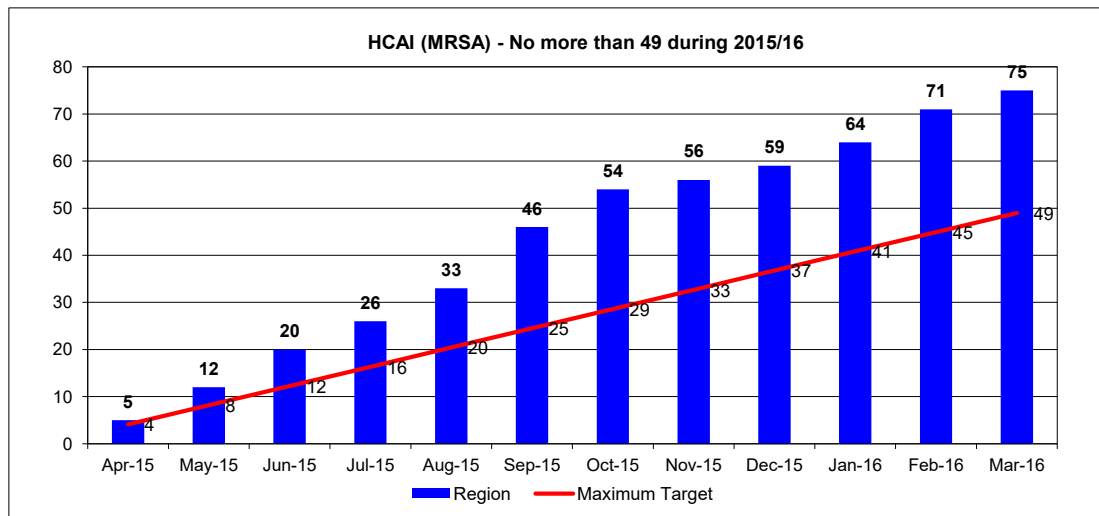


While all Trusts exceeded their target levels for 2015/16, it should be noted that the Northern Trust exceeded its annual target by only one.

| Trust         | C.Diff - No more than 309 during 2015/16 |                        |                |                             |
|---------------|------------------------------------------|------------------------|----------------|-----------------------------|
|               | 2014/15 Cumulative                       | 2015/16 Target Maximum | 2015/16 Actual | Variance (actual vs target) |
| Belfast       | 140                                      | 115                    | 129            | 14                          |
| Northern      | 62                                       | 59                     | 60             | 1                           |
| South Eastern | 67                                       | 55                     | 86             | 31                          |
| Southern      | 39                                       | 32                     | 53             | 21                          |
| Western       | 71                                       | 48                     | 64             | 16                          |
| <b>Region</b> | <b>379</b>                               | <b>309</b>             | <b>392</b>     | <b>83</b>                   |



- *Healthcare Associated Infections (MRSA)* – regionally, the 2015/16 target to have no more than 49 cases of MRSA has not been achieved – during 2015/16, there have been 75 cases of MRSA. This compares with 67 cases during 2014/15.

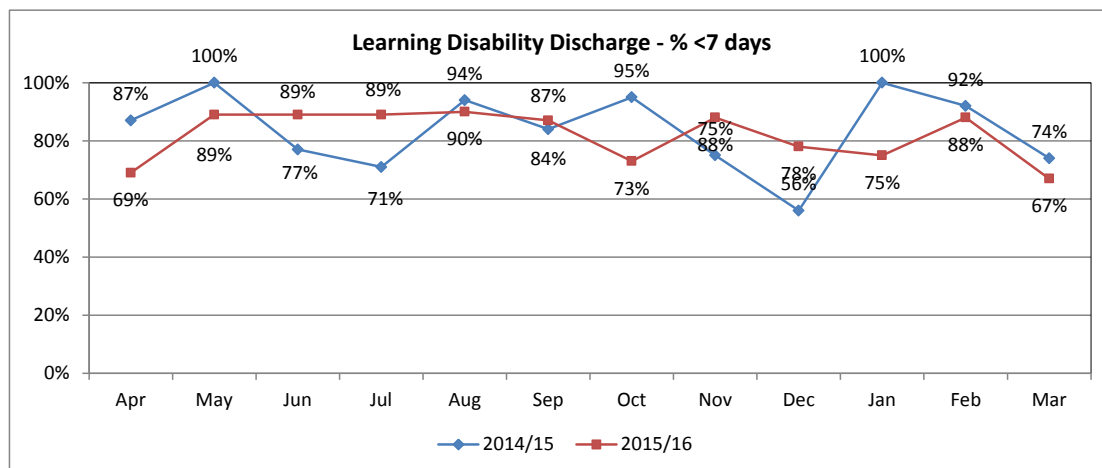


With regard to individual Trusts, the number of cases of MRSA in the Southern and Western Trusts was within their respective target levels for 2015/16 however, the remaining Trusts exceeded their target levels.

| Trust         | MRSA - No more than 49 during 2015/16 |                        |                |                             |
|---------------|---------------------------------------|------------------------|----------------|-----------------------------|
|               | 2014/15 Cumulative                    | 2015/16 Target Maximum | 2015/16 Actual | Variance (actual vs target) |
| Belfast       | 28                                    | 18                     | 34             | 16                          |
| Northern      | 11                                    | 10                     | 21             | 11                          |
| South Eastern | 7                                     | 7                      | 9              | 2                           |
| Southern      | 9                                     | 5                      | 2              | -3                          |
| Western       | 12                                    | 9                      | 9              | 0                           |
| <b>Region</b> | <b>67</b>                             | <b>49</b>              | <b>75</b>      | <b>26</b>                   |

The Public Health Agency is continuing to work with all Trusts to minimise the number of cases of C. Difficile and MRSA.

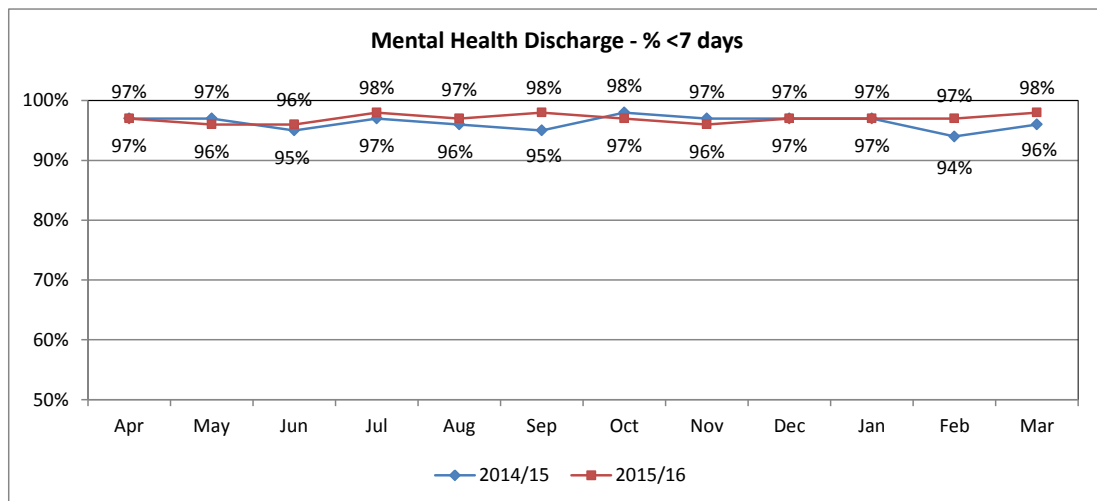
- Patient Discharge (learning disability)** – regionally during 2015/16, 83% (144 out of 173) of learning disability discharges took place within seven days of the patient being assessed as medically fit for discharge and 24 took longer than 28 days (standard: 99% within seven days and none longer than 28 days). This compares with 83% within seven days in 2014/15 and 26 longer than 28 days.



| Trust         | Learning Disability - % discharge within 7 days |            |            |            |            |            |            |            |            |            |            |            |            |            |
|---------------|-------------------------------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
|               | 14/15 Cum                                       | Apr-15     | May-15     | Jun-15     | Jul-15     | Aug-15     | Sep-15     | Oct-15     | Nov-15     | Dec-15     | Jan-16     | Feb-16     | Mar-16     | 15/16 Cum  |
| Belfast       | 79%                                             | 100%       | 60%        | 100%       | 100%       | 50%        | 75%        | 33%        | 100%       | 100%       | 100%       | 75%        | 75%        | 76%        |
| Northern      | 91%                                             | 75%        | 100%       | 75%        | 50%        | 100%       | 50%        | 100%       | 100%       | 100%       | 100%       | 100%       | 100%       | 90%        |
| South Eastern | 82%                                             | 100%       | 100%       | 50%        | 100%       | 67%        | 100%       | 100%       | 67%        | 100%       | 100%       | 67%        | 33%        | 79%        |
| Southern      | 74%                                             | 100%       | 100%       | 100%       | 100%       | 100%       | 100%       | 100%       | 75%        | 50%        | 50%        | 100%       | 0%         | 81%        |
| Western       | 84%                                             | 25%        | 100%       | 100%       | 100%       | 100%       | 100%       | 50%        | 100%       | 100%       | 50%        | 100%       | 100%       | 86%        |
| <b>Region</b> | <b>83%</b>                                      | <b>69%</b> | <b>89%</b> | <b>89%</b> | <b>89%</b> | <b>90%</b> | <b>87%</b> | <b>73%</b> | <b>88%</b> | <b>78%</b> | <b>75%</b> | <b>88%</b> | <b>67%</b> | <b>83%</b> |

| Trust         | Learning Disability - No of discharges >28 days |          |          |          |          |          |          |          |          |          |          |          |          |           |
|---------------|-------------------------------------------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
|               | 14/15 Cum                                       | Apr-15   | May-15   | Jun-15   | Jul-15   | Aug-15   | Sep-15   | Oct-15   | Nov-15   | Dec-15   | Jan-16   | Feb-16   | Mar-16   | 15/16 Cum |
| Belfast       | 12                                              | 0        | 2        | 0        | 0        | 1        | 1        | 1        | 0        | 0        | 0        | 1        | 1        | 7         |
| Northern      | 3                                               | 1        | 0        | 1        | 1        | 0        | 1        | 0        | 0        | 0        | 0        | 0        | 0        | 4         |
| South Eastern | 6                                               | 0        | 0        | 0        | 0        | 1        | 0        | 0        | 1        | 0        | 0        | 1        | 2        | 5         |
| Southern      | 4                                               | 0        | 0        | 0        | 0        | 0        | 0        | 0        | 1        | 0        | 0        | 0        | 1        | 2         |
| Western       | 1                                               | 3        | 0        | 0        | 0        | 0        | 0        | 2        | 0        | 0        | 1        | 0        | 0        | 6         |
| <b>Region</b> | <b>26</b>                                       | <b>4</b> | <b>2</b> | <b>1</b> | <b>1</b> | <b>2</b> | <b>2</b> | <b>3</b> | <b>2</b> | <b>0</b> | <b>1</b> | <b>2</b> | <b>4</b> | <b>24</b> |

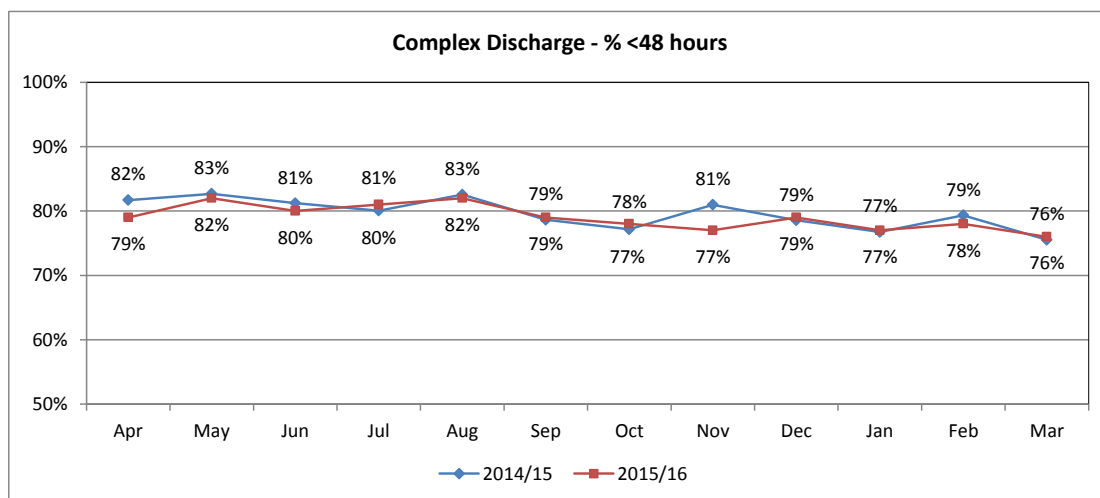
- Patient Discharge (mental health)** – regionally during 2015/16, 97% (5,015 out of 5,168) of mental health discharges took place within seven days of the patient being assessed as medically fit for discharge and 67 took longer than 28 days (standard: 99% within seven days and none longer than 28 days). This is an improvement on 2014/15 when 96% of discharges took place within seven days and 97 took longer than 28 days.



| Trust         | Mental Health - % discharge within 7 days |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|-------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                                 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 98%                                       | 93%    | 90%    | 98%    | 98%    | 100%   | 100%   | 93%    | 96%    | 94%    | 96%    | 98%    | 96%    | 96%       |
| Northern      | 100%                                      | 100%   | 97%    | 100%   | 100%   | 100%   | 100%   | 100%   | 99%    | 99%    | 100%   | 100%   | 100%   | 100%      |
| South Eastern | 94%                                       | 99%    | 96%    | 98%    | 98%    | 94%    | 100%   | 98%    | 97%    | 94%    | 97%    | 98%    | 99%    | 97%       |
| Southern      | 95%                                       | 96%    | 96%    | 94%    | 93%    | 96%    | 94%    | 100%   | 90%    | 96%    | 96%    | 97%    | 96%    | 95%       |
| Western       | 97%                                       | 97%    | 97%    | 95%    | 100%   | 98%    | 97%    | 99%    | 100%   | 99%    | 96%    | 93%    | 98%    | 98%       |
| Region        | 96%                                       | 97%    | 96%    | 96%    | 98%    | 97%    | 98%    | 97%    | 96%    | 97%    | 97%    | 97%    | 98%    | 97%       |

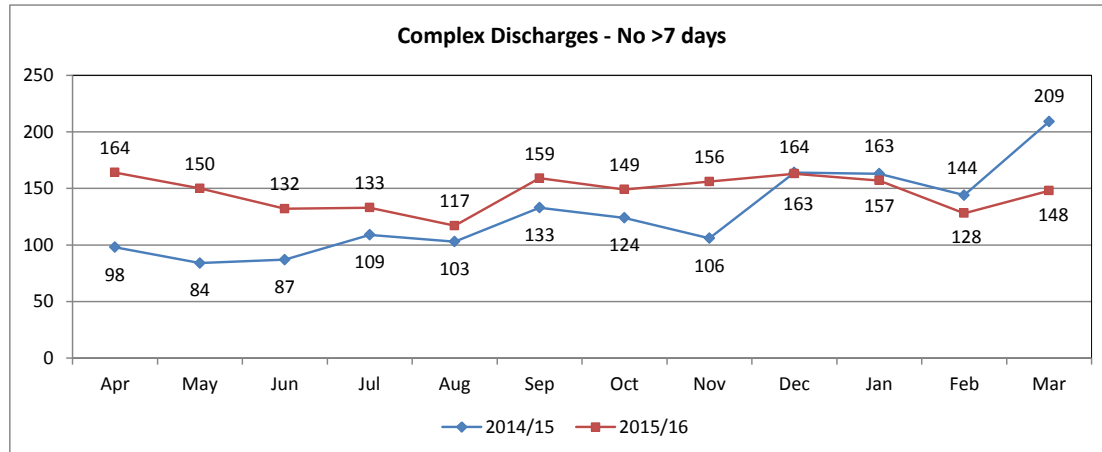
| Trust         | Mental Health - No of discharges >28 days |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|-------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                                 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 8                                         | 2      | 3      | 1      | 1      | 0      | 0      | 2      | 2      | 1      | 1      | 1      | 3      | 17        |
| Northern      | 0                                         | 0      | 1      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 1         |
| South Eastern | 33                                        | 0      | 0      | 1      | 0      | 3      | 0      | 0      | 0      | 0      | 1      | 1      | 0      | 6         |
| Southern      | 24                                        | 0      | 2      | 3      | 3      | 2      | 3      | 0      | 1      | 2      | 1      | 1      | 2      | 20        |
| Western       | 32                                        | 2      | 2      | 6      | 0      | 0      | 3      | 0      | 0      | 1      | 4      | 5      | 0      | 23        |
| Region        | 97                                        | 4      | 8      | 11     | 4      | 5      | 6      | 2      | 3      | 4      | 7      | 8      | 5      | 67        |

- Hospital Discharges (complex)** – regionally during 2015/16, 79% of complex discharges from an acute hospital took place within 48 hours and 1,756 took longer than seven days (standard: 90% within 48 hours and none longer than seven days). During 2014/15, 79% took place within 48 hours and 1,524 took longer than seven days.



| Trust         | Complex Discharges - % <48 hours |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|----------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                        | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 55%                              | 45%    | 58%    | 59%    | 62%    | 63%    | 51%    | 57%    | 55%    | 54%    | 47%    | 53%    | 45%    | 54%       |
| Northern      | 85%                              | 87%    | 89%    | 86%    | 85%    | 86%    | 87%    | 86%    | 82%    | 85%    | 83%    | 85%    | 85%    | 86%       |
| South Eastern | 75%                              | 75%    | 77%    | 78%    | 78%    | 81%    | 76%    | 77%    | 77%    | 81%    | 80%    | 79%    | 70%    | 78%       |
| Southern      | 96%                              | 92%    | 94%    | 91%    | 92%    | 93%    | 92%    | 89%    | 90%    | 86%    | 94%    | 98%    | 97%    | 92%       |
| Western       | 87%                              | 84%    | 87%    | 84%    | 86%    | 87%    | 80%    | 78%    | 78%    | 80%    | 76%    | 78%    | 76%    | 81%       |
| No ToR*       | 83%                              | 100%   | 94%    | 100%   | 75%    | 78%    | 100%   | 91%    | 88%    | 88%    | 82%    | 67%    | 100%   | 88%       |
| Region        | 79%                              | 79%    | 82%    | 80%    | 81%    | 82%    | 79%    | 78%    | 77%    | 79%    | 77%    | 78%    | 76%    | 79%       |

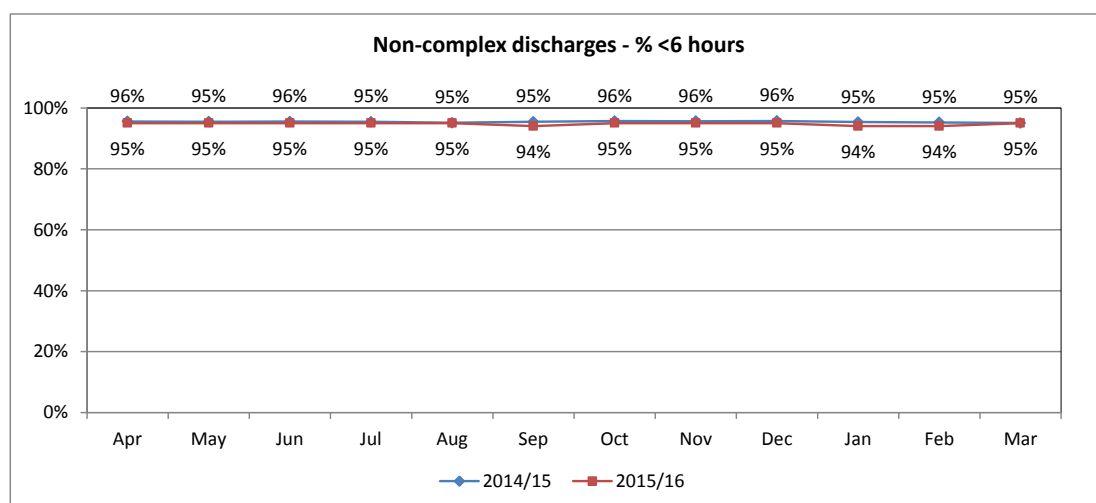
\*Trust of Residence



| Trust         | Complex Discharge - No >7 days |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|--------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                      | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 486                            | 68     | 46     | 35     | 38     | 26     | 55     | 47     | 50     | 54     | 58     | 47     | 61     | 585       |
| Northern      | 280                            | 22     | 32     | 23     | 25     | 32     | 24     | 25     | 29     | 33     | 28     | 21     | 22     | 316       |
| South Eastern | 439                            | 32     | 33     | 40     | 37     | 29     | 47     | 39     | 35     | 32     | 26     | 20     | 23     | 393       |
| Southern      | 23                             | 3      | 3      | 6      | 6      | 4      | 8      | 6      | 0      | 6      | 3      | 1      | 2      | 48        |
| Western       | 290                            | 39     | 36     | 28     | 25     | 25     | 25     | 31     | 41     | 37     | 41     | 37     | 40     | 405       |
| No ToR*       | 6                              | 0      | 0      | 0      | 2      | 1      | 0      | 1      | 1      | 1      | 1      | 2      | 0      | 9         |
| Region        | 1,524                          | 164    | 150    | 132    | 133    | 117    | 159    | 149    | 156    | 163    | 157    | 128    | 148    | 1,756     |

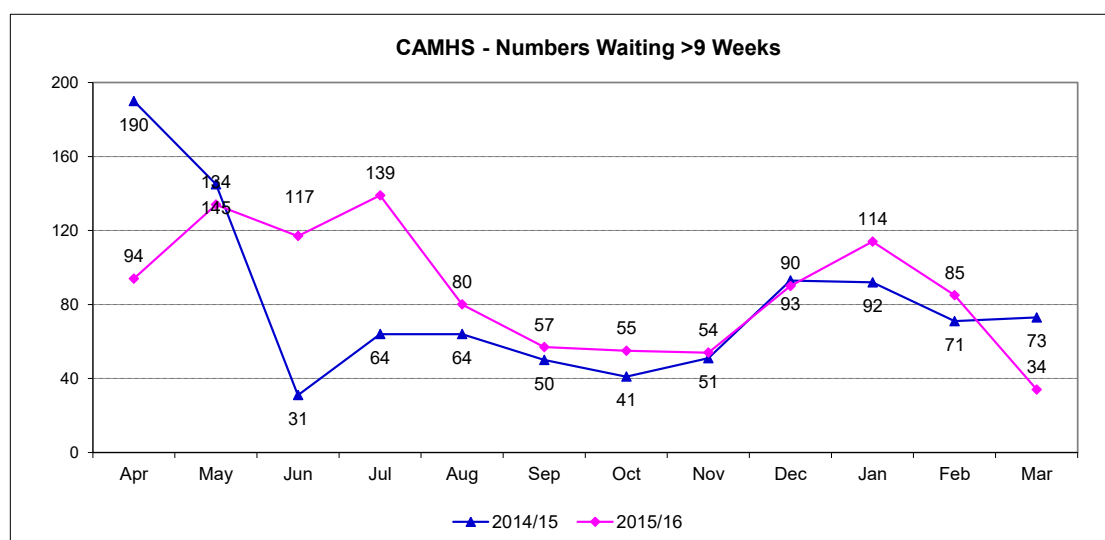
\*Trust of Residence

- Hospital Discharges (non-complex)** – regionally during 2015/16, 95% of non-complex discharges from an acute hospital took place within six hours (standard: 100%). This position is unchanged from 2014/15.



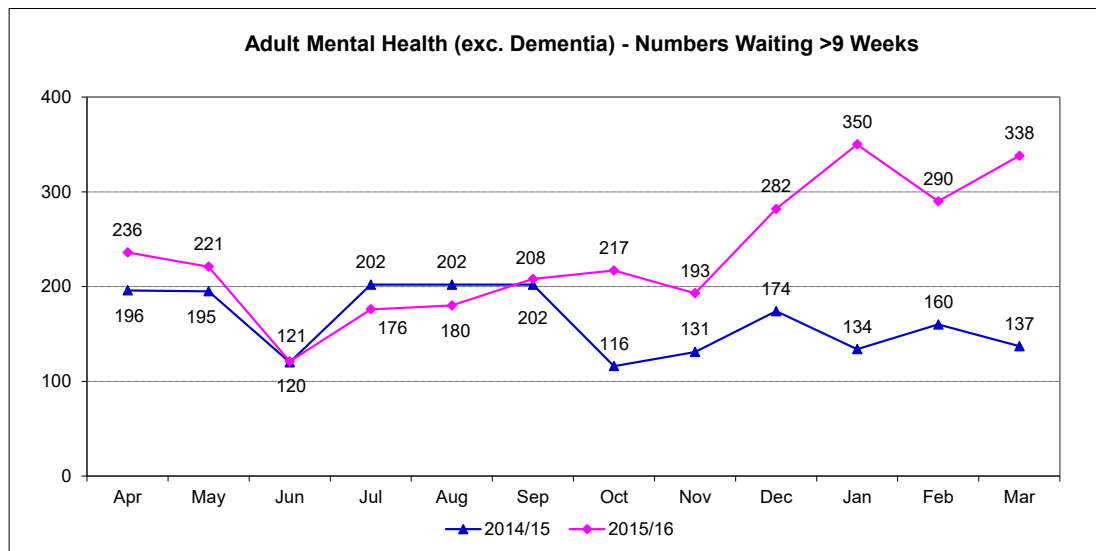
| Trust         | Non-Complex Discharge - % within 6 hours |        |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | 14/15 Cum                                | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 99%                                      | 98%    | 98%    | 98%    | 97%    | 96%    | 97%    | 97%    | 97%    | 97%    | 96%    | 96%    | 97%    | 97%       |
| Northern      | 95%                                      | 95%    | 95%    | 95%    | 95%    | 95%    | 93%    | 94%    | 95%    | 95%    | 95%    | 94%    | 96%    | 95%       |
| South Eastern | 92%                                      | 91%    | 91%    | 91%    | 91%    | 91%    | 90%    | 91%    | 92%    | 92%    | 91%    | 90%    | 89%    | 91%       |
| Southern      | 93%                                      | 93%    | 92%    | 94%    | 95%    | 96%    | 93%    | 92%    | 92%    | 91%    | 90%    | 92%    | 93%    | 92%       |
| Western       | 96%                                      | 96%    | 96%    | 96%    | 96%    | 97%    | 97%    | 97%    | 97%    | 97%    | 97%    | 97%    | 97%    | 97%       |
| Region        | 95%                                      | 95%    | 95%    | 95%    | 95%    | 95%    | 94%    | 95%    | 95%    | 95%    | 94%    | 94%    | 95%    | 95%       |

- CAMHS (9 weeks)** – waiting times to access child and adolescent mental health services (CAMHS) have continued to improve during the final quarter of 2015/16 – at the end of March 2016, 34 patients were waiting longer than nine weeks compared to 73 at the end of March 2015. It should be noted that no patients were waiting longer than nine weeks at the end of March 2016 in the Northern, South Eastern and Southern Trusts.



| Trust         | CAMHS - No > 9 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15               | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 1                    | 1      | 5      | 7      | 25     | 0      | 4      | 6      | 2      | 12     | 41     | 45     | 25     |
| Northern      | 72                   | 83     | 95     | 89     | 70     | 20     | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| South Eastern | 0                    | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| Southern      | 0                    | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |
| Western       | 0                    | 10     | 34     | 21     | 44     | 60     | 53     | 49     | 52     | 80     | 73     | 40     | 9      |
| Region        | 73                   | 94     | 134    | 117    | 139    | 80     | 57     | 55     | 54     | 92     | 114    | 85     | 34     |

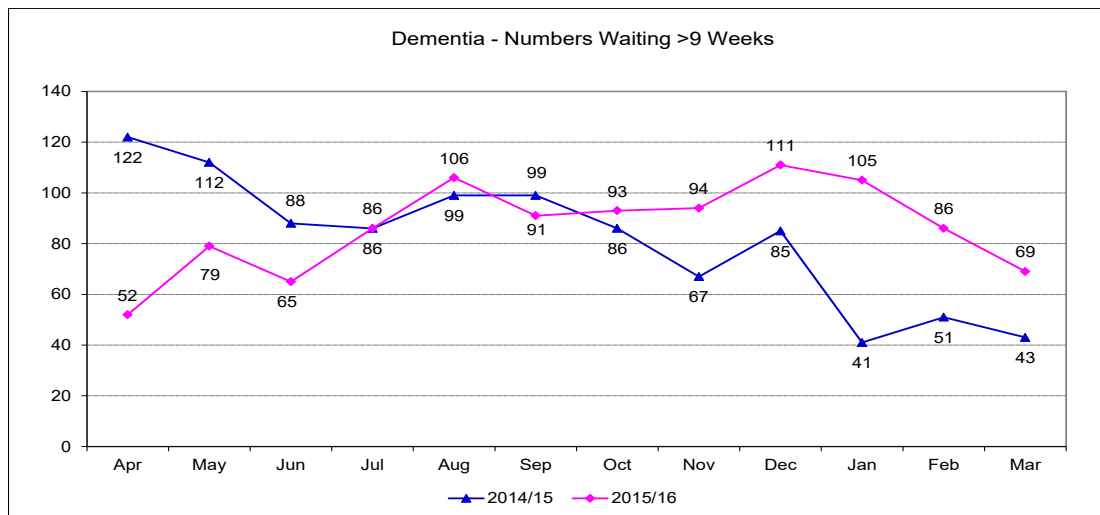
- Adult Mental Health Services (9 weeks)** – regionally at the end of March 2016, the number of patients waiting longer than nine weeks to access adult mental health services has increased compared to the position at the end of March 2015. At the end of March 2016, 338 patients were waiting longer than nine weeks, an increase of 201 compared to the previous year.



| Trust         | Adult MH - No >9 weeks |        |        |        |        |        |        |        |        |        |        |        |        |
|---------------|------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
|               | Mar-15                 | Apr-15 | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 |
| Belfast       | 35                     | 66     | 69     | 66     | 107    | 144    | 143    | 149    | 127    | 143    | 218    | 177    | 246    |
| Northern      | 0                      | 0      | 0      | 2      | 2      | 0      | 0      | 0      | 0      | 0      | 0      | 2      | 3      |
| South Eastern | 0                      | 0      | 0      | 0      | 0      | 0      | 1      | 0      | 0      | 2      | 0      | 0      | 0      |
| Southern      | 65                     | 115    | 85     | 16     | 33     | 19     | 40     | 52     | 45     | 102    | 100    | 90     | 81     |
| Western       | 37                     | 55     | 67     | 37     | 34     | 17     | 25     | 16     | 21     | 35     | 32     | 21     | 8      |
| Region        | 137                    | 236    | 221    | 121    | 176    | 180    | 209    | 217    | 193    | 282    | 350    | 290    | 338    |

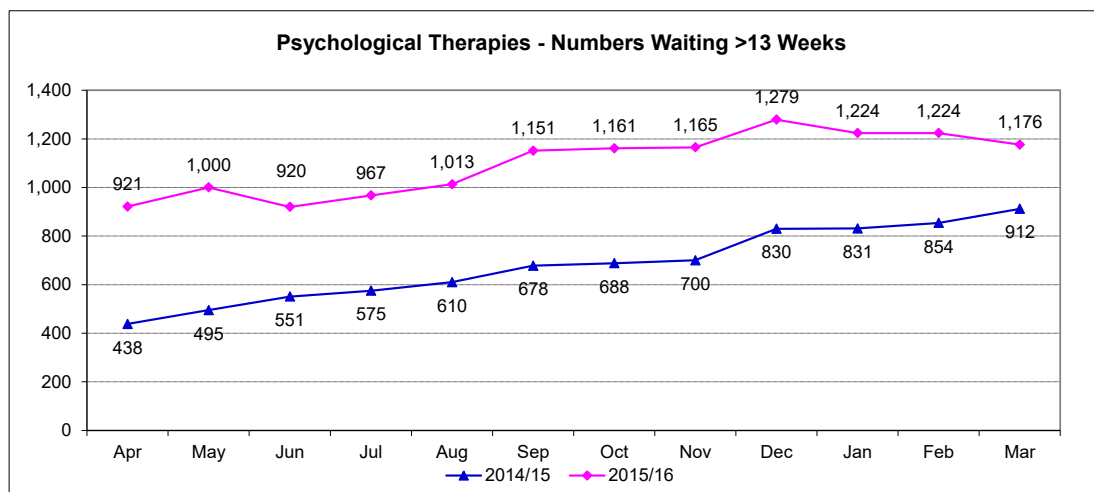
The majority (97%) of patients waiting longer than nine weeks to access adult mental health services at the end of March 2016 were in Belfast and Southern Trusts – 246 (73%) and 81 (24%) respectively. The increase in the number of patients waiting longer than nine weeks in Belfast Trust has been as a result of changes in the consultant team and service structure however, the Trust has a plan in place and is confident that the waiting time position will be resolved by September 2016. The Southern Trust has experienced a temporary reduction in capacity in the adult mental health service as a result of staff sickness and delays in recruiting to vacant posts. The Trust has now appointed to the vacant posts and the successful candidates are expected to be in post by the end of April. As a result, the Trust expects the waiting time position to continue to improve.

- **Dementia Services (9 weeks)** – at the end of March 2016, 69 patients were waiting longer than nine weeks to access dementia services (all in the Southern Trust), compared to 43 at the end of March 2015.



| Trust         | Dementia Services - No >9 weeks |           |           |           |           |            |           |           |           |            |            |           |           |
|---------------|---------------------------------|-----------|-----------|-----------|-----------|------------|-----------|-----------|-----------|------------|------------|-----------|-----------|
|               | Mar-15                          | Apr-15    | May-15    | Jun-15    | Jul-15    | Aug-15     | Sep-15    | Oct-15    | Nov-15    | Dec-15     | Jan-16     | Feb-16    | Mar-16    |
| Belfast       | 0                               | 0         | 0         | 0         | 0         | 0          | 0         | 0         | 0         | 0          | 0          | 0         | 0         |
| Northern      | 0                               | 0         | 0         | 0         | 0         | 0          | 0         | 0         | 0         | 0          | 0          | 0         | 0         |
| South Eastern | 0                               | 0         | 0         | 0         | 0         | 0          | 0         | 0         | 0         | 0          | 0          | 0         | 0         |
| Southern      | 41                              | 50        | 67        | 63        | 86        | 106        | 91        | 93        | 94        | 111        | 105        | 86        | 69        |
| Western       | 2                               | 2         | 12        | 2         | 0         | 0          | 0         | 0         | 0         | 0          | 0          | 0         | 0         |
| <b>Region</b> | <b>43</b>                       | <b>52</b> | <b>79</b> | <b>65</b> | <b>86</b> | <b>106</b> | <b>91</b> | <b>93</b> | <b>94</b> | <b>111</b> | <b>105</b> | <b>86</b> | <b>69</b> |

- *Psychological Therapies (13 weeks)* – regionally at the end of March 2016, 1,176 patients were waiting longer than 13 weeks for psychological therapy services compared to 912 at the end of March 2015.



| Trust         | Psychological Therapies - No >13 wks |            |              |            |            |              |              |              |              |              |              |              |              |
|---------------|--------------------------------------|------------|--------------|------------|------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
|               | Mar-15                               | Apr-15     | May-15       | Jun-15     | Jul-15     | Aug-15       | Sep-15       | Oct-15       | Nov-15       | Dec-15       | Jan-16       | Feb-16       | Mar-16       |
| Belfast       | 164                                  | 142        | 195          | 169        | 163        | 186          | 229          | 229          | 234          | 250          | 255          | 286          | 338          |
| Northern      | 112                                  | 96         | 114          | 122        | 136        | 122          | 136          | 155          | 143          | 206          | 216          | 204          | 142          |
| South Eastern | 487                                  | 509        | 491          | 437        | 450        | 493          | 547          | 566          | 569          | 592          | 586          | 577          | 588          |
| Southern      | 54                                   | 66         | 81           | 107        | 120        | 119          | 137          | 129          | 121          | 107          | 82           | 35           | 10           |
| Western       | 95                                   | 108        | 119          | 85         | 98         | 93           | 102          | 82           | 98           | 124          | 85           | 122          | 98           |
| <b>Region</b> | <b>912</b>                           | <b>921</b> | <b>1,000</b> | <b>920</b> | <b>967</b> | <b>1,013</b> | <b>1,151</b> | <b>1,161</b> | <b>1,165</b> | <b>1,279</b> | <b>1,224</b> | <b>1,224</b> | <b>1,176</b> |

| Psychological Therapies Services - Breach Analysis March 2016 |            |            |               |           |           |              |
|---------------------------------------------------------------|------------|------------|---------------|-----------|-----------|--------------|
| Service                                                       | Belfast    | Northern   | South Eastern | Southern  | Western   | Region Total |
| Adult Mental Health                                           | 23         | 83         | 304           | 10        | 1         | 421          |
| Primary Care Hub                                              | 0          | 0          | 0             | 0         | 0         | 0            |
| Older People-Functional Services                              | 0          | 0          | 29            | 0         | 0         | 29           |
| Adult Learning Disability                                     | 6          | 18         | 35            | 0         | 53        | 112          |
| Children's Learning Disability                                | 25         | 8          | 17            | 0         | 6         | 56           |
| Adult Health Psychology                                       | 215        | 33         | 180           | 0         | 0         | 428          |
| Children's Psychology                                         | 40         | 0          | 1             | 0         | 6         | 47           |
| Psychosexual Services                                         | 29         | 0          | 0             | 0         | 32        | 61           |
| Neurodisability Services                                      | 0          | 0          | 0             | 0         | 0         | 0            |
| Specialist Trauma Care                                        | 0          | 0          | 0             | 0         | 0         | 0            |
| Dementia / Memory Services                                    | 0          | 0          | 22            | 0         | 0         | 22           |
| <b>Trust Total</b>                                            | <b>338</b> | <b>142</b> | <b>588</b>    | <b>10</b> | <b>98</b> | <b>1,176</b> |

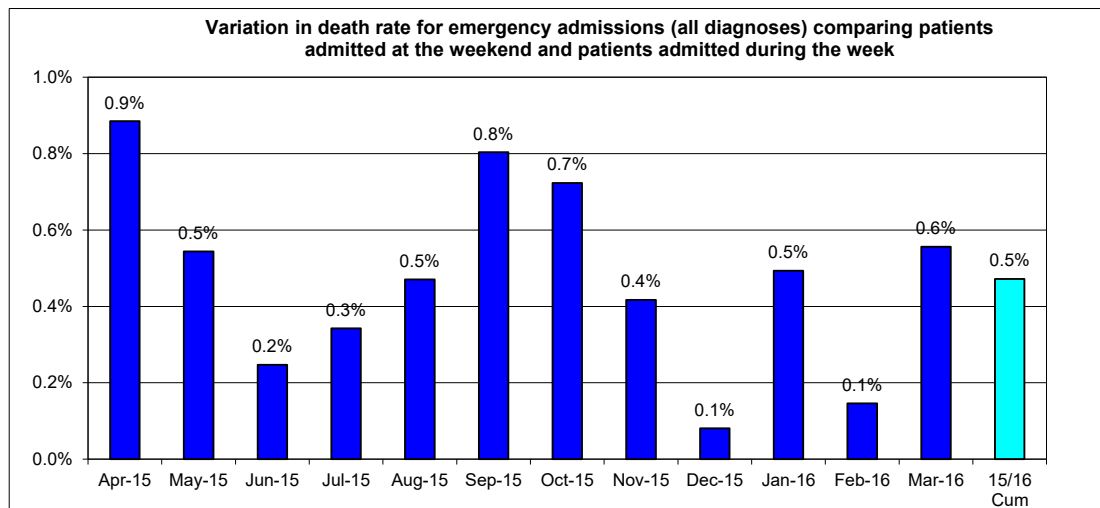
As previously reported, the HSCB has provided investment to the South Eastern Trust to address psychological therapy pressures within the Trust. Despite several attempts, the Trust has had limited success in recruiting the additional staff associated with this investment. The position has been further compounded by a loss in capacity due to staff absences and vacancies. The Trust is continuing to attempt to recruit permanent staff and, in the interim, is working with locum/agency staff and has overtime arrangements in place to deliver the activity associated with the additional investment.

The Belfast, Northern and Western Trusts have reported increased demand across a range of psychological therapy services and the HSCB is working with these Trusts to understand the increases and identify opportunities to address this position.

Funding has been made available to all Trusts for Primary Care Talking Therapy Hubs to provide a range of low intensity therapies, including facilitated self-help, life coaching, group therapy, one-to-one counselling and cognitive behavioural therapy for people with common mental health needs. Once fully operational, these Hubs are expected to improve the management of demand in to Community Mental Health services.

- *Patient Safety* – regionally during 2015/16, the variation in death rate for all emergency admissions, comparing patients admitted at the weekend and patients admitted during the week, was 0.5 percentage points (standard: 0.1 percentage points).

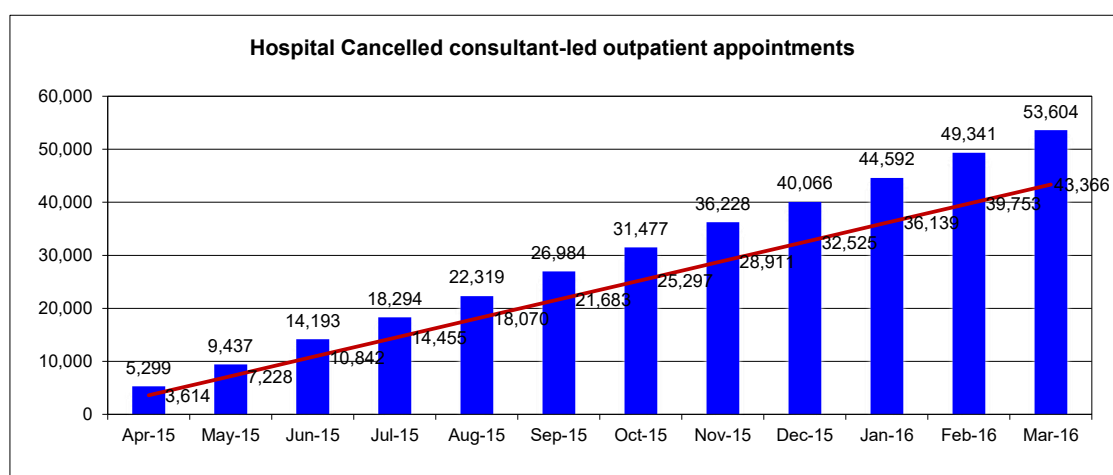




| Trust         | Patient Safety - death rates for unplanned weekend admissions vs death rates of unplanned weekend admissions |        |        |        |        |        |        |        |        |        |        |        |           |
|---------------|--------------------------------------------------------------------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|
|               | Apr-15                                                                                                       | May-15 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | 15/16 Cum |
| Belfast       | 0.1%                                                                                                         | 1.6%   | 0.0%   | 0.4%   | 1.0%   | 0.2%   | 0.5%   | 0.4%   | 0.8%   | 0.9%   | 0.0%   | 1.4%   | 0.6%      |
| Northern      | 0.8%                                                                                                         | 0.1%   | 1.2%   | 0.2%   | 0.8%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 0.8%   | 0.2%      |
| South Eastern | 0.6%                                                                                                         | 0.1%   | 0.1%   | 0.6%   | 0.9%   | 2.0%   | 1.1%   | 0.4%   | 0.0%   | 0.3%   | 0.6%   | 0.0%   | 0.5%      |
| Southern      | 0.6%                                                                                                         | 0.7%   | 0.5%   | 0.2%   | 0.0%   | 0.8%   | 1.4%   | 1.3%   | 0.0%   | 1.7%   | 0.6%   | 0.0%   | 0.6%      |
| Western       | 2.3%                                                                                                         | 0.0%   | 0.0%   | 0.0%   | 0.0%   | 1.2%   | 0.7%   | 0.6%   | 0.0%   | 0.0%   | 0.1%   | 1.5%   | 0.4%      |
| Region        | 0.9%                                                                                                         | 0.5%   | 0.2%   | 0.3%   | 0.5%   | 0.8%   | 0.7%   | 0.4%   | 0.1%   | 0.5%   | 0.1%   | 0.6%   | 0.5%      |

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

- *Cancelled appointments* – during 2015/16, 53,604 hospital cancelled consultant-led outpatient appointments (new and review) in the acute programme of care resulted in patients waiting longer for their appointment against a target to have no more than 43,366.



| Trust         | Cancelled Consultant led OP Clinics (new and review)<br>(reduce by 20% the number that resulted in longer w/time) |                                |                   |                                    |                                      |
|---------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------|------------------------------------|--------------------------------------|
|               | Baseline<br>(2014/15)                                                                                             | Target<br>Maximum<br>(2015/16) | Actual<br>2015/16 | Variance<br>(Actual vs<br>profile) | % Variance<br>(Actual vs<br>profile) |
| Belfast       | 25,703                                                                                                            | 20,562                         | 25,929            | 5,367                              | 26%                                  |
| Northern      | 7,982                                                                                                             | 6,386                          | 7,788             | 1,402                              | 22%                                  |
| South Eastern | 7,274                                                                                                             | 5,819                          | 6,309             | 490                                | 8%                                   |
| Southern      | 5,419                                                                                                             | 4,335                          | 5,439             | 1,104                              | 25%                                  |
| Western       | 7,830                                                                                                             | 6,264                          | 8,139             | 1,875                              | 30%                                  |
| <b>Region</b> | <b>54,208</b>                                                                                                     | <b>43,366</b>                  | <b>53,604</b>     | <b>10,238</b>                      | <b>24%</b>                           |

This performance should be viewed in the context of total outpatient activity. Typically, Trusts undertake in the region of 1.5 million outpatient appointments (new and review) in the acute programme of care each year therefore, the number of cancelled outpatient appointments that resulted in patients having to wait longer for their appointments accounts for less than 4% of total outpatient activity.

## Conclusion

More detail on the actions being taken in relation to these and other performance areas will be provided by the relevant Directors at the Board meeting.

**Michael Bloomfield**  
**Director of Performance and Corporate Services**  
**May 2016**

**Wright, Elaine**

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**From:** Wright, Richard [Personal Information redacted by the USI]  
**Sent:** 29 September 2015 10:05  
**To:** Gishkori, Esther; Trouton, Heather  
**Cc:** Clarke, Paula; Magwood, Aldrina; Mackle, Eamon; Nelson, Amie; Stinson, Emma M  
**Subject:** RE: General Surgicasl Situation

Happy to meet as required Richard

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**From:** Gishkori, Esther  
**Sent:** 28 September 2015 21:30  
**To:** Trouton, Heather; Wright, Richard  
**Cc:** Clarke, Paula; Magwood, Aldrina; Mackle, Eamon; Nelson, Amie; Stinson, Emma M  
**Subject:** RE: General Surgicasl Situation

Heather,  
 Thank you for the e mail below which is a reflection of the conversation we had first thing this morning.  
 I am of course more than willing to have a further meeting with Richard, you , Aimee and Eamonn in an attempt to help further.  
 Grateful if you would get this organised through Emma.  
 Best  
 Esther.

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**From:** Trouton, Heather  
**Sent:** 28 September 2015 14:55  
**To:** Gishkori, Esther; Wright, Richard  
**Cc:** Clarke, Paula; Magwood, Aldrina; Mackle, Eamon; Nelson, Amie  
**Subject:** FW: General Surgicasl Situation  
**Importance:** High

Dear Esther and Richard,

Please see below email that Eamon sent on 24<sup>th</sup> July when final allocation of surgical registrars was confirmed.

Currently we have 4 middle grades providing the full general surgical service including the out of hours cover and providing Urology OOH cover along with covering those nights when we are unable to get a locum.

To compound this situation further , one of our registrars has taken ill and has submitted a sick cert for 2 weeks initially.

We were alerted to this on Friday afternoon and had to look for agency cover for the weekend. No Agency was able to provide any cover and with one of the four middle grade on leave the crisis was only averted by one of the remaining 2 agreeing to cover at short notice.

Our serious concern is that this situation remains and presents a real governance risk to the Trust from an emergency cover perspective not to mention the impact on elective activity which we are attempting to address in another forum.

What we have done to date.

- 1) Contacted all former Registrars to see if they would be available to cover any date that suits them and we will work round them.
- 2) We have advertised the vacant posts 3 times with no success.

- 3) We have gone to Agencies for both long and short term locums with no success to date.
- 4) As DHH also have a gap they are not in a position to help the CAH rota especially as they are also required to support DHH ED.

Latest position, we have no cover for this Wednesday night or next Monday night. They are of course out to locum agency with no success as yet. Due to sick leave of one and annual leave of another, we only have 2 middle grades to cover the whole week. We may have to resort to one of the remaining 2 covering but we are mindful of the excessive pressure this puts on those staff.

We would appreciate an urgent meeting to discuss further and agree a way forward if that would be possible.

Best regards  
Heather and Eamon

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**From:** Mackle, Eamon  
**Sent:** 24 July 2015 11:45  
**To:** Burns, Deborah; Trouton, Heather  
**Subject:** General Surgicasl Situation  
**Importance:** High

Dear Debbie & Heather

I am writing to alert you to the dire Surgical staffing situation we will have from August.

We have only 3 registrars allocated and we also have 1 staff grade to work on the middle grade rota. This means that we will drastically have to cut the workload through surgery. 1 middle grade for nights and 1 on SOW leaves 2 to cover the rest of the duties ie theatres, ward work, endoscopy, OPD, patient administration and teaching. NB approximately half the time there will be a middle grade on leave.

I am proposing that Amie takes over the junior doctor weekly allocation from Richard Mayes thus we have a handle on which sessions need to be cancelled. We have met with Helen Mathers and Amie now has access to the junior leave timetable.

Theatre: I would no longer have a registrar at RFA lists or breast theatre lists unless one of them is here as a breast trainee (which I do not believe is the case). Other lists will have to be looked at for both educational content as well as the need for a registrar.

Ward work: Should be covered by the consultants but could become a problem if people are working off-site. I am introducing consultant teams to try to reduce potential problems in this respect.

Endoscopy: Registrars will need to perform some endoscopy on a weekly basis or else we could lose training posts.

Patient Administration: We will need to continue to allocate some time for the trainees to perform same if we don't want to build up a huge backlog of same.

Teaching: I will try to get the third years allocated consultant teaching but I am not sure if the consultants will be able to accommodate the final year teaching.

OPD: It is obvious that the number of clinics which will have a registrar will be significantly cut with a major downturn in the SBA.

On-call: We will need locums for the missing nights. I suspect that several units in N. Ireland will also be looking for same. I think we should decide what rate we are prepared to offer and see if the 4 will take on a 1 in 4 rota. Otherwise I think we will have nights with no on-call registrar so the question is what then? Does consultant live in? What rate of pay will they expect bearing in mind they are aware that ED SHOs are paid up to £90 per hour to be in

CAH/DHH? Will they expect WLI rates for the 15 hours each night? Will they want 2 days off in lieu of the time worked ie approximately 4 PAs? What if they refuse to work (I know at least one is not prepared to live in no matter what) are there contingency plans for shutting the hospital to surgical admissions? Also at present General Surgery covers Urology at night I know if there is no General Surgical registrar that the Gen Surg consultants will not be prepared to cover Urology.

Eamon



# Southern Health and Social Care Trust

## Policy Checklist

|                                                                                 |                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Name of Policy:                                                                 | Policy for the Management of Complaints (Working Draft)                                                                                                                                                 |
| Purpose of Policy:                                                              | To ensure that Trust staff are informed and aware off the Trust's complaints handling process and to provide service users, patients and clients with the information they require to make a complaint. |
| Directorate responsible for Policy                                              | Chief Executive's Office                                                                                                                                                                                |
| Name & Title of Author:                                                         | Joscelyn Magennis, Corporate Complaints Officer                                                                                                                                                         |
| Does this meet criteria of a Policy?                                            | Yes/No/Not Applicable                                                                                                                                                                                   |
| Trade Union consultation?                                                       | Yes/No/Not Applicable                                                                                                                                                                                   |
| Equality Screened by:                                                           |                                                                                                                                                                                                         |
| Date Policy submitted to Policy Scrutiny Committee:                             |                                                                                                                                                                                                         |
| Members of Policy Scrutiny Committee in Attendance:                             |                                                                                                                                                                                                         |
| Policy Approved/Rejected/Amended                                                |                                                                                                                                                                                                         |
| Policy Implementation Plan included?                                            |                                                                                                                                                                                                         |
| Any other comments:                                                             |                                                                                                                                                                                                         |
| Date presented to SMT                                                           |                                                                                                                                                                                                         |
| Director Responsible                                                            |                                                                                                                                                                                                         |
| SMT Approved/Rejected/Amended                                                   |                                                                                                                                                                                                         |
| SMT Comments                                                                    |                                                                                                                                                                                                         |
| Date received by Employee Engagement & Relations for database/Intranet/Internet |                                                                                                                                                                                                         |
| Date for further review                                                         | 2 year default                                                                                                                                                                                          |

*Southern Health and Social Care Trust  
Policy for the Management of Complaints*

| POLICY DOCUMENT – VERSION CONTROL SHEET      |                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Title</b>                                 | Title: Policy for the Management of Complaints<br>Version:<br>Reference number/document name:                                                                                                                                                                                                      |
| <b>Supersedes</b>                            | Supersedes: Policy for the Management of Complaints, November 2010<br>Description of Amendments(s)/Previous Policy or Version:<br>Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures. |
| <b>Originator</b>                            | Name of Author: Joscelyn Magennis<br>Title: Corporate Complaints Officer                                                                                                                                                                                                                           |
| <b>Scrutiny Committee &amp; SMT approval</b> | Referred for approval by:<br>Date of Referral:<br>ScrutinyPolicy Committee Approval (Date)<br>SMT approval (Date)                                                                                                                                                                                  |
| <b>Circulation</b>                           | Issue Date:<br>Circulated By:<br>Issued To: As per circulation List (details below)                                                                                                                                                                                                                |
| <b>Review</b>                                | Review Date:<br>Responsibility of (Name):<br>Title:                                                                                                                                                                                                                                                |



*Quality Care - for you, with you*

# **Policy for the Management of Complaints (Working draft)**

|                                |                                                               |
|--------------------------------|---------------------------------------------------------------|
| <b>Authors</b>                 | <b><i>Joscelyn Magennis, Corporate Complaints Officer</i></b> |
| <b>Directorate Responsible</b> | <b><i>Chief Executive's Office</i></b>                        |
| <b>Date of Issue</b>           |                                                               |
| <b>Review Date</b>             | <b><i>July 2015</i></b>                                       |

*Southern Health and Social Care Trust  
Policy for the Management of Complaints*



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## SECTION ONE: INTRODUCTION, PURPOSE AND SCOPE

### 1.0 Introduction to Policy

The Policy for the Management of Complaints has been based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated June 2011 and June 2013). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

### 1.1 Policy Statement

The Southern Health and Social Care Trust (hereafter referred to as the “Trust”) believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving.

### 1.2 Purpose and Aims

The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust’s activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

The aim of this policy is to:

- Inform staff of the Trust’s processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

### 1.3 Scope of Policy

This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

### 1.4 Legislative Compliance, Relevant Policies, Procedures and Guidance

The *Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009* requires HSC organisations to make arrangements in accordance with the provisions of the directions for

the handling and consideration of complaints. The *Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning* conform to this legislative framework. Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

### **1.5 Equality and Human Rights Consideration**

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the *Northern Ireland Act 1998*. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the *Human Rights Act 1998*, and deemed to be compatible with the *European Convention Rights* contained in that Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

### **1.6 Alternative Formats**

This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Corporate Complaints Officer. *Please refer to **Appendix 3** for contact details.*

*We Value Your Views* leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, is available from the Trust Intranet in large print and other languages (<http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html>).

## SECTION TWO: ROLES AND RESPONSIBILITIES

### **2.0 Role of the Chief Executive**

Our Chief Executive is responsible for ensuring that our complaints procedure is effective and that our approach ensures that appropriate investigations and actions have been completed before a response sent following the formal investigation of a complaint.

However, the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. The Chief Executive must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken in the light of the outcome of any investigation.

### **2.1 Role of the Assistant Director of Clinical and Social Care Governance**

It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

### **2.2 Role of Executive Directors**

It is the role of the Executive Directors to refer any professional issues, about which they have concerns to the relevant professional body.

### **2.3 Role of Operational Directors, Assistant Directors and Heads of Service**

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

It is the role of the Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

#### **2.4 Role of Line Managers and Front-Line Staff**

Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance for staff regarding the handling of complaints is available from the relevant Directorate Governance Team or the Corporate Complaints Officer.

The first responsibility of a staff member who receives a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff (i.e. line manager). The Corporate Complaints Officer and Directorate Governance Team are available to support and advise front-line staff on the handling of complaints.

Where a complainant raises a clinical or professional matter an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed complaint response being finalised.

All staff are required to promote and maintain service user and staff confidentiality and to comply

with the requirements of legislation, for example the Data Protection Act. The need for sensitivity and confidentiality is paramount.

### **2.5 Role of Corporate Complaints Officer**

The Corporate Complaints Officer (CCO) is responsible for providing a first contact for service users, signposting the service users around the organisation, assisting them in problem solving and facilitating them to access and use the Trust's complaints process.

The CCO is also responsible for screening service user contacts and determining if these are enquiries or complaints. The CCO will facilitate either resolution of the enquiry or complaint, or they will help facilitate the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team. The CCO will then update Datix with all relevant information and actions taken. The CCO will provide the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office. The CCO will alert the Directorate Governance Teams to significant issues at an early stage.

### **2.6 Role of Governance Co-ordinators and Governance Officers**

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety.

The Governance Co-ordinators will co-ordinate via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate. The Co-ordinators will ensure that the complaints process is conducted in accordance with Regional and Trust complaints procedures.

The Directorate Governance Team will:

- Manage all complaints received within their respective Directorates;
- Maintain a comprehensive IT system (Datix) of all complaints received;
- Provide support and advice to staff investigating/responding to complaints;
- Take account of any corroborative evidence available relating to the complaint;
- Identify training needs of staff and ensuring that appropriate programme are organised in conjunction with line managers;
- Provide the Directorate and the organisation with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints;



- Comply with Controls Assurance Standards criteria in respect of complaint management; and
- Be aware of the availability of and advise complainants about:
  - the support available from the Patient Client Council;
  - the role and availability of conciliation, advocacy, independent experts and lay persons; and
  - the Ombudsman/Commissioner for Complaints.

## SECTION THREE: MAKING A COMPLAINT

### 3.0 *What is a complaint?*

The Trust aims to provide the highest possible standard of care and treatment to all service users, at all times, but sometimes things do not always go according to plan. When this happens, it is important for us to put things right quickly.

A complaint is **“an expression of dissatisfaction that requires a response”**.<sup>1</sup> Complainants may not always use the word “complaint”. They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

### 3.1 *Who can complain?*

Any person can complain about care or treatment, or about issues relating to the provision of health and social care.

This policy may also be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased persons under the Access to Health Records (NI) Order 1993 as an alternative to making an application to the courts.

Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using Trust service and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient’s or client’s consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

**It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.**

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<sup>1</sup> *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning* (April 2009)

### **3.2 Issues this guidance does not cover**

**3.2.1** This Policy for the Management of Complaints does not deal with complaints about:

- private care and treatment or services, including private dental care<sup>2</sup> or privately supplied spectacles; or
- services not provided or funded by the Trust, for example, provision of private medical reports.

**3.2.2** Complaints may be raised within the Trust which we need to address, but which do not fall within the scope of this policy. While the Policy for the Management of Complaints does not cover the issues listed below the Trust has in place procedures to ensure that such concerns are dealt with. Such issues include:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998;
- an independent inquiry;
- a criminal investigation;
- the Children Order Representatives and Complaints Procedure;
- protection of vulnerable adults;
- child protection procedures;
- coroner's cases;
- legal action.

If any complaint received by the Trust indicates a need for referral under any of the issues above in section 3.3.2, they should immediately be passed to the relevant Directorate Governance Team for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under this Complaints Policy. In these circumstances, investigation under this Complaints Policy will only be taken forward if it does not or will not, compromise or prejudice the matter under investigation under any other process. The complainant will be informed of the need for referral.

While the Trust does not investigate complaints made regarding the Northern Ireland Ambulance Service (NIAS), any complaints received by the Trust in relation to the NIAS will be passed onto the NIAS Complaints Officer.

Complaints received by the Trust in relation to GP practices and services will be passed onto the Complaints Manager at the Health and Social Care Board (HSCB).

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<sup>2</sup> The Dental Complaints Service deals with private dental and mixed health service and private dental complaints. The Dental Complaints Service can be contacted via the General Dental Council at <http://www.gdc-uk.org/>

### **3.3 Complaints about Regulated Establishments/Agencies and Independent Service Providers**

On occasions the Trust may make use of Regulated Establishments/Agencies and Independent Service Providers (ISP), e.g. residential nursing homes, domiciliary care providers; to provide services for patients/clients. This form of treatment and/or care is subcontracted to the Regulated Establishment/Agency or ISP and funded by the Trust.

Regulated Establishments/Agencies and ISPs are contractually obliged to have in place appropriate governance arrangements for the effective handling of, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints procedures, including the investigation of complaints and the production of literature, which is available and accessible to patients/clients, which outline the establishment's complaints procedure. On commissioning of the services it would be good practice if the commissioner (i.e. Trust staff) informs the patient/client and relatives/carers that the Regulated Establishment/Agency or ISP will have a complaints procedure in place.

If a patient/client or relative/carer has a concern or complaint relating to the contracted services provided by a Regulated Establishments/Agency or ISP they should raise the concern/complaint directly with the provider of care in the first instance. However, where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so.

The Regulated Establishment/Agency or ISP is required to investigate the concern or complaint and provide a written response to the complainant which should be copied to the Trust. If there is a delay in responding to the complainant within the target timescales<sup>3</sup> the complainant will be informed and a revised date for conclusion of the investigation will be provided.

The response letter from the Regulated Establishment/Agency or ISP must advise the complainant that they can progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and who will be responsible for conducting the investigation. The Trust will work closely with the

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<sup>3</sup> Under SHSCT complaints procedure a written response should be issued to the complaints within 20 working of the establishment's receipt of the complaint. If the establishment is unable to meet these timescales the complainant should be informed, in writing, as to the reasons why.

Regulated Establishment/Agency or ISP to enable appropriate decisions to be made.

The complainant must also be informed by the Regulated Establishment/Agency or ISP of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the Regulated Establishment/Agency or ISP without Trust participation in local resolution will be referred to the Trust for investigation and action by the Ombudsman.

The Trust has agreed arrangements in place to ensure that Regulated Establishments/Agency or ISPs provide information to annual review meetings relating to all complaints received and responded to directly by them.

It is the role of Trust staff, such as Key Workers, to ensure that patients/clients and relatives/carers are aware of the importance of raising concerns or complaint as close to the source as possible, as this allows for early resolution through discussion and negotiation. The general principle in the first instance therefore would be that the Regulated Establishment/Agency or ISP investigates and responds directly to the complainant.

Should patients/clients or relatives/carers lack confidence in the Regulated Establishments/Agencies or ISPs' complaints handling procedures or are not happy with the response they had received from the provider of care, they can refer their complaint to the Trust's Corporate Complaints Officer so that an investigation can begin. *Contact details for the Trust's Corporate Complaints Officer are listed below.*

**Corporate Complaints Officer  
Southern Health and Social Care Trust,  
Trust Headquarters,  
Craigavon Area Hospital,  
Portadown,  
BT63 5QQ**

**Telephone: (028) 3861 4150**

**Email: [complaints@southerntrust.hscni.net](mailto:complaints@southerntrust.hscni.net)**

The Regulation and Quality Improvement Authority (RQIA) will monitor how complaints are handled and investigated by regulated services and the Trust. *For contact details please refer to Appendix 3.*

### **3.4 Complaints about Family Practitioners (family doctors, dentists, pharmacists, opticians)**

All Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure for handling complaints. The practice-based complaints procedure forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaint's Manager if he/she does not feel able to approach immediate staff. The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

*Please refer to Appendix 3 for contact details.*

### **3.5 How can complaints be made?**

#### ***Complaints can be made to a member of Trust staff at the point of service delivery***

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation, and by following the guidance in section 4.3 of this Policy.

It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised by service users and are able to distinguish those issues which would be better referred elsewhere. Staff across the Trust can assess the "Policy for the Management of Complaints" and "Complaints in Health and Social Care: A Need to Know Guide for Staff" through the Trust's Intranet.

Where possible complaints should be dealt with immediately and front-line staff should follow the procedures below in their handling of complaints received at point of service delivery:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be

beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form and return to the Corporate Complaints Officer. A *Complaints at Point of Service Delivery* form can be located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that if you are in this situation, you ask your supervisor or line manager for assistance, if necessary.

### **3.5.1 Formal Letter of Complaint received at Point of Service Delivery**

If a formal letter of complaint is received by staff at a point of service delivery' it should be sent by email the same day to the Trust's Corporate Complaints Officer so that an investigation can begin. Please refer to **Appendix 3** for contact details.

### **3.5.2 Complaints can be made to the Corporate Complaints Officer**

Complaints may be made verbally or in writing and will also be accepted via other methods such as the telephone (including voicemail) or electronically (e.g. e-mail). It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. The Trust is mindful of technological advances and has in place local arrangements which ensure that there is no breach of patient/client confidentiality. Contact details for the Trust's Corporate Complaints Officer are listed below.

|                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Corporate Complaints Officer<br/>Southern Health and Social Care Trust,<br/>Trust Headquarters,<br/>Craigavon Area Hospital,<br/>Portadown,<br/>BT63 5QQ</p> <p><b>Telephone:</b> (028) 3861 4150</p> <p><b>Email:</b> <a href="mailto:complaints@southerntrust.hscni.net">complaints@southerntrust.hscni.net</a></p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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### 3.5.3 What information should be included in a complaint?

| A complaint need not be long or detailed, but it should include: |                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Relevant Contact Details</b>                                  | <ul style="list-style-type: none"> <li>✓ Complainants name, address (including postcode) and telephone number</li> <li>✓ If you are making this comment/complaint on behalf of another person, please provide the following details: <ul style="list-style-type: none"> <li>▪ Their name, their address (including postcode) and their date of birth (if known)</li> <li>▪ And please indicate your relationship to this person</li> </ul> </li> </ul> |
| <b>Who or what is being complained about?</b>                    | <ul style="list-style-type: none"> <li>✓ Department/ward/facility where the issues occurred</li> <li>✓ Hospital site, e.g. Craigavon, Lurgan, Newry, etc.</li> <li>✓ Include the names of staff, if known</li> </ul>                                                                                                                                                                                                                                   |
| <b>When the events of the complaint happened</b>                 | <ul style="list-style-type: none"> <li>✓ Details of the issue(s) relevant to the complaint</li> <li>✓ Please include dates</li> </ul>                                                                                                                                                                                                                                                                                                                  |
| <b>Where possible, what remedy is being sought</b>               | <ul style="list-style-type: none"> <li>✓ Such as an apology, an explanation or changes to be made to our services</li> </ul>                                                                                                                                                                                                                                                                                                                           |

### 3.6 Complaints made by a 3<sup>rd</sup> Party (including those made by MPs, MLAs and Local Councillors) and Consent

Confidentiality must be respected at all times and complaints by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complaint the Trust will seek consent from the patient/client concerned or their next of kin where necessary.

There will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the subject of the complaint is deceased.

The relevant Governance Team will be able to provide further advice and guidance in relation to this matter. Consent forms can be obtained from the Complaints and User Views section of the Southern Health and Social Trust website.

([www.southerntrust.hscni.net/pdf/Patient\\_Client\\_Consent\\_form\\_May\\_2012\(2\).pdf](http://www.southerntrust.hscni.net/pdf/Patient_Client_Consent_form_May_2012(2).pdf))

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Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client. The Trust will consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/client's confidentiality.

### **3.7 Complaints made by staff**

As staff in the Southern Trust, we all have a responsibility to protect our service users, fellow members of staff, the public and the Trust. If you have a concern as a member of staff about any aspect of the quality and safety of our services, another member of staff or about any of the functions of the Trust, those concerns can be raised as per the Trust's *Whistleblowing Policy*. Staff can access the *Whistleblowing Policy* via the Trust's Intranet (<http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/WhistleblowingPolicyFINALREVIEWEDonintranetMay2012.pdf>).

### **3.8 Anonymous Complaints**

If someone approaches the Trust with a complaint we will request their name and contact details. This will enable us to acknowledge their complaint, confirm the issues causing concern and clarify or seek further information and provide information on the outcome of our investigation.

Any request to remain anonymous will be respected as all complaints received by the Trust are treated with equal importance regardless of how they are submitted. However, complaints received with anonymity may mean that a detailed investigation may not always be possible, for example when there is a need to access medical records. Also, a complaint response cannot be issued.

All complaints submitted to the Trust, whether anonymous or not, are viewed as a significant source of learning within the organisation and help us to continue to improve the quality of our services and safeguard high standards of care and treatment. The number of complaints and trends emerging from complaints are continually monitored by each Directorate's Governance meeting and at the Patient/Client Experience Committee meetings.

### **3.9 What are the timescales for making a complaint?**

A complaint should be made as soon as possible after the action giving rise to it, normally within **six months** of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is earlier.

In any case where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant will be advised of the options available to him/her to pursue this further.

The Trust will consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

### **3.10 Support for complaints**

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are an important way of enabling people to make informed choices. These services help people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

The Southern Trust's **Patient Support Services** is a confidential service for patients, families and carers within the **Acute Directorate**, i.e. Emergency Department, surgical wards, intensive care, etc. It provides:

- on the spot advice ;
- answers to your queries and questions ;
- information on the Trust and the services it provides ;
- information on local health services and support groups;
- support, when needed;
- information on making a complaint;
- a way for you to tell us what you think of our services so that we can improve them.

The Patient Support Services offices are located on both the Craigavon and Newry sites, with the support available at Craigavon from Monday to Friday and available on the Newry site Monday and Thursday. Contact details are listed below.

#### **Craigavon Contact Details:**

Patient Support Service

Craigavon Area Hospital

68 Lurgan Road

Portadown BT63 5QQ

**Telephone:** (028) 3861 2395 / 3861 4285

**Email:** [PatientSupport.CAH@southerntrust.hscni.net](mailto:PatientSupport.CAH@southerntrust.hscni.net)

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**Newry Contact Details:**

Patient Support Service  
 Daisy Hill Hospital  
 5 Hospital Road  
 Newry BT35 8DR

**Telephone:** (028) 3083 5070

**Email:** [PatientSupport.DHH@southerntrust.hscni.net](mailto:PatientSupport.DHH@southerntrust.hscni.net)

**Niamh (Northern Ireland Association for Mental Health)** is the largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland. Niamh is structured as a group consisting of three elements: Compass, beacon and Carecall. **Beacon** offers an independent advocacy service which is designed to listen to the compliments, concerns, problems or issues that people may be experiencing whilst using mental health services. An advocate can provide patients/clients with information in relation to the options available to them under four broad areas: clinical, legal, treatment and environment. An advocate will help patients/clients to express any concerns and to pass these on to relevant professionals. Advocates will support the individual to be heard and all discussions will be treated confidentially. *Please see below for contact details.*

80 University Street,  
 Belfast,  
 BT7 1HE

**Telephone:** (028) 9032 8474

**Email:** [info@beaconwellbeing.org](mailto:info@beaconwellbeing.org)

In the Southern Health and Social Care Trust, **Disability Action's** Centre on Human Rights provides an advocacy service specifically for people with learning disabilities. This service is confidential, provided free of charge and independent. The advocate supports people with learning disabilities to understand their rights and encourages them to speak up if they are unhappy about how they have been treated. The advocate will listen to the person's issue and identify the options available to them and will support the patient/client to take action.

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The advocate also provides non-instructured advocacy, when a patient/client cannot give a clear indication of their views or wishes in a specific situation, e.g. when a person has a profound learning disability. In these cases, the advocate works to uphold the person's rights, ensure fair and equal treatment and access to services and make certain that decisions are taken with due consideration for the patient/client's individual preferences and perspectives. Please see below for contact details.

Human Rights Advocate,  
Disability Action's Centre on Human Rights,  
Disability Action,  
Portside Business Park,  
189 Airport Road West,  
Belfast,  
BT3 9ED

**Telephone:** (028) 9029 7880  
**Textphone:** (028) 9029 7882  
**Email:** [humanrights@disabilityaction.org](mailto:humanrights@disabilityaction.org)

**VOYPIC (Voice of Young People in Care)** offers advocacy for children and young people with care experience aged 25 and under. This is a confidential and independent service where children and young people can get advice, information and support outside of Social Services. The service can:

- provide you with information and advice on your rights;
- Go to meetings with a child or young person;
- Help children/young people ask for a service;
- Help children/young people speak out about decisions that affect you; and
- Help children/young people make a complaint.

*Please see below for contact details.*

Voice of Young People In Care  
Flat 12, Mount Zion House  
Edward Street  
Lurgan  
BT66 6DB

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**Telephone:** (028) 3831 3380

**Website:** [www.voypic.org](http://www.voypic.org)

The **Northern Ireland Commissioner for Children and Young People's (NICCY)** Legal and Investigations team deal with queries and complaints from children, young people, their carers and relevant professionals about the services they receive from public bodies. This team can:

- investigate complaints against public bodies (schools, hospitals, etc) on behalf of children and young people;
- help a child or young person bring their complaint to a public body; and
- help children and young people in legal proceedings against public bodies.

*Please see below contact details.*

Legal and Investigations Team  
Northern Ireland Commissioner for Children and Young People  
Equality House  
7-9 Shaftesbury Square  
Belfast  
BT2 7DP

**Telephone:** (028) 9031 1616

(Monday – Friday: 9:00am to 5:00pm)

**Email:** [listening2u@niccy.org](mailto:listening2u@niccy.org)

**Website:** [www.niccy.org](http://www.niccy.org)

The **Age NI** Advice and Advocacy Service offer free, independent and confidential support to older people, their families and carers. The Age NI team provides advocacy support to people experiencing difficulties:

- negotiating the health and social care system
- accessing appropriate levels of community care
- dealing with issues relating to residential and nursing care
- those who have experienced or are at risk of abuse.

*Please see below for contact details.*

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Age NI  
3 Lower Crescent  
Belfast  
BT7 1NR

**Telephone:** 0808 808 7575  
(8:00am to 7:00pm, 7 days a week)  
**Email:** [advice@ageni.org](mailto:advice@ageni.org)  
**Website:** [www.ageni.org/advice](http://www.ageni.org/advice)

The ***Patient Client Council*** (PCC) is an independent non-departmental public body and its functions include:

- representing the interests of the public;
- promoting involvement of the public; and
- providing assistance to individuals making or intending to make a complaint.

If a person feels unable to deal with a complaint alone the staff of the PCC can offer a wide range of assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- helping in accessing medical/social services records.

All advice, information and assistance with complaints is provided free of charge and is confidential. *Please see below for contact details.*

Quaker Buildings,  
High Street,  
Lurgan,  
BT66 8BB

**Telephone:** 0800 917 0222  
**Email:** [info.pcc@hscni.net](mailto:info.pcc@hscni.net)

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Website: [www.patientclientcouncil@hscni.net](mailto:www.patientclientcouncil@hscni.net)

The Trust's Corporate Complaints Officer and Directorate Governance Teams will also be able to offer advice and support complainants and explain the Trust's complaints procedure, as well as attempt to resolve the complaint. *For contact details of these services please refer to **Appendix 3**.*

### **3.11 Making a compliment**

The staff who provide services do their best to meet your individual expectations and are often working in difficult circumstances. Therefore we are always keen to know when things have worked out well for our patients/clients and what aspect has made a positive experience for them.

Those patients/clients wishing to make a compliment can do so by completing a *We Value Your Views* leaflet and returned to the Trust's Corporate Complaints Officer. Alternatively, you can contact the Corporate Complaints Officer directly to make your compliment. (*Contact details can be found in **Appendix 3***) These compliments, which highlight good practice, will be forwarded to the relevant staff and departments.

## SECTION 4: HANDLING COMPLAINTS

### 4.0 Accountability

Accountability for the handling and consideration of complaints rests with the Chief Executive. The Assistant Director of Clinical and Social Care Governance is the Trust's designated senior person within the organisation who takes responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. All staff within the Trust are made aware of and must comply with the requirement of this complaints procedure. These arrangements ensure the integration of complaints management into the Trust's governance arrangements.

### 4.1 Co-operation

Arrangements are in place within the Trust to ensure a comprehensive response to the complainant and to that end there is necessary co-operation in the handling of complaints and the consideration of complaints between:

- all HSC organisations;
- Regulatory authorities, e.g. professional bodies, DHSSPS Pharmaceutical Inspectorate;
- NI Commissioner for Complaints (the Ombudsman); and
- the Regulation and Quality Improvement Authority (RQIA).

This duty to co-operate includes answering questions, providing information and attending any meeting requested by those investigating the complaint.

### 4.2 Actions on receipt of a complaint

All complaints received by the Trust are treated with equal importance regardless of how they are submitted. Complainants are encouraged to speak openly and freely about their concerns and are reassured that whatever they have to say will be treated with appropriate confidence and sensitivity. Complainants will be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. On receipt of a complaint the first responsibility of Trust staff is to ensure that the service user's immediate care needs are being met.

The Trust will involve the complainant throughout the consideration of their complaint as this provides for a more flexible approach to the resolution of the complaint. An early provision of information and explanation of what to expect is provided by the Trust to the complainant at the outset to ensure they are informed about the process and of the support that is available.

Each complaint received by the Trust is taken on its own merit and responded to appropriately. It



may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive manner.

#### **4.2.1 Informal Complaint**

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation.

Staff across the Trust can access 'Complaints in Health and Social Care: A Need to Know Guide for Staff' via the Trust's Intranet.

#### **Point of Service Delivery**

When a complaint is raised at the point of service delivery staff should follow the procedures laid out below.

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should contact the advocate directly with the patient/client's consent or seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at the point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's '**We Value Your Views**' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that staff in this situation ask their supervisor or line manager for assistance, if necessary.

**Complaints made directly to the Trust's Corporate Complaints Officer**

The Corporate Complaints Officer will facilitate either resolution of the complaint or they will facilitate the service user in accessing the Trust's formal complaints procedure.

**4.2.2 Formal Complaints**

This is the starting point for anyone is dissatisfied with attempts to resolve their complaint at the point of service delivery or any complainant who expects to receive a written (or alternative format) response from the Trust. The complainant should receive a full response within **20 working days** of the Trust's receipt of the formal complaint.

**Acknowledgement**

1. The Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office within **1 working day**.
2. The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint within **2 working days**. This acknowledgement should express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the Trust. A copy of the regional "*What Happens Next?*" leaflet should be included with the acknowledgment letter.
3. If a complaint is made by a third party (including those made by MPs, MLAs and local councillors) and it refers to an individual's care the matter of knowledgeable and informed consent must be considered.

If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is received. (*The 20 working days only starts in these instances on the day in which the consent is received.*)

4. All complaints which occur in the Trust are graded in a standardised manner using the Trust's *Risk Management Strategy*.
5. In the case of complaints which are applicable to more than one directorate, it is best practice for the Governance Team in the directorate where the complaint has first arisen to handle the complaint and seek input from other Directorate Teams where appropriate.

## ***Investigation***

1. By **day 2**, Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.

A copy of the complaint should be forwarded to the Assistant Director responsible for the service area. Where serious governance issues are identified on receipt of the complaint it must be shared with the relevant Director.

*Investigating staff can reference the Trust's 'Investigating Complaints Advice Sheet' for best practice guidance on investigations, which can be accessed via the Trust's Intranet.*

Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:

- line management support;
- occupational health;
- Care Call; and
- the relevant Governance Team.

2. The draft response to the complainant is to be validated by the Investigating Directorate Governance Team and then forwarded to the appropriate Assistant Director by **day 15** for approval/amendment.

The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong – staff should refer to the *Ombudsman's Guidance on Issuing an Apology* (May 2011) which can be found here: <http://www.ni-ombudsman.org.uk/niombudsmanSite/files/2d/2dfa3d4d-2b55-4bcb-8670-bd99f76eba4e.pdf>
- report the action taken or proposals to prevent recurrence, where the need for such actions have been identified following investigation of the complaint;
- indicate that a named member of staff is available to clarify any aspect of the letter; and
- advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

3. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. The relevant Assistant Director is required to approve and return to the relevant Governance Co-ordinator by **day 17**. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.

Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant Governance Co-ordinator.

4. All final responses are to be forwarded to the relevant Lead Director for approval by **day 18**.

The Lead Director's office is required to issue the response to the complainant by **day 20**, sending the Directorate Governance Team copy of the final signed response. The exception to this are those complaint responses being sent to Elected Representations whereby the Chief Executive will, following approval by the Director, sign the final response and send a signed copy to the Lead Director and relevant Governance Team within **10 working days**. **Responses should not be issued to the complainant electronically.**

5. There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Governance Co-ordinator will escalate any breaches of the timeframes to the appropriate line manager for further action.

#### **4.3 Acknowledgement of delays**

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 working days timescale. The relevant Director should be informed of any delay at this stage also.

#### **4.4 Further Local Resolution beyond 20 working days**

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain consideration needs to be given to how the remaining issue(s) can be resolved. All complainants will be advised that if they remain unhappy with the Trust's response they should

contact the relevant Governance Team in the first instance to discuss options available or refer their complaint to the Ombudsman. (Please refer to **Appendix 3** for contact details) At this point all complainants should be asked to state clearly which aspect(s) of their complaint remains unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the complainant;
- Local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;
- Use of independent experts.

#### ***4.4.1 Further written response to outstanding issues***

Complainants will be advised in the first response that they should contact the organisation **within 3 months** of the Trust's response if they are dissatisfied with the response or require further clarity. There is discretion for the Governance Co-ordinator to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

The first step of further local resolution should then be that of an offer of a further response to the complainant. This may be in the form of a further written response signed off by the Director(s). This response should be issued **within 20 days** of the complaint being re-opened.

#### ***4.4.2 Meeting with the Complainant***

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within **30 days** of a second response being issued.

#### ***4.5 Additional Measures***

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are a number of other options available. The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Governance Co-ordinator, with specific terms of reference and timescales also being agreed. Complainants may wish to include the involvement of the Patient and Client Council in this process and contact

details of this service can be found in **Appendix 3**. Once agreement is reached upon which option is to be used the decision should be acknowledged with the complainant and additional information should be provided on the option to be used. Options include the following:

- Local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by an Independent Panel

#### **4.5.1 Local resolution investigation by a second team**

Local resolution investigation by a second team should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Governance Co-ordinator(s). The local resolution team should be chaired and led by a Manager/Clinician from another service area within the Directorate and have a Manager/Clinician from another Directorate as well as the relevant Governance Co-ordinator. This membership will provide a more detailed response with a measure of independence in responding to the complainant and make best use of Trust resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Governance Co-ordinator.
2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and Governance Co-ordinator.
3. A final copy of the findings of the second complaint review team will be sent by the relevant Governance Co-ordinator to the Director for issue to the complainant by **day 30** of the decision to use this option.

#### **4.5.2 Conciliation**

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to

maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

#### **4.5.3 Involvement of Lay Persons**

Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process. They are not intended to act as advocates, conciliators or investigators, and neither do they act on behalf of the Trust or the complainant. The Lay Person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements. The relevant Governance Co-ordinator will provide advice regarding the use of Lay Persons should the need arise.

#### **4.5.4 Involvement of Independent Experts**

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time; however the Trust reserves the right to accept/decline this request. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in relationships which would threaten public confidence in services and damage the Trust's reputation. The relevant Governance Co-ordinator will provide advice regarding the use of Independent Experts should the need arise.

#### **4.5.5 Review by Independent Panel**

In a small number of cases where complainant is not satisfied with the Trust's response, the Trust may wish to use an independent panel as a final attempt to resolve the complainant issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert, etc.) and an external layperson. The panel would be supported by the relevant Governance Co-ordinator.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements, etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

#### **4.5.6 Northern Ireland Commissioner for Complaints (Ombudsman)**

Once all options available to the Trust under local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the Ombudsman and provided with contact details for same. It is for the Ombudsman to determine whether or not a case falls within that Office's jurisdiction. *For contact details please refer to Appendix 3.*

#### **4.6 Joint Complaint Investigations**

Where a complaint relates to the actions of more than one HSC organisation, the *Health and Social Care Trusts Interim Memorandum of Understanding Joint Working Processes for Handling Complaints* should be referred to. The relevant Governance Co-ordinator will advise on this process.

#### **4.7 Out of Area Complaints**

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. The Governance Co-ordinator will advise on this process.

HSC contracts include entitlement, by the Trust, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

#### **4.8 Confidentiality**

Trust staff are aware of their legal and ethical duty to protect the confidentiality of the patient/client's information. The legal requirements are set out in the *Data Protection Act 1998* and the *Human Rights Act 1998*. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required of

*Southern Health and Social Care Trust  
Policy for the Management of Complaints*



their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code Practice on Protecting the Confidentiality of Service User Information*.

When using a patient's personal information for the purpose of investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation. Where a complaint relates to the actions of more than one HSC organisation the complainant's consent must be obtained before sharing the details of the complaint across HSC organisation.

Complaint investigations will be conducted with appropriate consideration of the confidentiality due to the staff involved in the complaint.

#### **4.9 Support and advice for Trust Staff**

Support and advice should be provided to any member of Trust staff involved in either informal or formal complaints by their Supervisor and/or Line Manager at any stage of the process.

Advice and assistance is available to Trust staff at any stage in the complaints process from the Trust's Directorate Governance Teams. *For contact details please refer to **Appendix 3**.*

The Trust has selected Carecall as an independent source of support for staff. Carecall staff are trained to listen and can offer support, guidance and a fresh outlook on not only issues at work but also personal problems. This service is free to Trust staff and Carecall are committed to protecting your confidentiality and anonymity. Carecall is available 24 hours a day, 7 days a week, and 365 days a year, please refer to the contact details below.

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| <p style="text-align: center;"><b>CARECALL</b></p> <p style="text-align: center;"><i>For free, confidential and immediate support call:</i></p> <p style="text-align: center;"><b>Telephone:</b> 0808 800 002</p> <p style="text-align: center;">For further information about the service:</p> <p style="text-align: center;"><b>Website:</b> <a href="http://www.carecallwellbeing.com">www.carecallwellbeing.com</a></p> |
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## SECTION FIVE: POLICY FOR HANDLING UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

### 5.0 Introduction

People may act out of character in times of trouble distress. There may have been upsetting or distressing circumstances leading up to a complaint. The Trust does not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the Trust or unreasonable behaviour towards Trust staff to be unacceptable. It is these actions that the Trust aims to manage under this policy.

This policy aims:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the Trust, what the Trust can or cannot do in relation to their complaint. The Trust aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered to be unacceptable. All complainants have the right to be heard, understood and respected, as do Southern Trust staff;
- to provide a service that is accessible to all complainants. However, the Trust retains the right, where it considers the actions of a complainant to be unacceptable, to restrict or change access to the service;
- and to ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who are unreasonable, vexatious and/or abusive manner.

### 5.1 Unacceptable Actions

The Trust defines unacceptable action as the following:

#### 5.1.1 Aggressive or abusive behaviour

The Trust understands that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards Trust staff, it will be considered unacceptable. **Any violence or abuse towards Trust staff will not be tolerated.**

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of such behaviour include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. The Trust also considers that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

The Trust expects its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a *Zero Tolerance* approach must be adopted. Trust staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards Trust staff.

#### **5.1.2 Unreasonable demands**

The Trust considers these demands become unacceptable when they start to (or when complying with the demand would) impact substantially upon the work of the organisation. An example of such impact would be that the demand takes up an excessive amount of staff time and in doing so disadvantages other complainants. Examples of unreasonable demands include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; or
- repeatedly changing the substance of a complaint or raising unrelated concerns.

#### **5.1.3 Unreasonable levels of contact**

Sometimes the volume and duration of contact made to the Trust by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when complainant repeatedly makes long telephone calls to the Trust or inundates the Trust with copies of information that has been sent already or that is irrelevant to the complaint. The Trust considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone or via emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

#### **5.1.4 Unreasonable persistence**

It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the Trust persistently about the same issue. Examples of unreasonable persistence include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. The way in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do that is not. The Trust consider the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

### **5.1.5 Unreasonable use of the complaints process**

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about the Trust, with which they have a continuing relationship, if subsequent incidents occur. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the Trust from pursuing a legitimate aim or implementing a legitimate decision. The Trust considers access to a complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable – but the Trust reserves the right to do so in those exceptional circumstances.

### **5.2 How the Trust manages aggressive or abusive behaviour**

The threat or use of physical violent, verbal abuse or harassment towards Trust staff is likely to result in a termination of all direct contact with the complainant. Trust staff will directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the Trust are only taken after careful consideration by a more senior member staff. Wherever possible, the Trust will give the complainant the opportunity to change their behaviour or action before a decision is taken.

### **All incidents of verbal and physical abuse will be reported to the police.**

The Trust will not accept any correspondence (letter, fax or e-mail) that is abusive to staff or contains allegations that lack substantive evidence. If such correspondence is received by the Trust, we will inform the complainant that we consider their language to be offensive, unnecessary and unhelpful and will request that they refrain from using such language. The Trust will not respond the correspondence if the action or behaviour continues.

Trust staff will end telephone calls if they consider the caller to be aggressive, abusive or offensive. All staff members taking such calls have the right to make this decision.

In extreme situations, the Trust will inform the complainant in writing that their name is on a “no personal contact” list. This means that the Trust will limit contact with the complainant to either written communication or through a third party.

### **5.3 Managing other unacceptable actions**

The Trust has to take action when unreasonable behaviour impairs the everyday functioning of the Trust. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

Where a complainant repeatedly phones, visits the Trust, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the Trust may decide to:

- limit contact or telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of Trust staff who will deal with the future telephone calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; or
- take any other action which the Trust considers appropriate.

Where the Trust considers correspondence on a wide range of issues to be excessive, we may inform the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly. In exceptional cases, the Trust will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further. *The Trust will always inform the complainant of what action it is taking and why.*

### **5.4 How the Trust lets people know of its decision to restrict contact**

When a Trust member of staff makes an immediate decision in response to unreasonable behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing<sup>4</sup> why a decision has been made to restrict future contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

### **5.5 Appealing a decision to restrict contact**

The Trust believes that it is important that a decision can be reconsidered and it is on this basis that a complainant can appeal a decision to restrict contact. The Trust will only consider arguments that relate to the restriction and **not** to either the complaint made to the Trust or its decision to

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<sup>4</sup> This can be supplemented if written communications are not the most appropriate form for the individual.

close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable; or that they will adversely impact on the individual because of personal circumstances. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They will advise the complainant in writing<sup>5</sup> that either the restricted contact arrangements will apply or a different course of action has been agreed.

#### **5.6 How the Trust records and reviews decisions to restrict contact**

The Trust records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complaints with restricted contact arrangements on a regular basis.

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<sup>5</sup> This can be supplemented if written communications are not the most appropriate form for the individual.

## SECTION 6: LEARNING FROM COMPLAINTS

### 6.0 Reporting and Monitoring

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we, or those providing care on our behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with the Trust's Governance arrangements and continually monitoring the effectiveness of the Trust's complaints procedures. To ensure good practice the Trust:

- regularly reviews its policies and procedures to ensure they are effective;
- monitors the nature and volume of complaints;
- seeks feedback from service users and staff to improve our services and performance; and
- ensuring that lessons are learnt from complaints and using these to improve services and performance.

The volume of complaints received is regularly monitored within the Trust through the following methods:

- Complaints figures are routinely discussed at Directorate Governance meetings/fora, SMT, the Governance Committee and at the Patient and Client Experience Committee meetings.
- Closed complaints figures are regularly sent to the Health and Social Care Board (HSCB) for consideration.
- A Trust complaints report is compiled annually and details how complaints were received and handled, and what lessons were learnt.

### 6.1 Learning

The Trust aims to manage all complaints received effectively and ensures that appropriate action is taken to address the issues highlighted by complaints. We make sure that lessons are learnt from all complaints so as to ensure the same mistakes do not re-occur within the Trust. Learning takes place at different levels within the Trust, with the individual, the team and the organisation as a whole.

Each Directorate within the Trust is provided with analysis and intelligence on the complaints received to ensure that trends are identified and acted upon.

The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will feed into the Trust's Governance systems as well as being directly fed back to the staff involved.

Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service

and Senior Managers to utilise the information and trends from their complaints to ensure learning and development and to develop and monitor actions and learning plans.

An annual report is presented to Trust Board, which summarises the complaints we have received, how they were handled, the outcomes and lessons learnt. This is published to the public on the Trust website ([www.southerntrust.hscni.net](http://www.southerntrust.hscni.net)).

Learning is a critical part of the Trust Complaints Procedure and the Trust values complaints and comments as an opportunity to improve services for our patients and clients. It is for this reasons that the Trust continually contributes to and learns from regional, national and international quality improvement and patient safety initiatives, and shares intelligence gained through complaints with other HSC organisations in Northern Ireland, the RQIA and the Ombudsman.



## **SECTION SEVEN: REVIEW AND IMPLEMENTATION**

### **7.0 Consultation**

During development, this policy was considered in draft form by the Trust's Governance Coordinators and Officers from Acute Services, Older Persons and Primary Care, Children and Young Persons Services and Mental Health and Disability.

The Review of the Policy for the Management of Complaints was informed by focus groups held for service users and Trust staff. These discussions ensured that the reviewed Policy reflected the needs of Trust staff and service users.

### **7.1 Approval**

The Policy for the Management of Complaints was presented in final draft and approved by SMT on...

### **7.2 Review**

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

The Policy for the Management of Complaints will be reviewed bi-annually.

### **7.3 Policy Implementation**

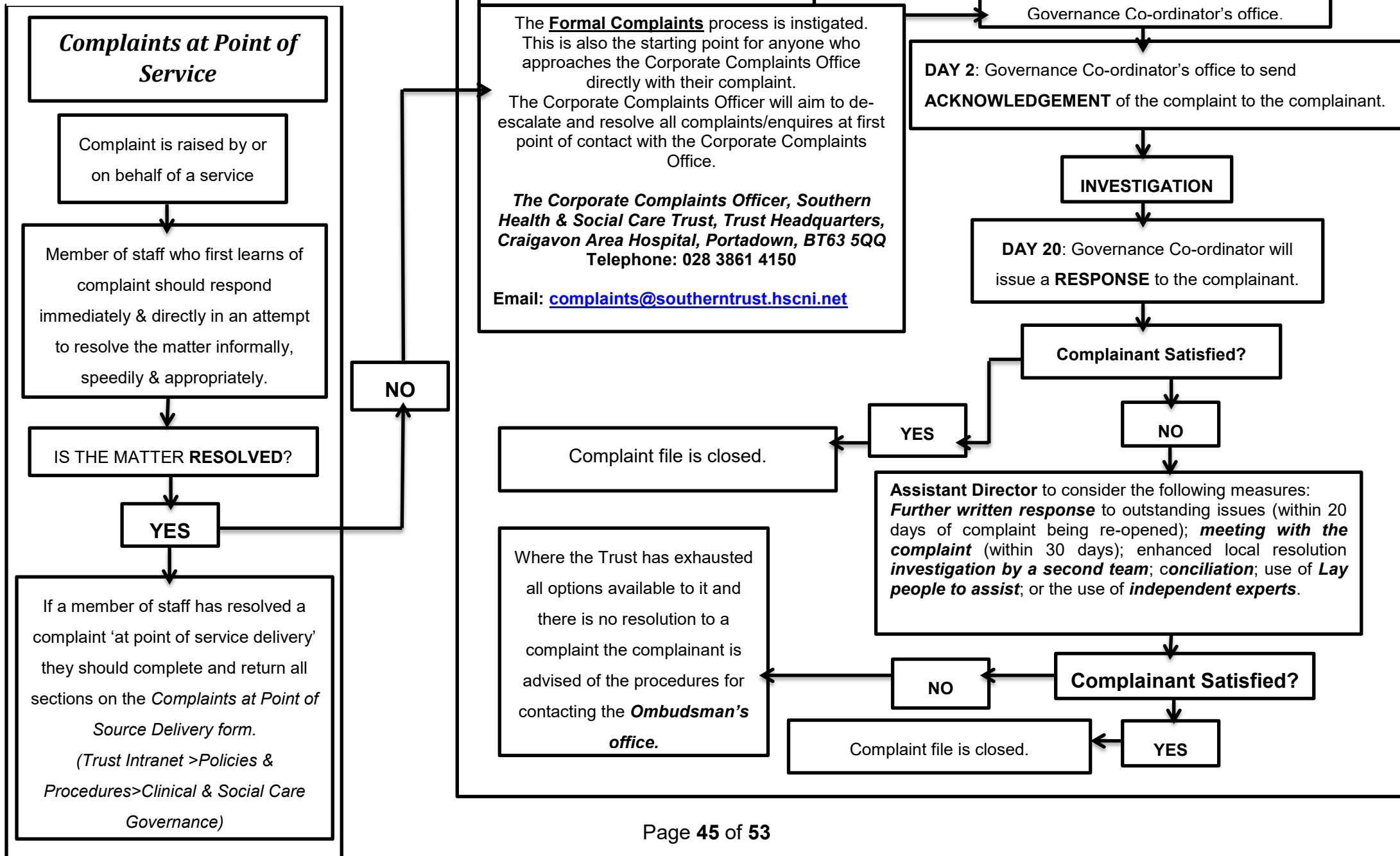
Following approval this policy will be circulated to all Trust staff via Global email.

A copy of the Policy for the Management of Complaints will be placed on the Trust's intranet.

#### **7.3.1 Training and Education**

All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

# Appendix 1 Complaints Process



## **Frequently Asked Questions**

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <p><b>“Will my services/care be hindered in making a complaint?”</b></p> | <p><i>No, making a complaint does not affect your rights and will not result in the loss of any services you have been assessed as requiring.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>“Who can make a complaint?”</b></p>                                | <p><i>Any person can complain about any matter connected with the provision of Trust services. Complaints may be made by:</i></p> <ul style="list-style-type: none"> <li><i>• a patient or client;</i></li> <li><i>• former patients, clients or visitors using Trust services and facilities;</i></li> <li><i>• someone acting on behalf of existing or former patients/clients (providing they have obtained the patient/client’s consent;</i></li> <li><i>• parents (or persons with parental responsibility) on behalf of a child; and</i></li> <li><i>• any appropriate person in respect of a patient/client unable by reason of physical or mental capacity to make the complainant himself or who has died, e.g. next of kin.</i></li> </ul>                                                                                                                                                                                               |
| <p><b>“How can I make a complaint?”</b></p>                              | <p><i>For the Trust it is important that we work closely with service users to find an early resolution to complaints when they arise.</i></p> <p><i>Initially you may wish to express your concerns to the person who is providing the care/services, or to other members of staff, such as receptionists, clinical/care staff. Every opportunity will be taken to resolve a complaint as close to the source as possible through discussion and negotiation.</i></p> <p><i>If you do this and are still not satisfied you may wish to express your concerns to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, the Trust advises complainants to address their complaint to the Trust’s Corporate Complaints Officer. Complaints may be made verbally or in writing, and will also be accepted via other methods, for example the telephone or electronically (e-mail).</i></p> |

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|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            | <p><b>Corporate Complaints Officer,<br/>Southern Health &amp; Social Care Trust,<br/>Trust Headquarter,<br/>Craigavon Area Hospital,<br/>Portadown,<br/>BT63 5QQ</b></p> <p><b>Telephone: 028 3861 4150</b><br/><b>Email: <a href="mailto:complaints@southerntrust.hscni.net">complaints@southerntrust.hscni.net</a></b></p> <p><i>When making a complaint it is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint.</i></p>                                                                                                                                                                                                                                                                                                                                                                      |
| <b>“Why is consent needed?”</b>                                            | <p><i>By law confidentiality must be respected at all times and it is for this reason that complaints made by a third party require the consent of the individual involved. Consent is required as the response to the complainant will include personal details about the individual involved.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>“How long does it take until I receive a response to my complaint?”</b> | <p><i>The relevant Governance Office will acknowledge receipt of the complaint within 2 working days. This acknowledgement will express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the Trust’s attention to the issue.</i></p> <p><i>After an investigation has been carried out by the relevant Directorate the Trust aims to issue a final response to the complainant within 20 working days of the Trust’s receipt of the complaint.</i></p> <p><i>In the event of the Trust being unable to meet the 20 working day target, which can be due to the complexity of a complaint, the Trust will issue a holding letter to the complainant. If this happens the Trust will remain in contact with the complainant and advise them as to when they should expect a final response in regards to the investigation of their complaint.</i></p> |

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| <p><b>“Who will investigate my complaint?”</b></p>           | <p><i>The complaint will be investigated by an investigating team made up of members of staff from within the Directorate where the complaint arose.</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <p><b>“What if I am not satisfied with my response?”</b></p> | <p><i>Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants will be advised that if they should be advised that if they remain unhappy with the Trust’s response they should contact the relevant Governance Office to discuss options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:</i></p> <ul style="list-style-type: none"> <li><i>• Further written response to outstanding issues;</i></li> <li><i>• Meeting with the complainant;</i></li> <li><i>• Enhanced local resolution investigation by a second team;</i></li> <li><i>• Conciliation;</i></li> <li><i>• Use of Lay people to assist;</i></li> <li><i>• Use of independent experts.</i></li> </ul> <p><i>If you are not happy with our response to your complaint, you can contact us again. We will discuss the options available which may assist in resolving any outstanding issues.</i></p> <p><i>If after this you remain unhappy, you can refer your complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman). The Ombudsman will consider your complaint to determine whether it warrants investigation by the Ombudsman’s office.</i></p> <p><b><i>The Ombudsman,<br/>Freepost BEL 1478,<br/>Belfast,<br/>BT1 6BR</i></b></p> <p><b><i>Telephone: 0800 34 34 24</i></b><br/> <b><i>Email: <a href="mailto:ombudsman@ni-ombudsman.org.uk">ombudsman@ni-ombudsman.org.uk</a></i></b><br/> <b><i>Website: <a href="http://www.ni-ombudsman.org.uk">www.ni-ombudsman.org.uk</a></i></b></p> |

**“What if I don’t want to make a formal complaint?”**

*The Southern Trust is committed to providing a high quality service to all its users. You can help us improve our services by telling us of your experiences. Your views are much appreciated and will be treated in confidence.*

*If you do not wish to make a formal complaint you can also make a comment or suggestion, which can be done by completing the ‘We Value Your Views’ leaflet.*

*An Informal complaint can also be made by speaking to a member of staff at the point of service delivery, or by speaking to the Trust’s Corporate Complaints Officer.*

**Corporate Complaints Officer,  
Southern Health & Social Care Trust,  
Trust Headquarters,  
Craigavon Area Hospital,  
Portadown,  
BT63 5QQ**

**Telephone: 028 3861 4150**

**Email: [complaints@southerntrust.hscni.net](mailto:complaints@southerntrust.hscni.net)**

**Useful Contacts**

| <b><u>Southern Trust Contacts</u></b>                                                           |                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Corporate Complaints Officer</b>                                                             | <p>Southern Health and Social Care Trust,<br/>Trust Headquarters,<br/>Craigavon Area Hospital,<br/>Portadown,<br/>BT63 5QQ</p> <p>Telephone: (028) 3861 4150<br/>Email: <a href="mailto:complaints@southerntrust.hscni.net">complaints@southerntrust.hscni.net</a></p> |
| <b>Acute Services Clinical &amp; Social Care Governance Office</b>                              | Telephone: (028) 3861 2987                                                                                                                                                                                                                                             |
| <b>Children &amp; Young People's Services Clinical &amp; Social Care Governance Office</b>      | Telephone: (028) 3839 8345                                                                                                                                                                                                                                             |
| <b>Mental Health &amp; Disability Directorate Clinical &amp; Social Care Governance Office</b>  | Telephone: (028) 3883 3366                                                                                                                                                                                                                                             |
| <b>Older People &amp; Primary Care Directorate Clinical &amp; Social Care Governance Office</b> | Telephone: (028) 3883 3365                                                                                                                                                                                                                                             |
| <b><u>Support &amp; Advocacy Services</u></b>                                                   |                                                                                                                                                                                                                                                                        |
| <b>Southern Trust Patient Support Service (Acute Directorate)</b>                               | <p>Patient Support Service<br/>Craigavon Area Hospital<br/>68 Lurgan Road<br/>Portadown BT63 5QQ</p> <p>Telephone: (028) 3861 2395 / 4285<br/>Email: <a href="mailto:PatientSupport.CAH@southerntrust.hscni.net">PatientSupport.CAH@southerntrust.hscni.net</a></p>    |

|                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                            | <p><b>Patient Support Service</b><br/> <b>Daisy Hill Hospital</b><br/> <b>5 Hospital Road</b><br/> <b>Newry BT35 8DR</b></p> <p>Telephone: (028) 3083 5070<br/> Email: <a href="mailto:PatientSupport.DHH@southerntrust.hscni.net">PatientSupport.DHH@southerntrust.hscni.net</a></p>                                                                                                                            |
| <b>Disability Action</b>                                                   | <p><b>Human Rights Advocate,</b><br/> <b>Disability Action's Centre on Human Rights,</b><br/> <b>Disability Action,</b><br/> <b>Portside Business Park,</b><br/> <b>189 Airport Road West,</b><br/> <b>Belfast,</b><br/> <b>BT3 9ED</b></p> <p>Telephone: (028) 9029 7880<br/> Textphone: (028) 9029 7882<br/> Email: <a href="mailto:humanrights@disabilityaction.org">humanrights@disabilityaction.org</a></p> |
| <b>Niamh (Northern Ireland Association for Mental Health)</b>              | <p><b>80 University Street,</b><br/> <b>Belfast,</b><br/> <b>BT7 1HE</b></p> <p>Telephone: (028) 9032 8474<br/> Email: <a href="mailto:info@beaconwellbeing.org">info@beaconwellbeing.org</a></p>                                                                                                                                                                                                                |
| <b>VOYPIC</b>                                                              | <p><b>Voice of Young People In Care</b><br/> <b>Flat 12, Mount Zion House</b><br/> <b>Edward Street</b><br/> <b>Lurgan</b><br/> <b>BT66 6DB</b></p> <p>Telephone: (028) 3831 3380<br/> Website: <a href="http://www.voypic.org">www.voypic.org</a></p>                                                                                                                                                           |
| <b>NICCY (Northern Ireland Commissioner for Children and Young People)</b> | <p><b>Legal and Investigations Team</b><br/> <b>NICCY</b><br/> <b>Equality House</b><br/> <b>7-9 Shaftesbury Square</b></p>                                                                                                                                                                                                                                                                                      |



|                                                     |                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                     | <b>Belfast</b><br><b>BT2 7DP</b><br><br><b>Telephone: (028) 9031 1616</b> (Monday – Friday: 9:00am to 5:00pm)<br><b>Email: <a href="mailto:listening2u@niccy.org">listening2u@niccy.org</a></b><br><b>Website: <a href="http://www.niccy.org">www.niccy.org</a></b>                                             |
| <b>Age NI</b>                                       | <b>Age NI</b><br><b>3 Lower Crescent</b><br><b>Belfast</b><br><b>BT7 1NR</b><br><br><b>Telephone: 0808 808 7575</b> (8:00am to 7:00pm, 7 days a week)<br><b>Email: <a href="mailto:advice@ageni.org">advice@ageni.org</a></b><br><b>Website: <a href="http://www.ageni.org/advice">www.ageni.org/advice</a></b> |
| <b>Patient &amp; Client Council</b>                 | <b>Telephone: 0800 917 0222</b><br><b>Website: <a href="http://www.patientclientcouncil.hscni.net">www.patientclientcouncil.hscni.net</a></b>                                                                                                                                                                   |
| <b>Carecall</b> ( <i>Mental Wellbeing at Work</i> ) | <b>Telephone: 0808 800 002</b><br><b>Website: <a href="http://www.carecallwellbeing.com">www.carecallwellbeing.com</a></b>                                                                                                                                                                                      |

### **What to do if you're still not happy?**

|                                                                     |                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Northern Ireland Commissioner for Complaints (the Ombudsman)</b> | <b>The Ombudsman,</b><br><b>Freepost BEL 1478,</b><br><b>Belfast,</b><br><b>BT1 6BR</b><br><br><b>Telephone: 0800 34 34 24</b><br><b>Email: <a href="mailto:ombudsman@ni-ombudsman.org.uk">ombudsman@ni-ombudsman.org.uk</a></b><br><b>Website: <a href="http://www.ni-ombudsman.org.uk">www.ni-ombudsman.org.uk</a></b> |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### **Complaints about Regulated Establishments**

|                                     |                                                    |
|-------------------------------------|----------------------------------------------------|
| <b>The Regulation &amp; Quality</b> | <b>The Regulation &amp; Improvement Authority,</b> |
|-------------------------------------|----------------------------------------------------|

|                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Improvement Authority (RQIA)                                                                                                                    | <p>9<sup>th</sup> Floor Riverside Tower,<br/>5 Lanyon Place,<br/>Belfast,<br/>BT1 3BT</p> <p>Telephone: (028) 9051 7500<br/>Fax: (028) 9051 7501</p> <p>Email: <a href="mailto:info@rqia.org.uk">info@rqia.org.uk</a><br/>Website: <a href="http://www.rqia.org.uk">www.rqia.org.uk</a></p> |
| <p align="center"><b><u>Complaints about Family Practitioner Services</u></b><br/><b>(family doctors, dentists, pharmacists, opticians)</b></p> |                                                                                                                                                                                                                                                                                             |
| HSC Board<br>Complaints Manager                                                                                                                 | <p>Southern LCG,<br/>Tower Hill,<br/>Armagh,<br/>BT61 9DR</p> <p>Email: <a href="mailto:Complaints.hscb@hscni.net">Complaints.hscb@hscni.net</a></p>                                                                                                                                        |

**Wright, Elaine**

---

**From:** Wright, Elaine [Personal Information redacted by the USI]  
**Sent:** 12 February 2016 09:51  
**To:** Clarke, Paula  
**Subject:** Constituent Enquiry Arelen Foster obo [Personal Information redacted by the USI]

fyi

---

**From:** Cardwell, David  
**Sent:** 11 February 2016 17:45  
**To:** [Personal Information redacted by the USI]  
**Cc:** Complaints; Wright, Elaine  
**Subject:** FW: Constituent Enquiry Arelen Foster obo [Personal Information redacted by the USI]

Dear Mrs Foster

Thank you for your email of 8 February 2016 in relation to [Personal Information redacted by the USI]. I am advised that Mrs Corrigan, Head of Urology for the Southern Trust has looked into this matter. She has confirmed that the referral to Dr K Rooney, Consultant Oncologist, at the Belfast Trust, was sent on 1 February 2016 along with a letter to the patient, from Mr O'Brien, Consultant Urologist, advising him of the referral.

In this instance if [Personal Information redacted by the USI] has not received an appointment then the Belfast Trust would be best placed to advise on their plans for [Personal Information redacted by the USI] treatment.

If you require any further information please do not hesitate to contact us.

Kind Regards

David Cardwell

Clinical and Social Care Governance Team  
Directorate of Acute Services  
Southern Health and Social Care Trust

Telephone: [Personal Information redacted by the USI]  
Email: [Personal Information redacted by the USI]

**Willis, Lisa**

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**From:** Trouton, Heather  
**Sent:** 29 October 2015 09:18  
**To:** Brown, Robin; Gilpin, David; Hurreiz, Hisham; McKay, Damian; Neill, Adrian; Farnan, Turlough; Hall, Sam; Korda, Marian; Leyden, Peter; McNaboe, Ted; Reddy, Ekambar; Epanomeritakis, Manos; Hewitt, Gareth; Lewis, Alastair; Mackle, Eamon; Mallon, Peter; Weir, Colin; Yousaf, Muhammad; Bunn, Jonathon; McKeown, Ronan; McMurray, David; Murnaghan, Mark; Patton, Sean; Wilson, Lynn; Glackin, Anthony; O'Brien, Aidan; Young, Michael; McArdle, Gerard; Gudyma, Jaroslaw; McCaul, David; Mathers, Helen; Doyle, Timothy; Alam, Ahsan; Watson, Bruce; Rajkumar, Shan; Haynes, Mark; ODonoghue, JohnP; Suresh, Ram  
**Cc:** Mackle, Eamon; Corrigan, Martina; Nelson, Amie; Reid, Trudy  
**Subject:** FW: WHISTLEBLOWING POLICY  
**Attachments:** WhistleblowingPolicyMarch2015-RevisedandFinal.pdf  
**Importance:** High  
**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Dear All

Following a recent Trust survey of staffs' understanding of Whistle Blowing, please see attached a re issue of the Whistle Blowing policy for your attention.

The Policy is also available on the Intranet in the Human Resources section.

Can you please ensure this is shared with your medical team.

Thanks  
Heather



## **WHISTLEBLOWING POLICY**

### **Policy Checklist**

|                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Name of Policy:                                                                 | Whistleblowing Policy and Procedure for Raising Concerns at Work                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| Purpose of Policy:                                                              | The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to safeguard anyone who raises concerns, and this policy encompasses the requirements of that Order. The policy provides a mechanism for staff to raise concerns about a range of matters at an early stage and in the right way thereby developing a culture of responsible openness and constructive criticism regarding all aspects of the Trust's activities including clinical care. |  |
| Directorate responsible for Policy                                              | Directorate of Human Resources & Organisational Development                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Name & Title of Author:                                                         | Vivienne Toal - Head of Employee Engagement & Relations                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| Does this meet criteria of a Policy?                                            | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Staff side consultation?                                                        | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Equality Screened by:                                                           | Vivienne Toal – Head of Employee Engagement & Relations                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| Date Policy submitted to Policy Scrutiny Committee:                             | 30 <sup>th</sup> March 2015                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Policy Approved/Rejected/Amended                                                | Approved subject to amendments                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |
| Communication / Implementation Plan required?                                   | Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Any other comments:                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| Date presented to SMT                                                           | April 2015                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| Director Responsible                                                            | Mr Kieran Donaghy                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| SMT / Trust Board Approved/Rejected/Amended                                     | Approved                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| Date returned to Directorate Lead for implementation (DHR&OD)                   | 30 <sup>th</sup> March 2015                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Date received by Employee Engagement & Relations for database/Intranet/Internet | 30 <sup>th</sup> March 2015                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Date for further review                                                         | March 2017                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |

| POLICY DOCUMENT – VERSION CONTROL SHEET             |                                                                                                                                                             |
|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Title</b>                                        | Title: Whistleblowing Policy<br>Version: 2_0<br>Reference number/document name:                                                                             |
| <b>Supersedes</b>                                   | Supersedes: Whistleblowing Policy version 1                                                                                                                 |
| <b>Originator</b>                                   | Name of Author: Vivienne Toal<br>Title: Head of Employee Engagement & Relations                                                                             |
| <b>Policy Scrutiny Committee &amp; SMT approval</b> | Referred for approval by: Vivienne Toal<br>Date of Referral:<br>Policy Scrutiny Committee Approval<br>SMT approval: As Above                                |
| <b>Circulation</b>                                  | Issue Date: September 2017<br>Circulated By: Vivienne Toal<br>Issued To: Directors, Assistant Directors, Heads of Service for onward distribution to staff. |
| <b>Review</b>                                       | Review Date: March 2017<br>Responsibility of (Name): Vivienne Toal<br>Title: Head of Employee Engagement & Relations                                        |



# **WHISTLEBLOWING POLICY**

## **AND**

# **PROCEDURE FOR RAISING ISSUES OF CONCERN AT WORK**

|                                |                                                        |
|--------------------------------|--------------------------------------------------------|
| <b>Author</b>                  | Vivienne Toal, Head of Employee Engagement & Relations |
| <b>Directorate responsible</b> | Human Resources & Organisational Development           |
| <b>Date</b>                    | March 2015                                             |
| <b>Review date</b>             | March 2017                                             |

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## **1.0 INTRODUCTION TO POLICY**

The Southern Health & Social Care Trust is committed to promoting a culture of openness in which staff are encouraged to raise concerns without fear of reprisal and victimisation; and to ensuring that health and social care services are provided with the highest standards of integrity and honesty. The Trust expects all employees to maintain high standards in all areas of practice. All employees are therefore strongly encouraged to report any perceived wrongdoing by the organisation, its employees or workers that fall short of these principles.

Each of us at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about dangers to or ill treatment of service users, staff or the public, issues relating to the quality of care provided, patient safety, professional misconduct, unlawful conduct, financial malpractice, fraud, health and safety, or dangers to the environment, it can be difficult to know what to do.

You may be worried about raising such issues. You may want to keep the concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or the organisation. You may decide to say something but find you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also not be clear how your own professional code of conduct relates to Trust procedures.

## **2.0 PUBLIC INTEREST DISCLOSURE (NORTHERN IRELAND) ORDER 1998**

The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to protect anyone who raises concerns from detriment and / or dismissal, and this policy encompasses the requirements of that Order. The Order protects employees or workers who make "protected disclosures", i.e. who reports wrongdoing within the workplace. This policy provides a process to enable employees or workers to inform the organisation about any wrongdoing in the workplace which they believe has occurred, or is likely to occur. Protection is against victimisation, disciplinary action or dismissal for employees who raise genuine concerns.

The Order 1998 has a tiered approach to disclosures which most easily gives workers protection for raising a concern internally. It is intended that this policy and associated procedure provide reassurance to staff who wish to raise such matters internally. Guidance from a range of regulatory / professional bodies encourages registrants to raise their concerns internally to ensure maximum level of protection under the Public Interest Disclosure Act.

Further details of the Order can be found using the following web address:  
<http://www.pcaw.co.uk/law/pida.htm>.

### 3.0 **PURPOSE AND AIMS**

#### **Purpose**

The Senior Management Team of the Trust is committed to running the organisation in the best way possible and to do so we need the help of those who work for us. We have this policy in place to reassure those who work for us that it is safe and acceptable to speak up and to enable all workers to raise any concerns that they may have at an early stage and in the right way.

There may be times when, after staff have raised a concern under this policy, it is deemed to be more appropriate to be dealt with differently. However this should not stop staff raising concerns under this Policy.

#### **This policy aims to:**

- Provide an avenue for you to raise a concern internally as a matter of course, and receive feedback on any action taken;
- Provide for matters to be dealt with quickly and appropriately and ensure that they are taken seriously;
- Reassure you that you will be protected from reprisals or victimisation for raising the concern in good faith;
- Allow you to take the matter further if you are dissatisfied with the Trust's response.

### 4.0 **POLICY STATEMENT**

The Trust would rather that you raised the matter when it is just a concern rather than waiting for proof. It is important to raise any concerns at an early stage, on the basis of any level of concern or relevant information. Indeed, if you have serious suspicions that an offence has been committed, you have a responsibility to report them as soon as possible. We all have a responsibility to protect the Trust, its service users, staff and public. **If in doubt – raise it!**

If something is troubling you that you think the Trust should know about or look into, please use the Procedure for Raising Concerns at Work – see section 10.0. You should never accuse individuals directly, and telling the wrong persons may jeopardise an investigation.

What we do ask is that in order to qualify for protection under this policy, you must:

- Act in good faith (effectively this means honestly) and

- Genuinely believe the information you are going to impart is accurate and
- Not act maliciously.

## **Our assurances to you**

### ***Your safety***

The Chair, Chief Executive & Trust Board are committed to this Policy. If you raise a genuine concern under this Policy, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this same assurance is not extended to someone who maliciously raises a matter they know is untrue, and in such cases disciplinary action will be considered.

### ***Your confidence***

#### Confidentiality

The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern under this Policy. However, we recognise that you may nonetheless want to raise a concern in confidence. If you ask us to protect your identity by keeping your confidence, we will respect your request and it will not be disclosed without your consent. However a situation may arise where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court, or the Trust has to act on the information), and this will be discussed with you in advance of any disclosure.

#### Anonymous allegations

Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. You are encouraged to put your name to any issue of concern you are raising. Allegations expressed anonymously and/or with little detail or information are much less powerful and more difficult to address but may be considered at the discretion of the Trust. Whilst we will give due consideration to anonymous reports, we cannot follow the procedure set out in Section 11.0 for any concerns raised anonymously. The Trust endeavours to promote a supportive environment in which you are able to express your concerns in confidence, thereby hopefully negating the need for raising concerns anonymously.

## **5.0 SCOPE OF POLICY**

This Policy applies to you whether you are a permanent, temporary or bank employee. The Trust is also very dependent on a wide range of contractors, suppliers, and others not directly employed by the Trust such as agency staff, trainees, volunteers, secondees, or a student or anyone on a work experience placement – the policy applies to all individuals in these categories where there are concerns about the activities of the Trust.

## **6.0 HOW WE WILL HANDLE YOUR CONCERN**

Members of staff, including students, can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or colleague where appropriate.

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal enquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her, the timescale for action and whether your further assistance may be needed.

All staff who raise a concern will be automatically allocated support from the Head of Employee Engagement & Relations or a nominated deputy throughout the investigation process in line with section 8.0.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can and confirm our response in writing. Please note that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

## **7.0 RESPONSIBILITIES**

### **7.1 Your responsibilities**

The Trust wishes to encourage you to highlight areas where you are aware of inadequacies in the provision of services. In doing so concerns can be addressed at the earliest opportunity thus ensuring an overall improvement in the level of services provided to service users.

In particular you have a responsibility to:

- report any genuine concern of wrongdoing or malpractice preferably to your line manager or alternatively via one of the other options set out in the procedure in section 10.0. Proof of wrongdoing is not required, merely a genuine and reasonable concern. At the same time, you have an equal responsibility not to raise issues maliciously, where no potential evidence or indication of malpractice or danger exists; and

- familiarise yourself with and to understand the procedure for raising concerns outlined in section 11.0.
- be aware that information given unjustifiably to the media may unreasonably undermine public confidence in the Trust and Health and Social Care generally.

## 7.2 Our Responsibilities

All **managers** contacted by a member of staff, are responsible for:

- ensuring at the earliest opportunity that the appropriate action is taken in line with section 10, considering the nature and seriousness of the concern raised, including informing others, responding to concerns quickly and in confidence, taking all concerns seriously. This action will include deciding how any person, against whom an allegation is made, is informed of the matter, ensuring that the investigation is not jeopardised by the disclosure.
- supporting and reassuring those raising concerns – it is recognised that raising concerns can be difficult and stressful
- responding to all concerns without pre-judging
- recording all concerns, including the date the concern was raised, dates of interviews with employees, who was present at each interview and the action agreed
- keeping all records safely and securely

The **Trust's Senior Management Team**, through the Director of Human Resources & Organisational Development is responsible for:

- ensuring that these procedures are explained to all new staff, as part of Trust Induction
- protecting the interests and confidentiality of staff, for treating any concerns raised seriously, and for investigating them fairly and thoroughly
- ensuring that an investigation report relating to each Whistleblowing concern raised is considered as part of the Trust's Corporate / Clinical & Social Care Governance arrangements.

## 8.0 SUPPORT FOR EMPLOYEES

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Head of Employee Engagement & Relations or a nominated deputy

throughout any investigation process. The Head of Employee Engagement & Relations will not undertake an investigation role in any whistleblowing case but will oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.

The Trust also provides Carecall services to all employees through its Employee Assistance Programme; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Head of Employee Engagement & Relations will arrange for you to receive advice about the process.

If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Head of Employee Engagement & Relations.

## **9.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS**

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

## **10.0 ALTERNATIVE FORMATS**

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

## **11.0 COPYRIGHT**

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe

copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

## **12.0 PROCEDURE FOR RAISING CONCERNS AT WORK**

There are a range of options from which you can choose if you wish to raise a concern.

Concerns are best raised in writing. You should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

### **12.1 How to raise a concern internally**

Staff should raise any concern internally using one of the options listed below:

#### **➤ Option 1**

Managers have a vital role to play in ensuring that you and your colleagues are able to make constructive contributions and to feel that your ideas are welcomed, appreciated and where appropriate, acted upon in a positive manner.

You are therefore encouraged in the first instance to raise concerns with your line manager. You may wish to involve a Trade Union representative or colleague to advise or assist you. As soon as you have a concern, you should make an immediate note of it. You should write down all the relevant details – what was said or done, date, time, names etc.

#### **➤ Option 2**

If, for any reason, you feel unable to raise the concern with your line manager, please raise the matter with another senior person you can trust. This might be another manager or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

#### **➤ Option 3**

If you feel that the concern is so serious that it cannot be discussed with any of the above you can contact:-

- |                                                         |                                                     |                                                         |
|---------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------|
| ➤ Director of Human Resources & OD                      | direct line                                         | <small>Personal Information redacted by the USI</small> |
| ➤ Chief Executive                                       | direct line                                         | <small>Personal Information redacted by the USI</small> |
| ➤ Non –Executive Director<br>(See Appendix 2 for names) | contacted through the Chair's office<br>direct line | <small>Personal Information redacted by the USI</small> |

The contact address for any of the above is: -

**Southern HSC Trust Headquarters, Craigavon Area Hospital, Lurgan Road, PORTADOWN, BT63 5QQ**

## **12.2 Response required from internal managers / Director to whom concerns are reported**

### **Stage 1**

ALL whistleblowing concerns MUST be notified by internal managers to the Director of Human Resources & Organisational Development for logging and investigation. The Director of Human Resources & Organisational Development will ensure that the Head of Employee Engagement & Relations is notified of the concern to ensure support can be provided to the employee.

The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff). Advice from Employee Engagement & Relations may help to clarify this at any early stage.

Any internal manager / Director to whom a concern is raised must then arrange to meet with the employee to discuss the concern without delay along with a representative from the Employee Engagement & Relations team.

The manager / Director and HR representative should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter.

A record should be made of all discussions at this stage by the manager and Employee Engagement & Relations.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is



decided that further action cannot be justified, the reasons for this decision should be documented and retained by the Employee Engagement & Relations Department.

## Stage 2

Once the preliminary facts / issues of concern have been established, the approach to investigating the concern must be discussed and agreed. A record should be made of the decisions and/or agreed actions which should be signed and dated.

## Stage 3

Within 10 working days of the concern being received, the manager receiving the concern must write to the employee:

- Acknowledging that the concern has been received;
- Indicating how the matter will be dealt with;
- Providing an estimate as to how long it will take to provide a final response; and/or
- Telling the employee whether any initial enquiries have been made; and
- Telling the employee whether further investigations will take place and if not why not; and /or
- Letting the employee know when s/he will receive further details if the situation is not yet resolved; and
- Providing the employee with details of whom to contact should s/he be dissatisfied with this response (see 10.4 below)

Advice from Employee Engagement & Relations should be sought when drafting the letter of response.

### 11.3 How to raise a concern externally

If you are unable to raise the matter internally as outlined above in Options 1 to 3, or if you feel it has not been dealt with properly, we would rather you raise it with an appropriate external agency, detailed in Option 4 below, than not at all.

➤ **Option 4.**

Provided that you are acting in good faith and have evidence to back up the concern, your concern may also be raised with: -

- Relevant Professional / Regulatory Bodies (e.g. Nursing & Midwifery Council, General Medical Council, Northern Ireland Social Care Council, Health Care Professions Council etc.)
- Statutory Bodies (e.g., Mental Health Commission, Regulation & Quality Improvement Authority (RQIA))
- The Health and Safety Executive for N. Ireland
- Department of Health, Social Services and Public Safety.

Contact addresses and telephone numbers are included in Appendix 1.

#### **11.4 If You Remain Dissatisfied**

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in Section 10.3. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly. By using this procedure, you will help us to achieve this.

#### **12.0 SOURCES OF INDEPENDENT ADVICE AND FURTHER INFORMATION**

You may also wish to access independent advice for example,

- A Trust JNCF Trade Union representative or any other recognised Trade Union official;

**or**

- The independent charity *Public Concern at Work*
  - telephone 0207 404 6609 where lawyers can give free confidential advice at any stage about how to raise a serious concern.

**Northern Ireland Social Care Council**

7<sup>th</sup> Floor Millennium House  
Great Victoria Street  
BELFAST  
BT2 7AQ  
028 90 417600

**Nursing & Midwifery Council**

23 Portland Place  
LONDON  
W1B 1PZ  
020 76377181

**Regulation & Quality Improvement  
Authority (RQIA)**

9<sup>th</sup> Floor Riverside Tower  
5 Lanyon Place  
BELFAST  
BT1 3BT  
028 90 517500

**General Medical Council**

20 Adelaide Street  
BELFAST  
BT2 8GD  
028 90 517022

**Health Professions Council**

184 Kennington Park Road  
LONDON  
SE11 4BU  
020 78409814

**Department of Health, Social Services &  
Public Safety (DHSSPSNI)**

Castle Buildings  
Stormont  
BELFAST  
BT4 3SJ  
028 90 520500

**Health & Safety Executive for Northern  
Ireland**

83 Ladas Drive  
BELFAST  
BT6 9FR  
028 90243249 (Free phone 0800 0320 121)

**Mental Health Commission for Northern  
Ireland**

4<sup>th</sup> Floor – Lombard House  
10-20 Lombard Street  
BELFAST  
BT1 1RD

**DHSSPS Fraud Hotline**

**Tel 08000 963396**

**List of Non-Executive Directors with whom a concern can be raised**

Mrs Deirdre Blakely

Mr Edwin Graham

Mrs Siobhan Rooney

Mrs Hester Kelly

Mrs Elizabeth Mahood

Mr Raymond Mullan

Mr Roger Alexander

**Contact can be made with any of the above Non-Executive Directors through the Office of the Chair on 028 38 613962.**

**Quality care – for you, with you**

## REPORT SUMMARY SHEET

|                      |                                                                                               |
|----------------------|-----------------------------------------------------------------------------------------------|
| Meeting:<br>Date:    | Trust Board<br>Thursday 26 <sup>th</sup> November 2015                                        |
| Title:               | Whistleblowing Survey Results 2015<br>(DRAFT report)                                          |
| Lead Director:       | Kieran Donaghy<br>Director of Human Resources & Organisational<br>Development                 |
| Corporate Objective: | Provide safe, high quality care<br>Be a great place to work<br>Make the best use of resources |
| Purpose:             | For Approval                                                                                  |

### Summary of Key Issues for Trust Board

#### High level context:

In April 2015 the Trust invited staff to complete a 'Raising Concerns - Whistleblowing Survey' via Survey Monkey online which focused on seeking staff views on the Trust's Whistleblowing Policy and Procedure for Raising Concerns and how comfortable and confident staff are about raising a concern internally. The purpose of this is to ensure staff views are incorporated into the review of the Trust's Whistleblowing Policy and Procedure for Raising Concerns, and how it is implemented in practice.

Sir Robert Francis, QC published his report "The Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS" in February 2015. This review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

In addition, RQIA has announced the commencement of a Review of the Operation of the HSC Whistleblowing Arrangements in November 2015 and expects to report on its findings by March 2016.

**Key issues/risks for discussion:**

This report provides detail on the following:

- Section 1: findings of the Trust's Whistleblowing survey – April 2015
- Section 2: a summary of the findings and employer actions recommended in the Francis Report – 'Freedom to Speak Up' published in February 2015
- Section 3: action plan to address Trust survey findings and Francis Report recommendations

A presentation to Trust Board will be provided on this report.

**Summary of SMT challenge/discussion:**

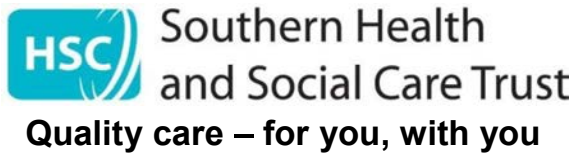
Members were concerned that the report indicated that staff felt that they were unable to raise concerns and welcomed the action plan that has been developed. However, they were keen that this should be kept under review at SMT.

**Internal/External engagement:**

- Staff Survey
- SMT
- Trade Union Side

**Human Rights/Equality:**

There are no Human Rights/Equality issues to be raised which are specific to the content of this month's report.



# DRAFT REPORT

## Raising Concerns

### Whistleblowing Survey Results 2015

|                                 |                                                                                                             |
|---------------------------------|-------------------------------------------------------------------------------------------------------------|
| Version                         | 1                                                                                                           |
| Presented to Board of Directors | Thursday 26 <sup>th</sup> November 2015                                                                     |
| Authors of report:              | <ul style="list-style-type: none"><li>• Vivienne Toal Head of Employee Engagement &amp; Relations</li></ul> |

|               |                                                                                                     |
|---------------|-----------------------------------------------------------------------------------------------------|
|               | <ul style="list-style-type: none"> <li>Anne Forsythe, Learning &amp; Development Manager</li> </ul> |
| Presented by: | <b>Kieran Donaghy, Director of HROD</b>                                                             |

## **Introduction**

In April 2015 the Trust invited staff to complete a 'Raising Concerns - Whistleblowing Survey' via Survey Monkey online which focused on seeking staff views on the Trust's Whistleblowing Policy and Procedure for Raising Concerns and how comfortable and confident staff are about raising a concern internally. The purpose of this is to ensure staff views are incorporated into the review of the Trust's Whistleblowing Policy and Procedure for Raising Concerns, and how it is implemented in practice.

1050 responses to the survey were received from staff.

This report provides detail on the following:

Section 1: findings of the Trust's Whistleblowing survey – April 2015

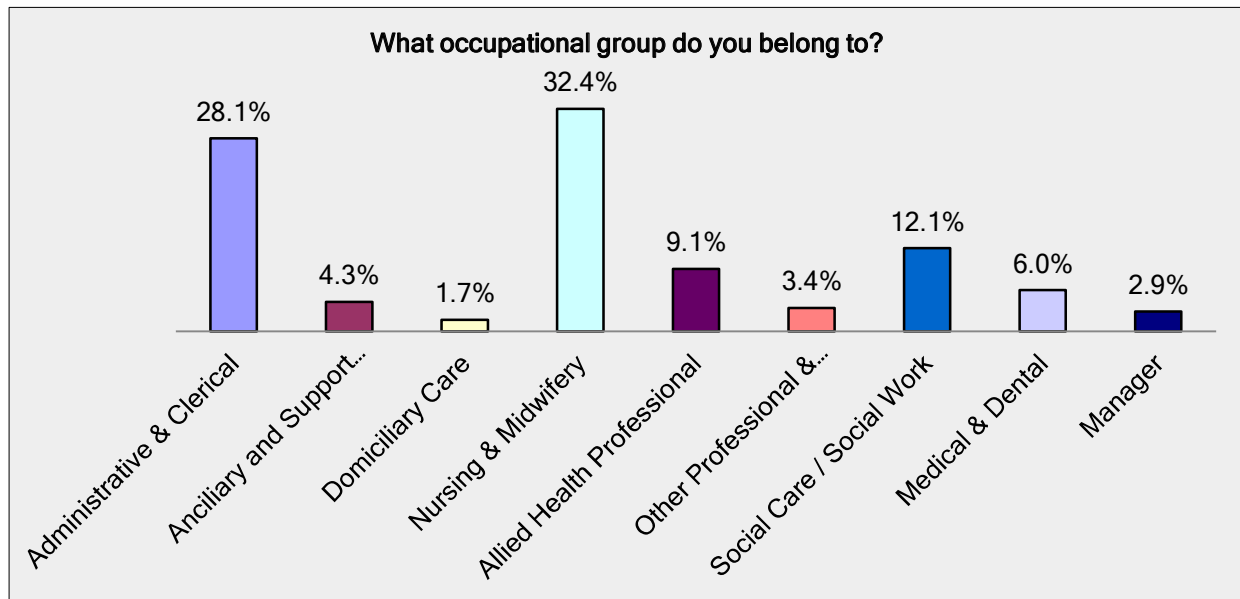
Section 2: a summary of the findings and employer actions recommended in the Francis Report – 'Freedom to Speak Up' published in February 2015

Section 3: action plan to address survey findings and Francis Report recommendations



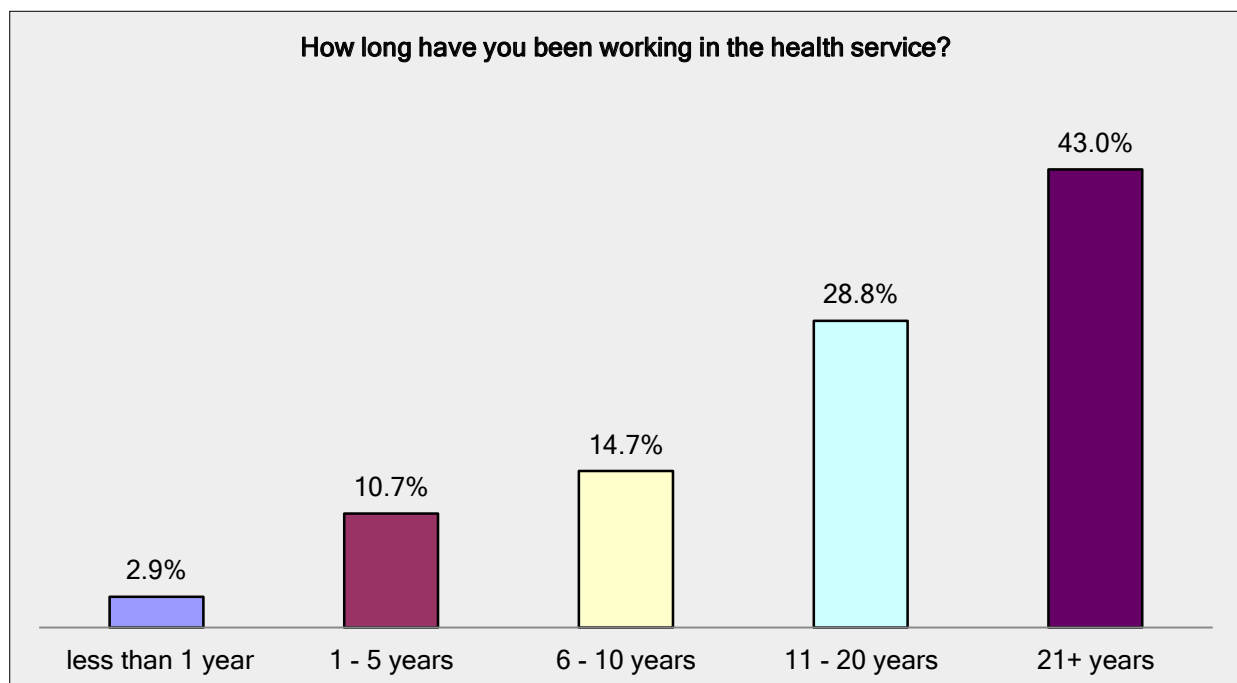
## SECTION 1 - Survey Findings

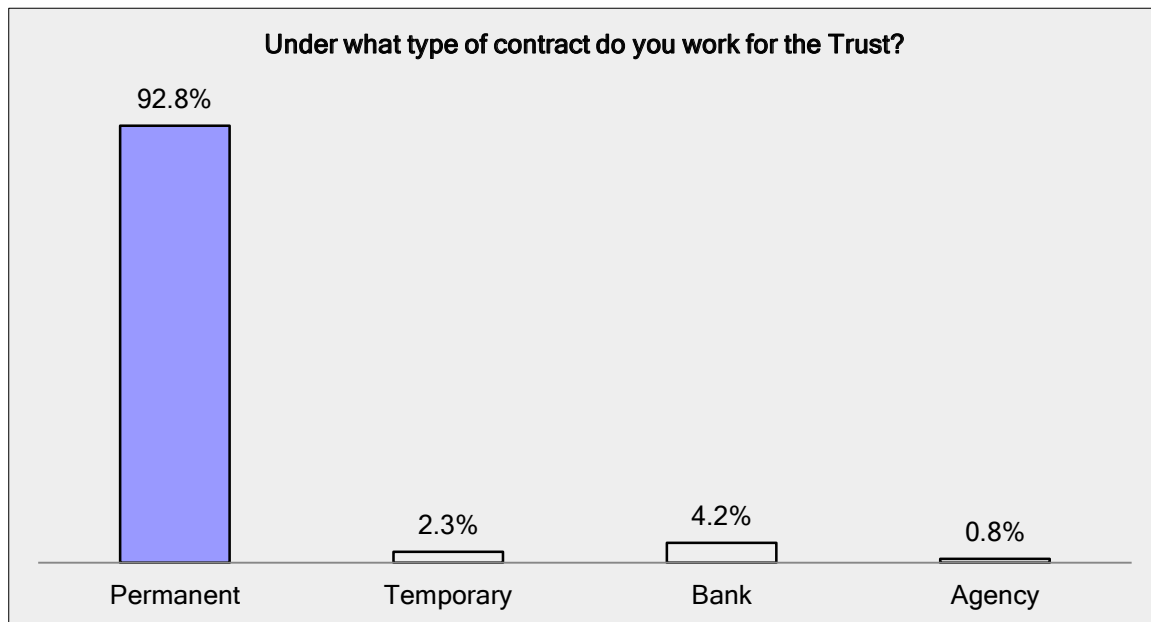
### Question 1 - What occupational group do you belong to?



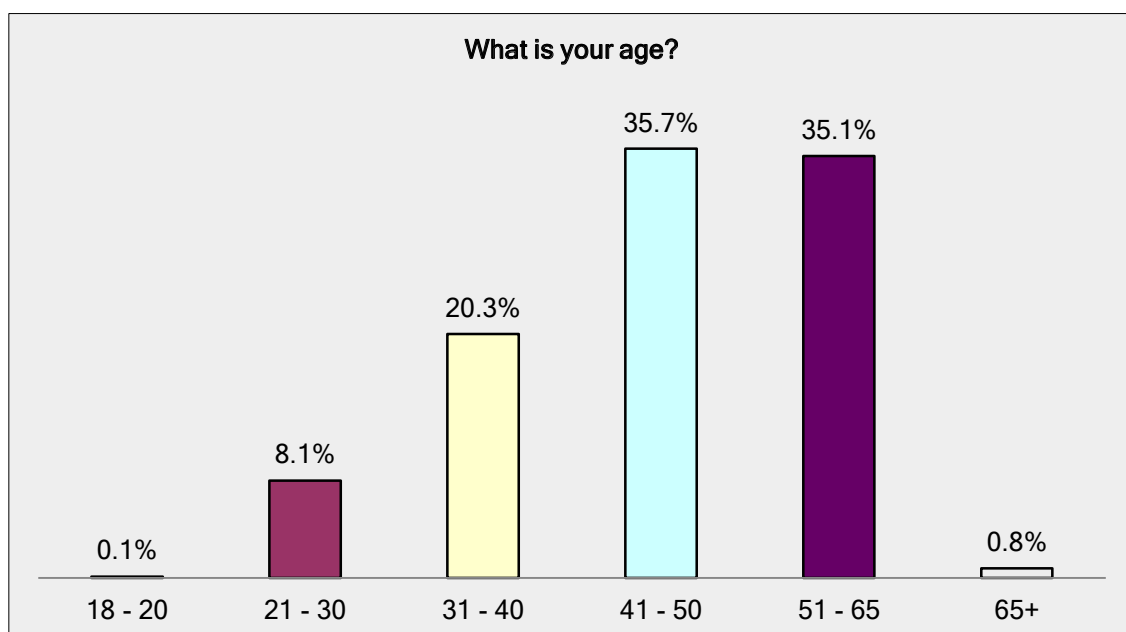
When analysing the survey results a check was made to see if there were significant differences in the responses from different staff groups. It was clear, however, that the responses across all staff groupings were broadly similar.

### Question 2 - How long have you been working in the health service?



**Question 3 - Under what type of contract do you work for the Trust?****Question 4 - What is your gender?**

| What is your gender?     |                  |                |
|--------------------------|------------------|----------------|
| Answer Options           | Response Percent | Response Count |
| Male                     | 12.8%            | 134            |
| Female                   | 87.2%            | 915            |
| <b>answered question</b> |                  | <b>1049</b>    |
| <b>skipped question</b>  |                  | <b>1</b>       |

**Question 5 - What is your age?**

**Question 6 - Does your job involve direct contact with patients / clients?**

| Does your job involve direct contact with patients / clients? |                  |                |
|---------------------------------------------------------------|------------------|----------------|
| Answer Options                                                | Response Percent | Response Count |
| No                                                            |                  | 221            |
|                                                               |                  |                |
|                                                               |                  |                |

**Question 7 - Are you aware that the Trust has a Whistleblowing Policy in place to give guidance on how to raise a concern?**

| Are you aware that the Trust has a Whistleblowing Policy in place to give guidance on how to raise a concern? |                  |                |
|---------------------------------------------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                                                                | Response Percent | Response Count |
| Yes                                                                                                           | 92.6%            | 854            |
| No                                                                                                            | 7.4%             | 68             |
| <b>answered question</b>                                                                                      |                  | <b>922</b>     |
| <b>skipped question</b>                                                                                       |                  | <b>128</b>     |

**Question 8 - Do you have confidence that the Trust would carry out a robust investigation of any concern you might raise?**

| Do you have confidence that the Trust would carry out a robust investigation of any concern you might raise? |                  |                |
|--------------------------------------------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                                                               | Response Percent | Response Count |
| Yes                                                                                                          | 60.5%            | 558            |
| No                                                                                                           | 39.5%            | 364            |
| <b>answered question</b>                                                                                     |                  | <b>922</b>     |
| <b>skipped question</b>                                                                                      |                  | <b>128</b>     |

| Do you have confidence that the Trust would carry out a robust investigation of any concern you might raise? - Occupational groupings of those who answered YES |     |     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Occupational Groups                                                                                                                                             |     |     |
| Administrative & Clerical                                                                                                                                       | 156 | 53% |
| Ancillary and Support Services                                                                                                                                  | 24  | 53% |
| Domiciliary Care                                                                                                                                                | 8   | 44% |
| Nursing & Midwifery                                                                                                                                             | 195 | 57% |
| Allied Health Professional                                                                                                                                      | 45  | 47% |
| Other Professional & Technical                                                                                                                                  | 16  | 44% |
| Social Care / Social Work                                                                                                                                       | 64  | 50% |
| Medical & Dental                                                                                                                                                | 27  | 43% |
| Manager                                                                                                                                                         | 23  | 77% |

**Do you have confidence that the Trust would carry out a robust investigation of any concern you might raise?**

**If no, please tell us why.....**

The following themes emerged from the responses:-

|                                                                                                         | Count |
|---------------------------------------------------------------------------------------------------------|-------|
| Due to previous/current experience of self/others                                                       | 71    |
| Lack of confidence in or issue with Line Manager/Senior Management                                      | 69    |
| Fear of repercussions/seen as troublemaker/bullying/victimisation                                       | 45    |
| Swept under carpet/covered up/close ranks/kept quiet/Trust protects self                                | 37    |
| Dissatisfied with outcome ie not actioned/nothing was done/issue not resolved                           | 28    |
| Depends who you report it to/where you are in structure/who investigates                                | 22    |
| Dissatisfied with initial response ie not taken seriously/dismissed/not listened to/ignored/lip service | 19    |
| Confidentiality/Anonymity/lack of trust or not sure who to trust                                        | 17    |
| Lack of support for whistle-blower                                                                      | 12    |
| Unhappy with how it was/would be handled/investigated during the process                                | 11    |
| Depends what concern is about                                                                           | 6     |
| Need independence from Department/Trust                                                                 | 5     |
| Time to resolve too long                                                                                | 5     |
| Staffing levels ignored                                                                                 | 5     |
| Fear of negative impact upon career/fear of losing job                                                  | 4     |
| Due to negative Media coverage of cases                                                                 | 4     |
| Not aware of policy/procedure                                                                           | 4     |
| Training required for staff and managers re policy, investigations, etc                                 | 4     |
| Lack of feedback to whistle-blower                                                                      | 4     |
| Trust doesn't have interests of patients and staff at heart                                             | 3     |
| Lack of confidence in HR                                                                                | 2     |
| If concern was not related to patient event eg about staffing                                           | 2     |
| Lack of confidence in system                                                                            | 2     |
| No consideration for working conditions                                                                 | 1     |
| Person left Trust, investigation did not proceed                                                        | 1     |

Examples of the responses received include:-

- *"I feel that an investigation may well be carried out but it would merely be a box ticking exercise. Line managers and those further on up the Trust hierarchy appear to view whistle-blowers as trouble makers. Both of these make raising concerns less likely and can in turn make an already difficult working experience even worse."*
- *"No confidence that anonymity would be maintained or repercussions would occur."*
- *"Just don't trust management in Trust, want to conceal everything, whenever issues are brought up, it is brushed under carpet. Managers just don't want to know."*
- *"Managers do not possess the quality of confidentiality, if staff involved in incidents the whole Trust knows."*
- *"I would be afraid of being victimized"*
- *"I am aware of a member of staff who after whistle blowing was given very poor support."*

- *“Previous experience when concerns were dismissed immediately.”*
- *“Due to previous experience of raising a concern, felt it was handled very badly, this would put me off from ever raising any further concerns.”*
- *“I have been involved in a previous external investigation which gave recommendations which the trust did not address adequately.”*
- *“On the occasions I have raised a concern, courses of action proposed by my manager have never been followed through”.*
- *“This response is not related to Southern Trust but due to recent media coverage of staff working in the NHS who have been treated very poorly from the top down when they raised concerns of theirs and who without the backing of the media would have been completely alone in facing the bureaucracy machine.”*

**Question 9 - Would you feel comfortable raising a concern with a senior manager / Director in the Trust and giving your name?**

| Would you feel comfortable raising a concern with a senior manager / Director in the Trust and giving your name? |                  |                |
|------------------------------------------------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                                                                   | Response Percent | Response Count |
| No                                                                                                               |                  | 434            |

| Would you feel comfortable raising a concern with a senior manager / Director in the Trust and giving your name? - Occupational groupings of those who answered YES |     |     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| Occupational Groups                                                                                                                                                 |     |     |
| Administrative & Clerical                                                                                                                                           | 125 | 42% |
| Ancillary and Support Services                                                                                                                                      | 23  | 51% |
| Domiciliary Care                                                                                                                                                    | 7   | 39% |
| Nursing & Midwifery                                                                                                                                                 | 166 | 49% |
| Allied Health Professional                                                                                                                                          | 37  | 39% |
| Other Professional & Technical                                                                                                                                      | 11  | 31% |
| Social Care / Social Work                                                                                                                                           | 65  | 51% |
| Medical & Dental                                                                                                                                                    | 35  | 56% |
| Manager                                                                                                                                                             | 19  | 63% |

**If no, please tell us why.....**

The following themes emerged:-

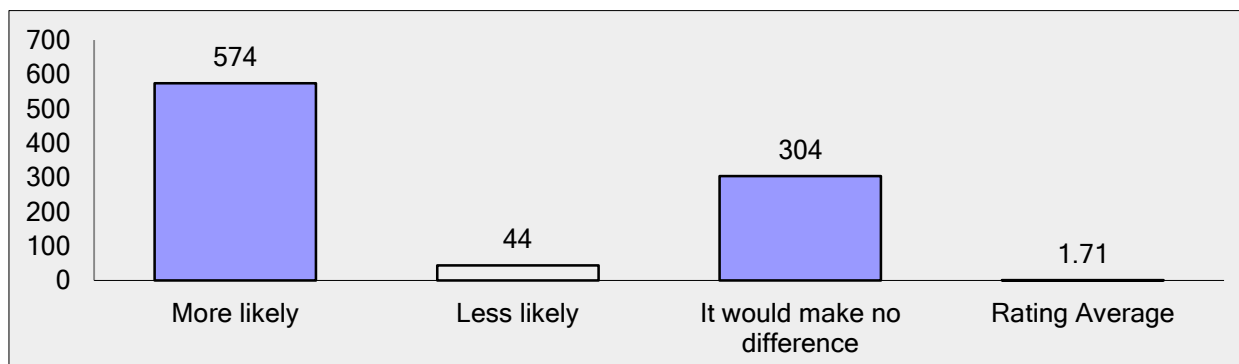
|                                                                    | Count |
|--------------------------------------------------------------------|-------|
| Fear of repercussions/seen as troublemaker/bullying/victimisation  | 140   |
| Confidentiality/Anonymity/lack of Trust or not sure who to Trust   | 60    |
| Lack of confidence in or issue with Line Manager/Senior Management | 42    |

|                                                                                                         |    |
|---------------------------------------------------------------------------------------------------------|----|
| Fear of negative impact upon career/fear of losing job                                                  | 28 |
| Dissatisfied with initial response ie not taken seriously/dismissed/not listened to/ignored/lip service | 25 |
| Due to previous/current experience of self/others                                                       | 16 |
| Depends who you report it to/where you are in structure/who investigates                                | 15 |
| Swept under carpet/covered up/close ranks/kept quiet/Trust protects self                                | 14 |
| Depends what concern is about                                                                           | 14 |
| Lack of support for whistle-blower                                                                      | 11 |
| Dissatisfied with outcome ie not actioned/nothing was done/issue not resolved                           | 10 |
| Unhappy with how it was/would be handled/investigated during the process                                | 9  |
| Due to negative Media coverage of cases                                                                 | 8  |
| Training required for staff and managers re policy, investigations, etc                                 | 2  |
| Lack of feedback to whistle-blower                                                                      | 2  |
| Lack of confidence in HR                                                                                | 1  |
| Not aware of policy/procedure                                                                           | 1  |
| If concern was not related to patient event eg about staffing                                           | 1  |
| Lack of confidence in system                                                                            | 1  |

Examples of the responses received include:-

- *"All of the managers are only thinking about their next job interview and not about staff welfare. HR always uses the term 'manager's discretion' or, 'that's between you and your manager'. The paid union officials also do not want to rock the boat. I feel there is actually nowhere to voice concerns."*
- *"I feel it would be detrimental to any career progression."*
- *"I have done this before and person in team was able to identify myself and other staff members involved in raising our concerns. I as an individual got no feedback or support."*
- *"I do feel it would be held against me and I would be treated differently. Nothing is confidential in the Trust. I think also it was raise suspicions with a department and create an uncomfortable atmosphere."*
- *"Not comfortable with management - previous concerns eg bullying don't seem to have been "robustly" dealt with."*
- *"I feel that certain managers/directors would be too interested in protecting their own department, rather than acknowledging that there are problems."*
- *"I am not confident that my concerns would be taken seriously and may actually jeopardise my current work situation."*
- *"I would not feel comfortable because I am not sure that it would be dealt with appropriately."*
- *"Previous experience - investigation carried out but individual was not disciplined despite massive amounts of evidence. Concerns were raised but not dealt with."*
- *"I am quite happy to raise a concern and give my name."*

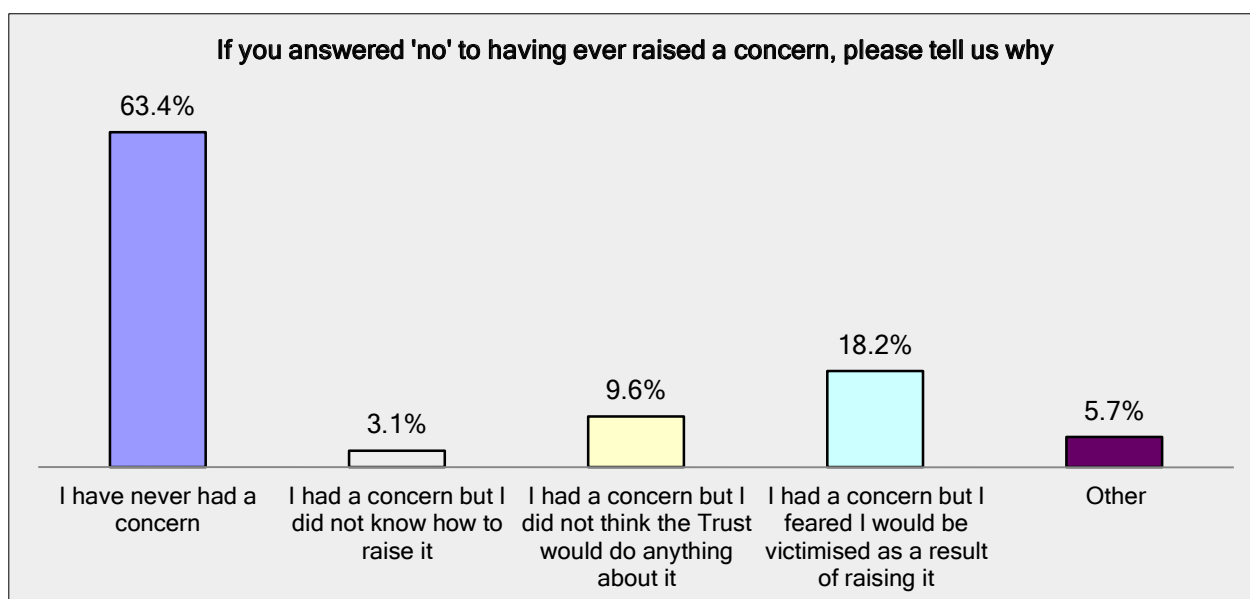
**Question 10 – If a completely anonymous web based 2 way dialogue system where you could report a concern to an identified Trust senior manager, provide more information on the web based system, if necessary, when asked by the senior manager to assist with the investigation, and receive feedback as to the outcome of any investigation.**



**Question 11 - Have you ever raised a concern about suspected wrongdoing in the Trust?**

| Have you ever raised a concern about suspected wrongdoing in the Trust? |                  |                |
|-------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                          | Response Percent | Response Count |
| Yes                                                                     | 27.5%            | 251            |
| No                                                                      | 72.5%            | 661            |
| <i>answered question</i>                                                |                  | <b>912</b>     |
| <i>skipped question</i>                                                 |                  | <b>138</b>     |

**Question 12 - If you answered 'no' to having ever raised a concern, please tell us why**



**Other, please specify.....**

The following themes emerged:-

|                                                                                                     | Count |
|-----------------------------------------------------------------------------------------------------|-------|
| Fear of repercussions/seen as troublemaker/bullying/victimisation                                   | 8     |
| Raised informally with Line Manager/in relevant forum/with colleagues                               | 8     |
| Fear of negative impact upon career/fear of losing job                                              | 4     |
| Perception of outcome ie not actioned/nothing was done/issue not resolved                           | 3     |
| Uncomfortable raising concerns/difficult to raise against colleagues                                | 3     |
| Concern not serious enough/did not directly involve myself                                          | 3     |
| Perception of initial response ie not taken seriously/dismissed/not listened to/ignored/lip service | 2     |
| Lack of confidence in or issue with Line Manager/Senior Management                                  | 2     |
| Confidentiality/Anonymity/lack of Trust or not sure who to Trust                                    | 2     |
| Due to previous/current experience of self/others                                                   | 2     |
| Lack of confidence in system                                                                        | 2     |
| Have raised other issues re communication/staffing                                                  | 2     |
| It was another Trust                                                                                | 2     |
| To maintain integrity of the Trust                                                                  | 1     |
| Swept under carpet/covered up/close ranks/kept quiet/Trust protects self                            | 1     |
| Lack of confidence in HR                                                                            | 1     |
| Trust doesn't have interests of patients and staff at heart                                         | 1     |
| Staffing levels ignored/are an issue                                                                | 1     |
| Mixture of not knowing how, that Trust wouldn't do anything and fear of repercussions               | 1     |
| Too much red tape                                                                                   | 1     |

Examples of the responses received include:-

- *"I have no confidence in the system and I do not trust Senior Management."*
- *"I have worked with people who have raised concerns in the past and seen how it has negatively affected them in the personal lives and in their work place. I also feel my career progression would be jeopardised by doing so."*
- *"I was worried about losing my job."*
- *"I also don't think the Trust would care enough to do anything about it. I would worry about levels of confidentiality."*
- *"I would still be afraid of being victimised."*
- *"I have seen what happened to others who raised concerns and it was very negative, bullying and inertia was beyond belief, culprits moved on to continue bad behaviour."*
- *"Did raise concern but it was brushed aside."*
- *"I have raised concerns in another trust. Not dealt with as I would have hoped. I didn't feel victimised but left with the feeling that I was wasting everyone's time."*
- *"I love my work, I work with excellent staff and teams through the southern trust working with individuals who are vulnerable adults due to the virtue of their learning disabilities and/or mental health problem. I work in many different settings as I am employed through the banking office and anywhere the bank has requested for me to go I have enjoyed it."*
- *"I think all of us have concerns but the NHS is the problem - not the Trust - we have to do our best within our powers to accommodate a lot of patients and keep the integrity of the Trust intact."*



**Question 13 - Who did you raise your concern with?**

| Who did you raise your concern with?                        |                  |                |
|-------------------------------------------------------------|------------------|----------------|
| Answer Options                                              | Response Percent | Response Count |
| Line manager                                                | 91.3%            | 209            |
| Trust Senior Officer specified in the Whistleblowing Policy | 6.1%             | 14             |
| Outside body                                                | 2.6%             | 6              |
| Other (please specify)                                      |                  | 24             |
| <b>answered question</b>                                    |                  | <b>229</b>     |
| <b>skipped question</b>                                     |                  | <b>821</b>     |

**Other, please specify...**

The following other types of people were given:-

- With the individual concerned
- My manager's line manager and HR
- Line manager, head of service then assistant director
- All of the above (2)
- A senior manager (3)
- HR (3)
- Assistant Director (2)
- Line manager and senior officer (survey did not allow me to tick both)
- Line manager above ward manager/line managers boss
- Bed manager
- Union (3)
- General manager
- NISCC
- Line manager's manager, HR official and management
- Consultant
- Line manager, head of service

**Question 14 - Did you refer to the Trust's Whistleblowing Policy before raising your concern?**

| Did you refer to the Trust's Whistleblowing Policy before raising your concern? |                  |                |
|---------------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                                  | Response Percent | Response Count |
| Yes                                                                             | 25.5%            | 62             |
| No                                                                              | 74.5%            | 181            |
| <b>answered question</b>                                                        |                  | <b>243</b>     |
| <b>skipped question</b>                                                         |                  | <b>807</b>     |

**Question 15 - Did you raise your concern anonymously?**

| Did you raise your concern anonymously? |                  |                |
|-----------------------------------------|------------------|----------------|
| Answer Options                          | Response Percent | Response Count |
| Yes                                     | 10.7%            | 26             |
| No                                      | 89.3%            | 217            |
| <b>answered question</b>                |                  | <b>243</b>     |
| <b>skipped question</b>                 |                  | <b>807</b>     |

If yes, please tell us why you did not wish to give your name....

The following types of reasons were given:-

- *"I would have become a target if I had of said who I was."*
- *"I felt I would be targeted badly."*
- *"Because the situation would undoubtedly have resulted in personal repercussions and an inability to progress my career safely."*
- *"I raised the issues directly with the managers involved at every opportunity."*
- *"Would have preferred to have been kept anonymous."*
- *"Bullying incidents - didn't want to be the next in line of fire!"*
- *"I raised the concern on behalf of the member of staff I was supervising. The band 5 had expressed concerns and asked me to assist her in raising her concerns."*
- *"Concerned about working with member of staff in question."*
- *"Fear of being victimised which was what happened anyway as person had realised who had reported them."*
- *"I felt there would be retaliation aimed directly at me and also was very aware that the person involved did not want to get "involved"."*
- *"So there would not be backlash."*
- *"Afraid of repercussions."*
- *"I did not wish to give my name as I am aware of how whistle blowers have been treated."*
- *"Fear of being pointed out and intimidated while at work."*
- *"I was told that if I wasn't to provide my name, the Trust couldn't investigate it fully."*
- *"I did not want more senior members of staff to know my name."*

**Question 16 - Did you feel your concern was dealt with appropriately?**

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

| Occupational Groups            | Response Count | Response Percent |
|--------------------------------|----------------|------------------|
| Administrative & Clerical      | 24             | 8%               |
| Ancillary and Support Services | 5              | 11%              |
| Domiciliary Care               | 3              | 17%              |
| Nursing & Midwifery            | 60             | 18%              |
| Allied Health Professional     | 13             | 14%              |
| Other Professional & Technical | 5              | 14%              |
| Social Care / Social Work      | 21             | 17%              |
| Medical & Dental               | 13             | 21%              |
| Manager                        | 4              | 13%              |

Please give a reason for your answer...

The following themes emerged:-

|                                                                                                         | Count |
|---------------------------------------------------------------------------------------------------------|-------|
| Dissatisfied with outcome ie not actioned/nothing was done/issue not resolved                           | 30    |
| Dissatisfied with initial response ie not taken seriously/dismissed/not listened to/ignored/lip service | 15    |
| Lack of confidence in or issue with Line Manager/Senior Management                                      | 13    |
| Repercussions/seen as troublemaker/bullying/victimisation                                               | 12    |
| Confidentiality/Anonymity/lack of Trust                                                                 | 11    |
| Swept under carpet/covered up/close ranks/kept quiet/Trust protects self                                | 11    |
| Unhappy with how it was/would be handled/investigated during the process                                | 11    |
| Lack of feedback to whistle-blower                                                                      | 11    |
| Time to resolve too long                                                                                | 5     |
| Lack of support for whistle-blower                                                                      | 3     |
| Due to previous/current experience of self/others                                                       | 3     |
| Person left Trust, investigation did not proceed                                                        | 3     |
| Staffing levels ignored/are an issue                                                                    | 3     |
| Lack of confidence in system                                                                            | 2     |
| Negative impact upon career/fear of losing job                                                          | 1     |
| Depends who you report it to/where you are in structure/who investigates                                | 1     |
| Lack of confidence in HR                                                                                | 1     |

Examples of the responses received include:-

- *"Confidentiality was not respected."*
- *"HR & Management all stick together. I was told 'your manager has the right to manage'. But surely that doesn't give him the right to micro manage & bully staff. He also lies to our face to suit himself."*
- *"Swept under carpet, was intimidated and my career was threatened."*
- *"On 3 occasions have spoken to manager about one staff nurses attitude to patients, Patients have complained to my manager about this nurse. Other staff have raised concerns and one consultant, I have raised concerns with lead nurse. No action appears to have been taken by managers; the nurse continues to be rude to patients and staff."*
- *"I felt somewhat removed from the process and that there was no follow up or consultation following my interview."*
- *"Ignored."*
- *"I did not feel listened to".*
- *"Management at the time dealt with the situation in a non-professional manner and it took nearly 3 years to resolve."*
- *"Not fully investigated."*
- *"It was investigated, but little seemed to result."*
- *"The proposed course of action was not followed through."*
- *"The information was not acted on when the concerns were first expressed. Management then confused the issue with working well together. The issues I raised (as with many whistleblowing concerns) involved patient care so then safeguarding issues (PVA) took over which further confused the initial concerns raised."*

**Question 17 - Do you consider that you suffered any detriment as a result of raising the concern?**

| Do you consider that you suffered any detriment as a result of raising the concern? |                  |                |
|-------------------------------------------------------------------------------------|------------------|----------------|
| Answer Options                                                                      | Response Percent | Response Count |
| Yes                                                                                 | 47.7%            | 113            |
| No                                                                                  | 52.3%            | 124            |
| <b>answered question</b>                                                            |                  | <b>237</b>     |
| <b>skipped question</b>                                                             |                  | <b>813</b>     |

Please provide any information to support your answer....

|                                                                     | Count |
|---------------------------------------------------------------------|-------|
| Under pressure/stressed/upset/worried/annoyed                       | 22    |
| Repercussions/seen as troublemaker/bullying/victimisation           | 20    |
| Strained relationships with person reported/colleagues/line manager | 14    |
| Negative/intimidating behaviour from person reported/colleagues     | 10    |

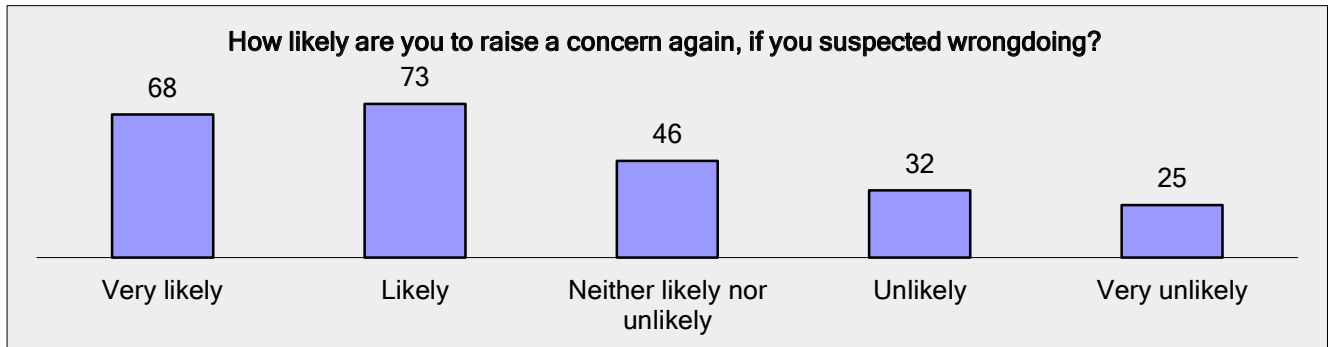
|                                                                                                         |   |
|---------------------------------------------------------------------------------------------------------|---|
| Lack of support for whistle-blower                                                                      | 7 |
| Unhappy with how it was/would be handled/investigated during the process                                | 6 |
| Dissatisfied with initial response ie not taken seriously/dismissed/not listened to/ignored/lip service | 4 |
| Lack of confidence in or issue with Line Manager/Senior Management                                      | 4 |
| Dissatisfied with outcome ie not actioned/nothing was done/issue not resolved                           | 4 |
| Negative impact upon career/fear of losing job                                                          | 4 |
| I got moved                                                                                             | 4 |
| Health suffered                                                                                         | 4 |
| Reputation tarnished                                                                                    | 3 |
| Confidentiality/Anonymity/lack of Trust or not sure who to Trust                                        | 2 |
| Training required for staff and managers re policy, investigations, etc                                 | 1 |
| Time to resolve too long                                                                                | 1 |
| Lack of feedback to whistle-blower                                                                      | 1 |
| I asked to be moved                                                                                     | 1 |
| I was wrongly disciplined                                                                               | 1 |
| People have joked about ensuring they do things 'by the book' when 'dealing' with me                    | 1 |
| Loss of confidence in self                                                                              | 1 |

Examples of the responses received include:-

- *"Felt under pressure which caused ill health. Did not feel supported."*
- *"The person, who was reported, made it clear that she was aggrieved about myself and others. It was a very stressful and upsetting time."*
- *"The department was effectively split, with some people not talking to me at all, in one instance for over a year."*
- *"Being scapegoated for raising genuine concerns which affected both staff and service users. Being seen by senior management as a trouble maker as opposed to a concerned staff member."*
- *"Professionally, psychologically and medically I was made to feel a lesser person whose opinion did not count."*
- *"I was victimised and bullied by said person after they had come to conclusion who had actually reported them, my managers were aware and i felt i got no support at all throughout. My immediate manager actually told me she had no idea how to deal with the whole situation as had no experience or guidance herself."*
- *"Emotional distress. Distrust from other colleagues towards me. I was made to work alongside the nurse being investigated throughout the investigation."*
- *"Targeted by Line Manager, subject to bullying and demeaning behaviour, undermined and embarrassed, pitted against colleagues. Loss of colleagues to other locations because they could no longer tolerate being in this environment. Currently on medication to enable me to attend work."*
- *"I had to receive counselling, my hair fell out, I was shunned by staff, I had a terrible fear of meeting the person I raised concern about, avoided going certain places. I had anxiety and developed stomach ulcers."*
- *"I feel that my concerns were not recognised which is detrimental to the care of the patient."*

- *"I was not given opportunity to discuss my concerns with manager in question and felt that information was passed on unnecessarily"*
- *"But nothing has been done".*

**Question 18 - How likely are you to raise a concern again, if you suspected wrongdoing?**



**Question 19 - What would have improved the experience for you?**

| What would have improved the experience for you? |                |
|--------------------------------------------------|----------------|
| Answer Options                                   | Response Count |
|                                                  | 166            |
| <b>answered question</b>                         | <b>166</b>     |
| <b>skipped question</b>                          | <b>884</b>     |

The following types of themes to improve their experience were:-

|                                                                                                                             | Count |
|-----------------------------------------------------------------------------------------------------------------------------|-------|
| To be taken seriously/Not dismissed/Being listened to/Not ignored/Not just paying lip service                               | 32    |
| Better support for whistle-blower                                                                                           | 29    |
| Action/something done/issue being resolved/dealt with                                                                       | 24    |
| Stronger Leadership - confidence in Line Manager/Senior Management                                                          | 16    |
| Better feedback to whistle-blower                                                                                           | 16    |
| Better Confidentiality/Anonymity/warning that name would be used/being able to trust or being sure who to Trust             | 14    |
| Not being swept under carpet/not covered up/not closing ranks                                                               | 9     |
| Being handled/investigated better                                                                                           | 8     |
| Need independence from Department eg (Dedicated Point of Contact) and/or Trust (eg Independent Body/Agency)                 | 8     |
| A more open and transparent learning culture rather than a blame culture/genuine engagement                                 | 7     |
| Improved time to resolve                                                                                                    | 6     |
| No repercussions/Not seen as troublemaker/No bullying/No victimisation/being treated with respect/not feeling like a victim | 5     |
| Training required for staff and managers re policy, investigations, care and compassion, etc                                | 5     |
| Better communication with Line Manager/Head of Department                                                                   | 5     |
| Dedicated impartial member of staff to liaise with whistle-blower (before, during and after)                                | 5     |
| Explain process to Whistle-blower                                                                                           | 5     |
| Improved confidence in HR                                                                                                   | 2     |

|                                                                                                                                                      |   |
|------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Manager dealing with it promptly                                                                                                                     | 2 |
| Not being 'interrogated'                                                                                                                             | 2 |
| Anonymous system                                                                                                                                     | 2 |
| No negative impact upon career/no fear of losing job                                                                                                 | 1 |
| Even if person left Trust, investigation should proceed                                                                                              | 1 |
| Not being moved                                                                                                                                      | 1 |
| A fair and equitable system where HR have the power to manage senior managers the same as everyone else                                              | 1 |
| Managers who care for their staff                                                                                                                    | 1 |
| Improved access to Occupational Health                                                                                                               | 1 |
| Better way of dealing with overlap when raising a concern eg Whistle-blowing, Protection of Vulnerable Adults, Working Well Together, Grievance, etc | 1 |
| Observation of the problem and serious repercussions for staff                                                                                       | 1 |
| Keeping my mouth shut                                                                                                                                | 1 |

Examples of the responses received include:-

- *"My manager confronting the situation and nipping the problem in the bud before it getting to the stage it did."*
- *"Concerns about managers are not taken seriously. HR closes ranks and always sides with the manager. Just take it seriously."*
- *"Complete guarantee that my anonymity and confidentiality is kept. Also follow up support is very important."*
- *"A dedicated staff member to liaise with me and keep me informed with the process and the outcome and meet following investigation to ensure no adverse treatment was experienced."*
- *"Anonymous system as suggested before where the immediate line manager is not dealing with the concern it goes to a different manager."*
- *"Some sense that there is a fair and equitable system in place where the HR department has the power to manage very senior members of staff in the same way as everyone else. This does NOT currently seem to be the case."*
- *"Support and information from management. More confidentiality. Acknowledgement and verification from the trust to support the decision to "whistle blow"."*
- *"Having an identified third party manager to whom I could raise a concern."*
- *"Independent body overseeing whistle blowing complaints. Should be a body designated as this would stop people having to go to different agencies such as RQIA etc."*
- *"Information prior to the interviews about what is expected of you."*
- *"If I was better informed about outcome of investigation and reasons why actions or no actions were taken."*
- *"Support, unison reps all spent time with the person being investigated, no rep acknowledged me as a member needing support. Not having to work alongside the other nurse."*
- *"My experience in the Southern Trust has been excellent."*

- *"My experience was fine because my line manager was very supportive and the venue was a private facility as opposed to Trust. So my manager & the care manager were able to address the issues I had raised."*
- *"I was satisfied with the experience. It comes down to trust...I trusted my assistant director's ability to effectively act with discretion, my assistant director trusted my integrity."*
- *"I thought it was dealt with well."*
- *"I was happy with the way things were dealt with. Human Resources were excellent."*

**Question 20 - Have you any comments you wish to add in relation to the Trust's Whistleblowing Policy or its implementation?**

| Have you any comments you wish to add in relation to the Trust's Whistleblowing Policy or its implementation? |                |
|---------------------------------------------------------------------------------------------------------------|----------------|
| Answer Options                                                                                                | Response Count |
|                                                                                                               | 195            |
| <b>answered question</b>                                                                                      | <b>195</b>     |
| <b>skipped question</b>                                                                                       | <b>855</b>     |

The following types of reasons were given:-

|                                                                                                                 | Count |
|-----------------------------------------------------------------------------------------------------------------|-------|
| Need to eliminate negative/intimidating behaviour from person reported/colleagues                               | 37    |
| Need reassurance of no repercussions/Not seen as troublemaker/No bullying/No victimisation                      | 18    |
| Better Confidentiality/Anonymity/warning that name would be used/being able to trust or being sure who to Trust | 15    |
| It is important that staff feel able to raise concerns for patient safety                                       | 12    |
| Better support for whistle-blower                                                                               | 11    |
| Stronger Leadership - confidence in Line Manager/Senior Management                                              | 8     |
| Need an anonymous system/web based                                                                              | 8     |
| Taken seriously/Not dismissed/Being listened to/Not ignored/Not just paying lip service                         | 7     |
| Whistleblowing policy is worthless/should be taken seriously/waste of time/waste of paper/tick box exercise     | 7     |
| Need independence from Department eg (Dedicated Point of Contact) and/or Trust (eg Independent Body/Agency)     | 6     |
| A more open and transparent learning culture rather than a blame culture/genuine engagement                     | 6     |
| Being handled/investigated better                                                                               | 5     |
| Fear of negative impact upon career/fear of losing job                                                          | 5     |
| Training required for staff and managers re policy, investigations, care and compassion, etc                    | 5     |
| Policy is only as good as its implementation                                                                    | 5     |
| There is potential for the policy to be abused and someone maliciously accused                                  | 5     |
| I welcome the opportunity of completing these types of surveys/thank you                                        | 5     |
| Action/something done/issue being resolved/dealt with                                                           | 4     |
| Better feedback to whistle-blower                                                                               | 4     |
| Share examples of where raising concerns made a difference                                                      | 4     |
| Clarity about when it is appropriate to use the Whistleblowing Policy is required                               | 4     |
| I hope it is of benefit to the organisation/hope this is more than a paper exercise                             | 4     |



|                                                                                                                                                                            |   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| Due to negative Media coverage of cases                                                                                                                                    | 3 |
| Staffing levels ignored/are an issue                                                                                                                                       | 3 |
| Dedicated impartial point of contact to liaise with whistle-blower (before, during and after)                                                                              | 3 |
| Concerns should be dealt with at ground level                                                                                                                              | 3 |
| I feel I would have good support from management if I had to raise any concerns                                                                                            | 3 |
| I am proud of working with the Trust/my experience has been excellent/my experience is policy has been effective                                                           | 3 |
| Swept under carpet/covered up/closing ranks                                                                                                                                | 2 |
| Lack of confidence in HR                                                                                                                                                   | 2 |
| Lack of confidence in system                                                                                                                                               | 2 |
| Better communication with Line Manager/Head of Department                                                                                                                  | 2 |
| Better way of dealing with overlap when raising a concern ie triage eg Whistle-blowing, Protection of Vulnerable Adults, Working Well Together, Grievance, Governance, etc | 2 |
| There is little protection for the accused when concern has been raised anonymously/anything of a serious nature needs to be proven                                        | 2 |
| It is difficult to implement a fool proof method of whistleblowing                                                                                                         | 2 |
| Due to previous/current experience of self/others now more reluctant to raise concerns                                                                                     | 1 |
| Depends who you report it to/where you are in structure/who investigates                                                                                                   | 1 |
| If concern was not related to patient safety then deemed unimportant                                                                                                       | 1 |
| Uncomfortable raising concerns/difficult to raise against colleagues                                                                                                       | 1 |
| I would fear being under pressure/stressed/upset/worried/annoyed                                                                                                           | 1 |
| Observation of the problem and serious repercussions for staff                                                                                                             | 1 |
| Keeping my mouth shut/definitely would not do it again                                                                                                                     | 1 |
| Looking forward to the finished product                                                                                                                                    | 1 |
| Keep things simple                                                                                                                                                         | 1 |
| The accused should have the right to face their accuser                                                                                                                    | 1 |
| Consultation re policy should include Staff Side and Carers Groups                                                                                                         | 1 |
| My experiences may have been prior to policy implementation                                                                                                                | 1 |
| Well organised, effective and understandable survey                                                                                                                        | 1 |
| A confidential questionnaire should be completed in relevant areas of work                                                                                                 | 1 |
| If funding already received was better spent without waste this would be better for the staff and more money would be available for patient care                           | 1 |
| A different policy/approach may be needed when senior managers are the concern                                                                                             | 1 |
| The management of anonymous concerns - unable to progress to full investigation as the concern lacked detail                                                               | 1 |
| Trust is trying, but there needs to be a limit/cap on what is achievable by the individual as demand is outstripping capacity                                              | 1 |
| Staff still reluctant to raise concerns, especially if more about someone more senior                                                                                      | 1 |
| There is a problem in the Southern Trust in how staff are treated by colleagues                                                                                            | 1 |
| There should be an audit of how concerns have been dealt with                                                                                                              | 1 |
| Whistleblowing is the wrong term - it should be Improvement Initiative                                                                                                     | 1 |
| Policy is not encouraged by department managers. It remains to be frowned upon or seen as a weakness or failure of the department.                                         | 1 |
| Issue with communication - out of date directories, etc                                                                                                                    | 1 |
| Need to change individuals perception on whistleblowing                                                                                                                    | 1 |

Examples of the responses received include:-

- *"I am quite cynical about whistle-blowing in general. I hope I am not in the situation again where I am concerned about a colleague and his/her practice."*
- *"Whistleblowing should be encouraged. Inappropriate practice and service provision shouldn't be acceptable."*

- *"Staff need to be assured that there is a secure means of raising their concerns without fear of retribution. If the issues pertain to the management line, staff need to have an independent person to go to who will deal confidentially with their concerns."*
- *"I feel that seminars in whistleblowing should be arranged for all staff in the Southern Trust to give the policy maximum awareness and that all line/ward managers are given extensive training in this area by HR."*
- *"Staff need supported. They need to take on board concerns. I had grave concerns about a person and they were reported but no action was taken. When the whole thing came to light all I heard from numerous people was "sure everyone knows what he's been doing for years"."*
- *"I feel staff at all levels should have training in how they can not only raise issues but what systems are in place to support or evidence their concerns ie complaints/increase Datix/Normative staffing levels/To be aware of FSL/ and know where to go to present this in a meaningful way."*
- *"I would welcome an appropriate anonymised system, as a number of high profile media examples have shown the significance for any individual choosing to take this route."*
- *"During my experience I often felt I was being investigated it was a very traumatic experience with limited support for managers who were part of the investigation process more help should be available for those who genuinely raise concerns I was pushed to depths of despair at times."*
- *"Staff need to have a confidential service where concerns can be discussed. Staff provide an excellent service but often don't feel valued. And there is a problem in the Southern Trust in how staff are treated by colleagues there needs to be more work done on this."*
- *"If a patient/client/tenant was being endangered in any way I would have no hesitation in raising a concern."*
- *"I feel I would have good support from management if I had to raise any concerns concerning children or staff."*
- *"I feel it will be a step forward. If people have concerns they will know who to go to."*
- *"My experience in the Southern Trust has been excellent."*
- *"I am proud of working with the Trust and embrace the new policies which build the trust and accountability for a fair and equal working environment and very much welcome the opportunity of completing these types of surveys."*
- *"I welcome this survey. I am hopeful it might help restore faith in the importance of whistleblowing. Thank you."*
- *"This survey is hopefully a positive step to the setting up of a system where people feel safe to raise concerns."*

## SECTION 2

### **Sir Robert Francis – “Freedom to Speak Up” February 2015**

Sir Robert Francis, QC, published his report “The Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS” in February 2015. This review was set up in response to continuing disquiet about the way NHS organisations deal with concerns raised by staff and the treatment of some of those who have spoken up.

The aim of his Review was to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. Its purpose was to draw lessons from the experiences of those involved in raising and handling concerns.

The message from staff who have suffered as a result of raising concerns was loud and clear. There is a culture within many parts of the NHS which deters staff from raising serious and sensitive concerns and which not infrequently has negative consequences for those brave enough to raise them. However, concerns are indeed raised daily throughout the NHS, and are heard, addressed and resolved.

Sir R Francis summarised the evidence from his review under five overarching themes. These are, the need for:

#### **1. Culture change**

In particular, the report emphasises a need for a culture of safety and learning in which all staff feel safe to raise a concern and for these conversations to take place as part of everyday practice, without fear of blame or reprisal. Sir Robert identified that there remains a disparity between policies and standardisation of procedures and the level of support given to staff.

The report recognises some of the excellent leadership in some Trusts, which should be harnessed and adopted across organisations. To further improve culture, employers are encouraged to celebrate the benefits for patients and the public when concerns are raised.

The report concludes that evidence gathered from other sectors where safety is an issue, such as Oil, Aviation and Nuclear industries reflects that a good safety culture needs time and effort to embed – this is most successful in organisations where responsibility and accountability for local policy and procedures for raising concerns sits with the wider executive team as opposed to Human Resources.

Having a champion or guardian who has lead responsibility to dealing with concerns raised, is considered key to ensuring policies and practices are robust and staff are appropriately supported and listened to, and issues are resolved quickly and professionally. This does not necessarily entail a member of the Board having this responsibility but can be a nominated manager who has authority and autonomy to report directly to the Chief Executive on the issue of concerns. The report suggests that for this to work efficiently the postholder needs to have ‘the right interpersonal skills, courage, tenacity and the respect of colleagues as well as the full confidence of the Chief Executive. The postholder also needs to be pragmatic, fair and understand the structure of his / her organisation and its place in the healthcare system nationally.’ The report is silent on how organisations might determine the individual best suited to fulfilling this role.

The report does however make some very clear recommendations about the role of designated Executive and Non-Executive leads with specific responsibility for whistleblowing. The report suggests that organisations may wish to consider having both but that in whatever configuration it should be an oversight role, demonstrating the commitment of the Board as a whole to effective handling of concerns raised by staff.

The report recognises that it would not be practicable for a Non-Executive Director to act as a sole point of contact for whistleblowers in an organisation, given the time constraints inherent in the role. However, it would be desirable to use a Non-Executive Director’s ability to act as an independent voice and Board level champion for those who raise concerns. The Non-Executive Director would work closely with the Freedom to Speak Up Guardian and, like them, could act as a conduit through which information is shared between staff and the Board. The Non-Executive Director should be expected to provide challenge alongside the Freedom to Speak Up Guardian to the Executive Team on areas specific to raising concerns and the culture in the organisation.

The Executive Board lead, or leads, would oversee internal processes and keep them under review, ensure staff felt empowered to raise concerns, ensure learning from concerns was shared across the organisation, and should be accountable for the treatment of whistleblowers within the organisation. They should have the executive responsibility to account to the Board, for the system of handling concerns and supporting those who raise them.

Out of all the evidence gathered in regard to experiences of staff who had reported concerns, the issue of bullying featured highly. He has identified the need for a system-wide approach when assessing this issue along with honest and direct feedback to staff about the impact of actions and behaviour.

Finally, the review heard many examples of reflective practice and how these are invaluable. Despite pressures on the system, Sir Robert stresses the importance of staff having time to explore issues, analyse systems and share good practice.

## **2. Improved handling of cases**

The report provides clear evidence that in many of the cases presented, much of the pain and expense could have been more easily avoided if concerns had been handled effectively early on. It is important that organisations investigate concerns raised to identify the facts, and appropriate feedback is given to the individual(s) raising the concern. This is critical in building staff confidence in local systems and in encouraging others to speak up.

The report recommends that all organisations should have measures in place which help facilitate informal and formal resolution of concerns raised. Encouraging staff to raise concerns early on, as part of everyday practice will help with some of this e.g. inviting open conversation about what went well and what didn't go so well as part of any staff briefings, 1:1's, team meeting etc will be key to fostering an open and transparent approach to dealing with some of the issues raised.

The report recommends that chief executives, or other designated officer in organisations, should be involved and have responsibility for regularly reviewing all concerns that have been formally recorded, to ensure local procedures are effective, and to identify areas for improvement.

The report also identifies a bigger role for system regulators and the need for improved co-ordination in relation to their approach to whistleblowing. In particular, around how they capture information about how organisations handle concerns and in taking the appropriate regulatory action. In addition the report identifies a greater role for professional regulatory bodies in relation to how they record, investigate and handle fitness to practise concerns raised with them.

## **3. Measures to support good practice**

While creating the right culture and enabling effective reporting and handling of concerns is essential, the report highlights some major gaps in training for all staff so that they understand the importance of raising concerns and how to raise a concern, and for managers so that they are appropriately equipped and supported to deal with concerns raised with them efficiently and effectively.

In all cases where staff had reported that their experience had been a positive one, they stated that they had received good support from their manager both before and after they had raised concerns with them. The report also highlights the need for organisational and

personal accountability when raising and handling concerns, especially in relation to the prevention of bullying or other repercussions that the individual raising the concern may be vulnerable to.

As already alluded to above, the report highlights the benefits of having a champion in the organisation who staff can go to when they have a concern, and who has lead responsibility for ensuring concerns are dealt with appropriately and staff are supported.

Having open and transparent in the way organisations conduct their responsibilities in relation to dealing with concerns, sends an important message to staff and provides opportunity to share learning to improve the quality of services and patient safety.

In response to the report, the Government confirmed that 'going forward we will ensure that every member of staff, every NHS Manager and every NHS Leader has proper training in how to raise concerns and how to treat people who raise concerns'. NHS England is awaiting confirmation of what the expectation is with regards this training.

#### **4. Particular measures for vulnerable groups**

The review found that certain groups of staff were particularly vulnerable when raising concerns because of the nature of their term of employment which means that they are less likely to be a fully integrated member of a team, and they may miss out on the same level of induction, training, and communications that permanent members of staff may have around raising concerns.

The report specifically makes reference to locums, agency and bank workers being more vulnerable and how essential it is that employers consider how they engage, communicate and support all workers in their organisation on issues relating to raising concerns. This includes students, volunteers and permanent staff who are required to provide services within the community and within primary care.

The report also recommended that Boards should also be aware of any black and minority ethnic (BME) issues and consider whether they need to take action over and above what is recommended in the Freedom to Speak Up report. While the evidence gathered as part of the review reflected that the experience of BME groups was broadly the same as other staff, it did highlight that a large number of minority groups felt more vulnerable and excluded, with difficulties quite often being exacerbated by cultural misunderstanding.

#### **5. Extending the legal protection**

The report highlights that while fostering the right kind of culture in the NHS to enable staff to raise concerns has to be the key priority, legal protections for whistleblowers (in the NHS, and across all other sectors) is not considered to be adequate and should be reviewed.

### SECTION 3: ACTION PLAN

It is very clear that the results of the Trust's survey and the findings of the Francis Report have a very strong correlation. It is also clear that the feedback from staff in this survey references many of the Trust's stated core values and associated behaviours such as openness, integrity, honesty, trust, fairness, listening and learning, respect. The core underlying message from the staff who responded is that these values are not evident in all of our actions in the context of handling concerns, and as a result a high proportion of staff are not confident and / or comfortable enough to speak up freely.

The comments from staff in response to this whistleblowing survey, however, evidence clear indications of deeper cultural issues and concerns, which will require to be addressed at each level of the organisation – not just in the context of whistleblowing.

Following the findings of the survey and the Francis Review, a number of recommendations were presented and agreed by the Senior Management Team in October 2015. Set in the wider context of the need for a clear shift in our current organisational culture, the following actions have been specifically agreed by SMT:

| Action                                                                                                                      | Lead      | Timescale     |
|-----------------------------------------------------------------------------------------------------------------------------|-----------|---------------|
| 1. Communicate high level survey findings to staff and summary of actions to be taken forward as a result of staff feedback | CX<br>SMT | November 2015 |
| 2. Agree an Executive Director lead with operational responsibility for Raising Concerns arrangements within the Trust.     | CX        | November 2015 |
| 3. Request a Non-Executive Director lead to act as independent voice and Board level champion for those who raise concerns. | Chair     | December 2015 |

|                                                                                                                                                                                       |                                              |                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------|
| 4. Review internal and external reporting arrangements for staff to whom concerns can be raised taking into consideration findings from RQIA review                                   | Executive Director lead for raising concerns | January to March 2016  |
| 5. Revise current policy and procedural documents to reflect new arrangements, required cultural shift and other best practice guidance.                                              | Executive Director lead for raising concerns | January to March 2016  |
| 6. Strengthen monitoring, reporting and oversight arrangements relating to concerns raised.                                                                                           | Executive Director lead for raising concerns | February 2016          |
| 7. Devise comprehensive communications and training plan to underpin the launch, ongoing visibility and implementation of the revised policy to all staff at all levels in the Trust. | Executive Director lead for raising concerns | February to March 2016 |
| 8. Launch revised Policy and Procedure                                                                                                                                                | Executive Director lead for raising concerns | April 2016             |



# Local Trust Framework on Job Planning for Medical Managers

## Southern Health and Social Care Trust

**FINAL VERSION** – Management document agreed by the Senior Management Team & Associate Medical Directors

*This guidance document does not replace the Regional guidance on Job Planning but should be read as background information to be discussed between clinical manager and the Director within the Southern Health and Social Care Trust.*

*Please also refer also to:*

- *Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland*
- *SHSCT Medical Staff Annual Leave Guidance,*
- *NI Code of Conduct for Private Practice*
- *SHSCT procedural guidelines on the use of accommodation for private medical practice.*

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## Local Trust Framework for Job Planning

Southern Health and Social Care Trust

### 1.0 Direct Patient Care – Personal & Team Capacity – Refer to Section 8 in Regional Guidance

- 1.1 Prediction of an indicative number of fixed clinical PA's delivered per year will facilitate accurate capacity and workforce planning. A consultant job plan should deliver a predictable number of clinical PA's each year based upon agreed annual leave, study leave and professional leave allocations. There may be some individual variation, particularly for individuals with specific agreed responsibilities.
  - 1.2 This information should be recorded clearly on the job planning template as part of individual and/or team job planning objectives.
  - 1.3 The content of each Direct Clinical Care PA should be reviewed e.g. new patients per clinic, start and finish time and a time allocation for dictation/letter writing.
  - 1.4 The number of fixed activities (such as outpatient clinics or theatre lists) appearing in a weekly job plan is multiplied by the number of weeks in the working year, 42 weeks to establish an indicative number of sessions per year, i.e. 52 weeks minus bank holidays, annual leave and study/professional leave.
  - 1.5 Those responsible for scheduling PA's should note that any consultant wishing to complete their 42 weeks commitment (e.g. if 2 theatre PA's/wk = 84 theatre PA's/year) in *significantly* less time than the 42 working weeks may not be able to carry this out for the following reasons:
    - 1.5.1 In order to carry out a DCC, a resource, usually involving other staff, will be required and it is unlikely that such resources will be available to accommodate a consultant wishing to work their annual commitment in a short time.
    - 1.5.2 On a full time contract with DCCs and SPA's, the only way to work an annual commitment in less than the agreed weeks would be to exceed the EWTD.
    - 1.5.3 The idea behind these changes to the job plan are to spread out the work evenly across the year to the mutual benefit of both the Trust and the consultants, resulting in a safer environment for patients and a healthy life/work balance for the consultants.
    - 1.5.4 If the AMD / CD feel that a service will be better supported/delivered through such an arrangement, then such flexibility may be agreed in these circumstances.
  - 1.6 An example of building in capacity into job plans would be as follows: if there are 3 PA's of outpatient clinics, per week on the job plan, then the indicative annual clinic contribution should be  $3 \times 42 = 126$  expected clinics per year. If clinics have been cancelled for reasons of SPA (educational events or urgent meetings), then replacement clinics should take place in designated time which was previously SPA time or time off.
-

- 1.7 The inclusion of an indicative number of sessions per year in a job plan is to facilitate better capacity and workforce planning. Where a consultant does not deliver the expected number of sessions per year for reasons outside their control, the Trust will not use this as criteria for deferring pay progression. For example, factors which may affect this could include the impact of sick leave, planned or unplanned. These issues should be discussed and agreed at job planning.

## 2.0 Direct Patient Care Productivity

- 2.1 For outpatient clinics and operating theatre sessions, an indicative estimate of the number of patients per fixed clinical PA should be included in the job plan template under individual/team job plan objectives. Justification will be from agreed levels of service for clinic and theatre capacity or from retrospective data including new to follow up ratio.
- 2.2 A clinical manager can use national norms or accepted best practice to determine/alter new and review ratios. Clinicians will be encouraged to find new ways to discharge/review patients e.g. telephone reviews, letters to patients or GP's agreeing primary care follow-up etc.
- 2.3 An individual's or teams' capacity should be agreed with clinical teams and signed off by the divisional management. Issues which are outside the control of the consultant must be discussed and recorded at job planning. This might include the impact of sick leave, planned or unplanned and the impact of any significant deficiencies in supporting infrastructure.

## 3.0 Direct Patient Care Additional Points

- 3.1 In all instances, consultants and clinical managers should ensure there is no double counting of time within job plans. One example of this might be where a consultant is undertaking teaching whilst in an outpatient clinic such activity should only be counted once for programmed activity purposes. The clinical manager and the consultant should agree the appropriate split between DCC and SPA.
- 3.2 It is the Trust's intention that job planning should work towards no consultant being contracted to work more than an average total of 48 hours in order that the Southern Trust fulfils its responsibilities regarding standards set out in the European Working Time Directive. In practice this normally translates to a 10 + 2 PA contract - if the additional PA's are paid for actual working time and not responsibility payments.
- 3.3 Direct patient care should generally comprise:
- 3.3.1 Depending on agreed SPA's and Clinical Administration; normally between 6.5 -7.5 PA's (26-30 hours) for Patient related activities including ward rounds, theatre lists, procedure lists, MDT meetings, consultations, outpatient clinics, emergency reviews and labour ward. Within the 1PA allocated to an outpatient clinic, it would be expected this would include an agreed time allocation of direct patient contact with time allowed for immediate letter writing /dictation in specialties where this is customary.
- 3.3.2 An agreed PA allocation for Clinical Administration e.g. letters, review of results, discussions with GP's and relatives.

#### 4.0 Team Job Planning *Refer to Section 4 in Regional Guidance*

- 4.1 The presence of a team job plan is entirely acceptable so long as each individual agrees to participate without coercion and that they still retain the right to sign an individual job plan agreement with the Trust.
- 4.2 The total workload (DCC, SPA, On-call) for a group of consultants should be estimated and then each element factored into individual job plans. The principal of team job planning is that all DCC and SPA activity is seen as shared and collective responsibility.
- 4.3 The following should be considered when developing a team job plan:
  - 4.3.1 Determine what direct patient care activities are required to deliver the service.
  - 4.3.2 Identify the number of consultant hours required to deliver each activity
  - 4.3.3 Determine the number of weeks in the year when each activity occurs (e.g. 42)
  - 4.3.4 Determine the annualized hours for each activity (based on point 4.2.1 & 4.2.3)
  - 4.3.5 Quantify how many consultants are available week to week to deliver the service (taking account of absences for annual/study leave)
  - 4.3.6 Divide the annualized hours by the figure identified in 4.2.5 to determine the average DCC working week per full time consultant
  - 4.3.7 Quantify the total SPA commitment as well as any additional duties (e.g. Additional Responsibilities/External Duties) across the team.
  - 4.3.8 Add the figures identified in 4.2.6 and 4.2.7 together to determine the total weekly PA figure. If this figure lies outside 10 PA's basic contract, discussions will be needed about how to manage the gap – e.g. additional Programmed activities, consultant expansion, new ways of working.
  - 4.3.9 Individuals within the team should have personalized job plans based on their individual commitments. It would be good practice that the team agree and sign a statement about how they work as a team defining their shared objectives. Where objectives are team based, the role of each individual consultant needs to be clear.
- 4.4 Please refer to the Appendix Section for a working example of team job planning.

#### 5.0 Annualised Job Planning – *Refer to Section 15 in Regional Guidance*

- 5.1 There may be some consultants who have activities that do not fall on a regular weekly basis and therefore do not lend themselves to preparing a weekly job plan. Therefore it will be necessary to have an element of their job plan annualized. However, the principles of job planning remain unchanged.

- 5.2 Where a consultant undertakes irregular clinics or additional roles, this will need to be annualized. For example, if a consultant has been approved to take on an examining role (EPA's) which will involve approximately 5 days per year – this is annualized as follows: 5 full days per year equate to 40 hours/yr, or 10 programmed activities. 10 PA's divided by 52 weeks = 0.19 PA per week. (No prospective cover).

## 6.0 On call Activity

- 6.1 Allocations for unpredictable emergency work must be evidenced by a diary data on a team basis. For example:
- 6.1.1 A diary analysis indicates 37 hours of unpredictable on-call activity worked by the team in 1 week.
- 6.1.2  $37 \text{ hours} / 3 = 12.3 \text{ PA's}$  of unpredictable on-call activity per week for the team
- 6.1.3 To allow for prospective cover –  $12.3 \times 52 \text{ weeks} / 42 \text{ working weeks} = 14.5 \text{ PA's}$
- 6.1.4 This must be divided by the number of consultants on the on-call rota e.g. 16 consultants on rota = 0.91 PA each for on-call.
- 6.1.5 Therefore if a consultant team was offered 0.91 PA for unpredictable on-call, this equates to approximately 37 hours. It is useful to ask if this represents the actual workload. If not, a re-diary card exercise may need to be undertaken.
- 6.2 **Change to workload/New Appointment** - It is essential that if there has been a change to the workload or following a new consultant appointment, the unpredictable on-call activity for the team must be reviewed and changes notified appropriately.
- 6.3 **Frequency of the on-call rota** – If there has been a change to the on-call frequency e.g. High frequency (1 in 1 to 1 in 4); Medium frequency (1 in 5 to 1 in 8); Low frequency (1 in 9 or less frequent) which takes it from one category to another, a notification (Proforma attached) of this change must be completed.
- 6.4 **Predictable On-call** - should be agreed in advance (e.g. weekend ward rounds or fixed operating which are scheduled and include other resources i.e. nursing/other clinicians joining the activity.) Time allocated should be on the basis of the number and complexity of the activities or sound diary exercise to account for the time allocation. The above calculation to include prospective cover can also be included.

### Method for calculating on-call

|   |                                                                                                                               |
|---|-------------------------------------------------------------------------------------------------------------------------------|
| 1 | Determine the total number of emergency out of hours worked by the team of consultants, identified via a diary card exercise. |
| 2 | Divide the total hours by three to determine premium time PA's                                                                |
| 3 | Multiply by 52 weeks per year                                                                                                 |
| 4 | Divide by 42 working weeks per year (as this includes prospective cover)                                                      |
| 5 | Divide the weekly PA's by the number of consultants working on the on-call rota                                               |
| 6 | This weekly PA figure will represent the on-call to be allocated to each consultant.                                          |

## 7.0 Supporting Professional Activities *Refer to Section 9 in Regional Guidance*

- 7.1 ***Please refer to further guidance on Supporting Professional Activities in Appendix Section***
- 7.2 A minimum of 1.5 PA's for supporting professional activities should be allocated to all consultants and considered as the minimum time resource for maintaining a professional career. This allocation will be the same for full and part time consultants. This allocation will require evidence of full participation in mandatory training programmes evidenced at appraisal and copies available for the Job Plan meeting. Evidence of CPD must also be presented at appraisal.
- 7.3 This SPA activity should include as a minimum CPD outside study /professional leave, requirements for licensing & recertification and mandatory training, appraisal and job planning, basic teaching, training and supervision of junior staff, administration related to these duties and attendance at audit meetings and clinical governance activity to meet minimum standards required i.e. average 1 hour per week.
- 7.4 Additional SPA allocation over 1.5 must be evidenced and timetabled into the job plan and agreed by the Clinical Director/Associate Medical Director. It is expected that this additional activity would deliver quality improvements and align with Trust objectives.
- 7.5 It is expected that SPA's should normally be worked onsite. Clinical Managers should work to ensure adequate space/facilities are available to encourage protected time for all consultants.
- 7.6 Any clinical activity lost due to scheduled SPA (e.g. the rolling governance programme) should be re-provided flexibly at a time agreed by the consultant and clinical manager. Where this is not possible, this should be discussed with the clinical manager and service director.
- 7.7 Clinical managers should be careful to ensure that SPA's are evenly divided between members of a team and that individual SPA's do not rise year on year.

## 8.0 Travel Time

- 8.1 Travelling time between a consultant's main place of work and home (for purposes other than emergency work) or private practice premises will not be regarded as part of working time.
- 8.2 Where consultants are expected to spend time on more than one site during the course of a day, travelling time to and from their main base to other site(s) will be included as working time. Such working time (for travel) will be deemed to fall within the same category of Programmed Activity as the work undertaken at the other site(s).
- 8.3 All regular travel times to external sites from base hospital should be included in the job plan using the current suggested travel times (See Appendix Section for SHSCT Travel Time Chart)
- 8.4 Job Plans should be designed to minimize disruption of fixed clinical episodes by time spent traveling between sites e.g. arranging for a full day in one clinical area rather than movement between site A&B during the day.

- 8.5 Travel to and from work for HPSS emergencies, and 'excess travel' will count as working time. 'Excess travel' is defined as time spent travelling between home and a working site other than the consultant's main place of work, after deducting the time normally spent travelling between home and main place of work.
- 8.6 **Working Example** - If a consultant normally takes 45 minutes to travel from their base hospital (e.g. CAH) to an outlying clinic (e.g. DHH) and a consultant doesn't travel to base but goes straight from home to the outlying clinic, then they can claim for "excess time" in their job plan if it takes them longer to travel from home. Therefore if consultant X lives in Belfast and it takes them 1 hour to travel to DHH, then they could claim 15 minutes in their job plan. However if they lived further away and it took them 1.5 hours to travel to DHH straight from home (or they had to come to base first for clinical reasons) then they would claim 45 minutes in their job plan.

## 9.0 External Duties & Additional HPSS Responsibilities – Refer to Sections 10 and 11 in Regional Guidance.

- 9.1 **External Duties** - The Trust would seek to facilitate consultants wherever possible for such work that is not directly for the Trust but is relevant to and in the interests of the wider HPSS. External duties should normally be connected to activities relevant to clinical medicine.
- 9.1.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.
- 9.1.2 Consultants must have approval from their Associate Medical Director before accepting external duties. Service Directors must also be involved and advised of the commitment and its impact on delivering the job plan. The timing and duration of the role and an indication on whether the role is funded externally MUST accompany this request.
- 9.1.3 Where possible all external HPSS duties MUST be included within the job plan with a clear time allocation and set within an agreed timeframe with a specific end date. It may be necessary to annualize due to the nature/irregular timing of the work.
- 9.1.4 Clinical managers should seek to spread this work equitably across consultant teams and the Trust where possible. Any agreement should acknowledge the importance of the priority of consultants' commitments to direct clinical care and supporting professional activities. Measurable objectives for External Duties MUST be discussed, agreed and be clearly specified on the job plan template.
- 9.1.5 Facilitating consultants for external duties must be governed by the need to retain a balance between different elements of the job plan in a way that maintains the required delivery of services to patients in terms of both activity and quality. It is reasonable for the clinical manager to seek to secure/maintain required direct clinical care commitments.
- 9.1.6 Clinical Managers must keep detailed records of external commitments and provide an annual report of such commitments to the Medical Director and the Senior Management Team in the Trust.

9.1.7 External duties that do not contribute to the interests of the HPSS should either be carried out during professional or study leave or where the consultant so chooses, during his/her annual leave.

9.2 **Additional HPSS Responsibilities** – These are activities agreed between a consultant and the Trust and which cannot be absorbed within the time that would normally be set aside for SPA's e.g. Clinical Director, Clinical Tutor, Regional Education Advisor etc

9.2.1 All these roles require Trust approval and the SHSCT External Duties & Additional HPSS Responsibilities approval proforma must be completed prior to acceptance.

9.2.2 Where a clinical director post becomes available, the Trust will undertake an internal appointment process. This will set out the nature of the role including time/PA allocation and the terms and conditions associated.

9.2.3 Each clinical manager needs to be aware of the roles of the consultant and how the roles are funded to ensure appropriate job planning. In some cases the allocation will vary among specialties, depending upon the required commitment and in some circumstances (e.g. Clinical Tutors), the number of junior doctors. Further guidance and support should be sought regarding teaching roles, their time commitments and job planning for them.

9.2.4 An appropriate PA allocation for Additional HPSS Responsibilities should be agreed between the clinical manager and the individual consultant and included on the job plan template.

## **10.0 Job Planning Objectives** *Refer to section 3 in Regional Guidance*

10.1 Job Plan Objectives are an essential part of the new consultant contract (Schedule 3 paragraph 10). These should be set out in the job plan and tailored to reflect local service development plans and priorities.

10.2 Objectives should state specifically what an individual consultant (or team) will be expected to deliver and how these objectives will be measured on an annual basis. It is recommended that the SMART framework is adopted. (i.e. Specific, Measurable, Achievable, Relevant, Timed and tracked.)

10.3 Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreed by the consultant and his/her clinical manager. The consultant and his/her clinical manager should use job planning to identify resources that are likely to be needed to help the consultant carry out his/her job plan commitments over the year and achieve his/her agreed objectives for that year.

10.4 Sample Objectives may incorporate the following: waiting list targets, quality of service as measured by PFA targets to balance capacity and demand, safer patient issues arising from patient safety issues, professional standards, lessons' learned from national, regional and local incidents & CHKS information.



- 10.5 Examples of “Hard Objectives” in relation to direct patient care should include the indicative capacity/productivity information discussed and agreed e.g. “Annual clinic contribution will be 126 expected clinics per year” (where there are 3 PA’s of outpatient clinics per week in a job plan) Or “Annual operating theatre contribution will be 84 expected theatre PA’s per year” (where there are 2PA’s of theatre PA’s per week in a job plan).

### **11.0 Private Practice – Refer to Section 13 in Regional Guidance**

- 11.1 Regular work for other providers should be identified on the job plan indicating time and location. Such work should not occur in remunerated direct patient care or SPA time contracted to the Trust. It is the responsibility of the Clinical Director and the Consultant to ensure there is no double counting of time.
- 11.2 All consultants are expected to conform to the Northern Ireland Code of Conduct for Private Practice and the handbook concerning the management of private practice in Health Service Hospitals in Northern Ireland. In addition to these documents, it is also important to note that any private practice done when on-call should not prevent immediate return to the hospital to attend emergencies if required.
- 11.3 Consultants should also refer to the Southern Trust procedural guidelines on the use of accommodation for private medical practice.
- 11.4 The notification of private patients using the agreed paperwork e.g. PP1, PP4 and undertaking to pay forms should be agreed.
- 11.5 If a consultant undertakes regular Domiciliary visits then this should be allocated time in his/her job plan and no fee will be paid other than travel expenses.
- 11.6 If a consultant undertakes occasional domiciliary visits outside his/her job plan, he or she may claim the appropriate fee and travel expenses.
- 11.7 Family Planning fees are not paid for by SHSCT to consultants or non training grades.

### **12.0 Overarching Principles**

- 12.1 Work outside of the contracted job plan will be reimbursed in a way that is mutually agreeable between the Chief Executive and the individual consultant. Please refer to further guidance in relation to payment of waiting list initiative payments, which has been agreed with the Local Negotiating Committee.
- 12.2 Clinical Managers must ensure they meet with their Service Manager and Performance and Review team prior to job planning to obtain relevant demand and capacity information for their specialty. See Job Planning Flowchart in the Appendix Section.

### **13.0 Job Planning Timeline**

See Appendix Section for Job Planning Summary and Timeline

# Appendix Section

1. Summary of Job Planning Key Principles
2. SHSCT Consultant Job Plan Review Template
3. Further Guidance on Supporting Professional Activities
4. SHSCT External Duties & Additional HPSS Responsibilities approval proforma
5. Job Planning Flowchart and timeline
6. SHSCT Suggested Travel chart
7. Sample Template for Objective Setting
8. Sample Team Job Planning Proforma
9. Approaches to Team Job Planning

## Other Relevant Guidance which should be considered

1. Regional Guidance on Job Planning for Medical & Dental Consultants in Northern Ireland
2. SHSCT Consultant, Locum Consultant and Career Grade Doctors Appraisal Scheme
3. SHSCT Medical Staff Annual Leave Guidance
4. SHSCT procedural guidelines on the use of accommodation for private medical practice
5. Management of Private Practice in Health Service Hospitals in Northern Ireland – A Handbook.
6. NI Code of Conduct for Private Patients

### REPORT SUMMARY SHEET

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|
| Meeting:<br>Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Trust Board<br>28 <sup>h</sup> January 2016 |
| Title:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Medical Directors Report                    |
| Lead Director:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Dr Richard Wright – Medical Director        |
| Corporate Objective:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Safe, high quality care                     |
| Purpose:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | For assurance                               |
| <b>Summary of Key Issues for Trust Board</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                             |
| <u>High level context:</u> <ul style="list-style-type: none"> <li>Update on Medical Revalidation process YTD (22<sup>nd</sup> January 2016) 261 doctors have successfully revalidated (1.1.1)</li> <li>Medical Appraisals 2014 – 98% completed / awaiting final sign-off (1.1.2)</li> <li>Progress on Junior Doctor Mandatory Training for August 2015 intake</li> <li>Reports on recent NIMDTA Deanery visits</li> </ul>                                                                                                       |                                             |
| <u>Key issues/risks for discussion:</u><br><br>Work on achievement of Internal Audit paying patients recommendations continues.                                                                                                                                                                                                                                                                                                                                                                                                 |                                             |
| <u>Summary of SMT challenge/discussion:</u> <ul style="list-style-type: none"> <li>Efficiency and effectiveness of revalidation process noted and to be used as part of information provided in recruitment processes</li> <li>Junior doctors changeover noted as 3 February and plans in place to seek to mitigate impact as part of winter pressure plans</li> <li>Excellent Deanery report for ICU commended</li> <li>Benefits of E&amp;G funding into R&amp;D to be assessed to inform continuation into 2016/17</li> </ul> |                                             |

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## 1 Medical Workforce Governance

### 1.1 Medical Appraisal and Revalidation

The Trust's Revalidation Team continue to oversee quality control of the appraisal process and review all appraisal documentation received into the Medical Director's Office to ensure there is sufficient evidence of appropriate documentation and discussion. Where gaps are identified a feedback template is returned to the Appraiser and Appraisee asking them to address the specified areas and resubmit the documentation for final approval. The current simple checklist has also been augmented to further assist doctors in the completion of the forms.

An annual report for 2014 was produced which included an analysis of the content of appraisal documentation received and an analysis of appraiser and appraisee feedback questionnaires in relation to the quality of the Trust's Medical Appraisal processes. Comparisons were drawn between the 2012 and 2013 analyses and findings indicate that the Trust's comprehensive medical appraisal and revalidation processes are very well received by the medical workforce. A report for the 2014 appraisal round is currently being developed which will also draw comparisons with the previous two years' findings. This will be available shortly.

#### Revalidation Recommendations:

To date (22<sup>nd</sup> January 2016) 261 doctors have now been revalidated and the remaining Year Three (2015-16) doctors are set to revalidate on schedule.

#### Appraisal Round 2014

The 2013 appraisal round completed with a 100% completion rate. Work commenced in April 2015 for the 2014 Appraisal Round as key information became available to issue to medical staff (e.g. CLIP reports, complaints/incidents information). The current appraisal status for 2014 is as follows:-

| Division/Directorate                            | No. of Eligible Doctors | % of 2014 Appraisals Completed/In Progress* |
|-------------------------------------------------|-------------------------|---------------------------------------------|
| Children & Young People's Services Directorate  | 40 eligible doctors     | 100% complete                               |
| Mental Health & Learning Disability Directorate | 27 eligible doctors     | 100% complete                               |
| Anaesthetics, Theatre & ICU Division            | 36 eligible doctors     | 100% complete                               |
| Surgery & Elective Care                         | 51 eligible doctors     | 96% complete                                |
| Cancer & Clinical Services                      | 33 eligible doctors     | 100% complete                               |
| Medicine & Unscheduled Care                     | 69 eligible doctors     | 100% complete                               |
| Integrated Maternity & Women's Health           | 24 eligible doctors     | 96% complete                                |
| Emergency Medicine                              | 18 eligible doctors     | 100% complete                               |
| <b>TOTAL</b>                                    | <b>297</b>              | <b>99% complete</b>                         |

Table 1.0 2014 Appraisal Status as at 22 January 2016

\*NB: In Progress means the appraisal paperwork has been completed and is currently awaiting final sign-off by the Appraiser of which there are only 10% of the total outstanding. These are due to be submitted by the end of January 2016.

## 2 Medical Education and Training

### 2.1 Postgraduate Education

#### 2.1.1 Junior Doctors Induction - Mandatory Training

Following Junior Doctor changeover in August 2015 junior doctors e-declarations continue to be recorded on the Filemaker Postgraduate database. Below is the competency report for the following mandatory training competencies as at 19<sup>th</sup> January 2016.

- Right Patient Right Blood Assessment and Module
- BMJ Hyponatremia
- Training Tracker
- Infection Control
- National Early Warning System\*

\*Trainees in IMWH are required to complete OEWS [Obstetric Early Warning System] module in addition to NEWS / Trainees in CYP are required to complete PEWS [Paediatric Early Warning System] only. PEWS module is currently delivered at speciality teaching sessions.

### 2.2 Competency Report

| Competency                 | STATUS as at 12/11/15 |                         | STATUS as at 19/01/16 |                         |   |
|----------------------------|-----------------------|-------------------------|-----------------------|-------------------------|---|
|                            | % Completed           | % Not Required / Desist | % Completed           | % Not Required / Desist |   |
| Right Patient, Right Blood | 81%                   | 19%                     | 79%                   | 21%                     | ↓ |
| BMJ Hyponatraemia          | 85%                   | N/A                     | 84%                   | N/A                     | ↓ |
| Training Tracker           | 83%                   | N/A                     | 85%                   | N/A                     | ↑ |
| Infection Control          | 92%                   | N/A                     | 91%                   | N/A                     | ↓ |
| NEWS*                      | 82%                   | 12%                     | 82%                   | 4%                      | ↔ |
| PEWS (CYPS only)           | 7%                    | 91%                     | 8%                    | 90%                     | ↑ |
| OEWS (IMWH only)           | 7%                    | 90%                     | 8%                    | 88%                     | ↑ |

Non-compliance continues to be followed up on a monthly basis in accordance with the Standard Operating Procedure. This includes reminders of modules which have expired or are due to expire in the next 40 days. AMDs are issued with divisional competency reports on a bi-monthly basis.

### **2.1.2 Junior Doctor Changeover**

Preparations are underway for Junior Doctor changeover which will take place on Wednesday 3<sup>rd</sup> February 2016. Generic induction will be held for all new trainees on the Wednesday morning with Speciality based induction programmes taking place in the afternoon or on the following day.

Generic and speciality induction information is currently being reviewed and updated on Southern Docs web-portal in advance of changeover. Trainees will be directed to the Southern Docs web-portal to undertake their online induction requirements. An updated report of mandatory training competencies based on new starts at February will be available for the next Trust Board report.

### **2.1.3 NIMDTA Deanery Visits**

The Northern Ireland Medical and Dental Training Agency (NIMDTA) carried out a series of cyclical visits and regional speciality reviews throughout the year. Below is summary and update of the most recent visits:-

#### **Obstetrics & Gynaecology Deanery Visit – 15<sup>th</sup> October 2015**

The Deanery carried out a visit to Obstetrics and Gynaecology at both Daisy Hill Hospital and Craigavon Area Hospital on 15<sup>th</sup> October 2015.

The Daisy Hill Hospital visit outlined that trainees had difficulties printing from their own IT accounts, however this issue has now been resolved and the visit outcome was B1: Satisfactory. The report is now closed.

The Craigavon Area Hospital visit outlined issues raised by trainees regarding practical experience, induction and EWTR compliance. Trust action plan has been submitted and a grading of B2: Satisfactory with conditions has been issued, pending an update on EWTR compliance by 5<sup>th</sup> February 2016.

#### **Emergency Medicine Deanery Visit – 26<sup>th</sup> November 2015**

The Deanery carried out a Deanery Visit to Emergency Medicine at both Daisy Hill Hospital and Craigavon Area Hospital sites on 26<sup>th</sup> November 2015.

The Daisy Hill Hospital visit outlined issues including informal handover and patient care due to lack of sustainable senior supervision in the Department. Trust action plan response is due to be returned to NIMDTA by 2<sup>nd</sup> February 2016.

The Craigavon Area Hospital visit outlined issues including informal handover, clinical supervision, practical experience, lack of simulation facilities and seminar room within the department for dedicated training. Trust action plan response is due to be returned to NIMDTA by 4<sup>th</sup> February 2016.

## **2.3 Intensive Care Medicine Speciality Programme Review – 2<sup>nd</sup> December 2015**

The Deanery carried out a regional specialty programme review of Intensive Care Medicine Training which included Craigavon Area Hospital on 2<sup>nd</sup> December 2015. The review received a grading at A1: Excellent. Patient safety, consultant supervision and handover were all reported to be very good. Dr Raymond McKee was commended for organising an FICM exam preparation course, which was very welcomed by trainees.

### **2.1.4 GMC Recognising and Approving Trainers**

All hospital clinical and educational supervisors will be required to have their Trainer status formally recognised and approved by the GMC by July 2016. In order to achieve this status postgraduate medical trainers will be required to have evidence of training in the following areas:

- Teaching the Teacher (or equivalent)
- Supervisory Skills (or equivalent)
- Trainee Support Workshop (formerly Doctors in Difficulty) (or equivalent)
- Equality, Diversity and Opportunity Training
- Recruitment and Selection

The Medical Education Team continues to highlight these requirements with trainers and has organised in-house training for Teaching the Teacher and Trainee Support Workshop.

## **2.4 Undergraduate Education**

### **2.2.1 New Undergraduate Teaching Leads**

New Undergraduate teaching leads have been appointed as follows:-

- Dr Sylvia Perrott, 4<sup>th</sup> Year Paediatrics, CAH
- Mr Mick McCann, 4<sup>th</sup> Year POEM ED, DHH

Mr Robin Brown, 3<sup>rd</sup> and Final Year lead for Surgery in DHH is due to retire in the near future. Discussions are on-going as to who will look after the students once he retires.

### **2.2.2 Careers Symposium**

Annual Career's Symposia are due to be held at Daisy Hill Hospital on Wednesday 16<sup>th</sup> March 2016 and Craigavon Area Hospital on Wednesday 23<sup>rd</sup> March 2016. The symposia are targeted at local A Level students to give them an insight into the role of the doctor including QUB entry requirements, the student years, the junior doctor, the Hospital Consultant and the General Practitioner. Practical skills stations will be organised to demonstrate CPR, blood pressure, suturing, etc

### **2.2.3 FY0 Assistantship**

Preparations are underway for FY0 9 week assistantship in the Trust from 15<sup>th</sup> March – 13<sup>th</sup> May 2016 (21 FY0 CAH site and 13 FY0 DHH site). FY0s will be required by QUB have their log-books signed off for topics including RPRB competency training, how to complete a GP discharge, how to order investigations. This year all FY0 will spend one week of their



assistantship placement in General Practice. FY0s will closely shadow FY1 doctors during their placement in preparation for taking up FY1 posts in August 2016.

### **3 Research & Development**

#### **3.1 Charitable Funds for Research & Development**

There had been a proposal to use the Charitable Funds of £32,281.49 transferred to Research and Development for a project focusing on quality and patient safety issues. On 19 November 2015, it was confirmed that the funding was not required for that project and therefore could be utilised for other Research and Development initiatives.

Trust researchers were given opportunity to submit proposals and the following were approved – three temporary full time Clinical Research Nurses, Band 6 for Respiratory, Mental Health and Gastroenterology for three months to 31 March 2016. A Critical Care Study was allocated additional funding to meet Pharmacy and statistical costs; an Occupational Therapy Study received funding for additional staff costs; and research equipment for Cardiology and Pharmacy was funded.

This additional funding has proved very beneficial and it is hoped a similar allocation will be made available to Research and Development in 2016/2017.

#### **3.2 Options to enhance research activity in the Trust**

Following the Research and Development presentation to Trust Board on 22 October 2015, the Medical Director asked that a paper be prepared on options to enhance research activity. That paper has now been provided to the Medical Director.

### **3.3 Meetings with Armagh City, Banbridge and Craigavon Borough Council**

Dr Sharpe and Miss Knox have been invited by the Borough Council to a North American Linkages event on 27 January 2016 when the United States Consul General Daniel Lawton will be present. The Borough Council has identified the growth of the local economy as a priority and the opportunity to develop partnerships which will expand and increase their business and stakeholder base, improve international relationships and make the area more prosperous.

### **3.4 Horizon 2020 Application – GEMS – Gestational, Type 1 and Type 2 Diabetes, Empowerment of Mothers through Mobile Technologies**

The application is being co-ordinated by the Small Business Research Initiative within Business Services Organisation and two Consultants from the Trust are contributing to the initiative; Dr Mae McConnell, Consultant Physician with interest in Diabetes and Endocrinology and Clinical Lead for Diabetes and Endocrinology and Dr Harmini Sidhu, Consultant Obstetrician and Gynaecologist. Three countries are participating; Northern Ireland, Republic of Ireland and Italy with Catalonia considering participation. The closing date for the application is 12 February 2016.

### **3.5 Qualcomm Tricorder XPrize**

The Qualcomm Tricorder Xprize is a \$10 million global competition to stimulate innovation and integration of precision diagnostic technologies helping consumers make their own reliable diagnosis anywhere, anytime.

Dr David McEneaney, Consultant Cardiologist is a member of a team of finalists led by Professor James McLoughlin with Dr Mary Jo Kurth, Randox and Mr Michael Caulfield, Intelesens also involved. The formal announcement of finalist teams was made on 27 August 2014 in Chicago when it was anticipated the Awards Ceremony would be in January 2016. However in December, 2015 it was announced that the Qualcomm Tricorder Xprize had been officially extended to early 2017, providing the finalist teams additional time to make adjustments to their tricorder devices. The period from December 2015 until August 2016 will be a requalifying round and the final round will be from September 2016 until early 2017 when the Awards Ceremony will now take place.

The Team was one of ten finalists out of several hundred applicants and the device is a non-intrusive, wearable, wireless health monitors which has been in development for ten years.

### **3.6 UK Policy Framework for Health and Social Care Research**

The four United Kingdom Health Departments have issued the UK Policy Framework for Health and Social Care Research for public consultation with a closing date for the receipt of comments by 24 March 2016. The Framework will replace the Policy issued in February 2007.

## 4 Emergency Planning/Business Continuity

### 4.1 Pandemic Plans

Reporting arrangements have been implemented through this report to allow Directors and Trust Board to monitor the review and testing of plans in line with requirements (Controls Assurance Standard 5.11 : Are the organisation's updated plans validated and tested through regular review and exercises?). The inventory of pandemic plans is provided in Appendix A.

### 4.2 Business Continuity

The Trust is required to have business continuity measures in place to enable it to anticipate, prepare for, prevent, respond to and recover from disruptions to a pre-defined level, whatever their source and whatever aspect of the business they affect.

Controls Assurance Standards require the Trust to provide evidence that appropriate plans are in place and that business continuity management measures form part of the organisation's core business and are not just an adjunct to it.

A corporate Emergency Management plan, incorporating Business Continuity is in place and is supported by a number of service/department plans. An inventory of these plans has now been compiled to facilitate monitoring of the review and testing of plans. The inventory is attached in Appendix B.

### 4.3 Special Incidents Plan - Chemical, Biological, Radiological, Nuclear (CBRN)

In line with DHSSPS requirements, the Emergency Planner has drafted and shared internally, a new CBRN plan to address the potential issue of contaminated casualties self-presenting at Emergency Departments. The new plan will replace the current guidance incorporated into the Acute Hospitals Major Incident Plan and will cover new guidance on the use of dry decontamination for non-caustic contaminants which Trusts are required to have implemented. The completed plan will provide clear guidance to staff who would be directly involved in responding to such incidents (security, porters, domestic services, medical and nursing staff).

The working group established to progress this work has been expanded to ensure the full requirements of the plan are now implemented. A meeting took place on 28/10/15 and a further meeting is scheduled for 19/1/16 to progress the actions necessary to complete the plan and to ensure preparedness for such incidents.

When complete, the plan will be shared with other emergency responders through the multi-agency Southern Civil Emergency Preparedness Group.

### 4.4 Emergency Planning Training Activity

#### 4.4.1 Initial Operational Response

A staff training DVD on the new arrangements for dry decontamination, "Initial Operational Response (IOR)" was made available to both Emergency Departments (EDs) and was uploaded to the Trust's

e-learning platform. The short film clearly demonstrates how casualties or self-presenters contaminated with non-caustic chemical agents should be decontaminated. ED staff who would be involved in this process, (nursing, medical, security and receptionists) have watched the DVD as part of their training for the implementation of the new process.

| IOR TRAINING - % STAFF WHO HAVE WATCHED IOR TRAINING DVD |                       |                            |                                 |
|----------------------------------------------------------|-----------------------|----------------------------|---------------------------------|
| Date                                                     | Total Number of Staff | Staff who have watched DVD | % of staff who have watched DVD |
| 7/12/15                                                  | 98                    | 53                         | 62                              |

#### **4.4.2 HMIMMS (Hospital Major Incident Medical Management & Support)**

Trust Staff continue to be nominated to attend relevant courses as they arise (e.g. Hospital Major Incident Medical Management & Support, Major Incident Medical Management & Support). Another course will run in February and nominations have been sought from the Acute Directorate.

#### **4.5 Evacuation and Sheltering Guidance**

In line with DHSSPS requirements, a working group was established in 2014 to develop an Evacuation and Sheltering plan for the two acute hospitals. The plan is now complete and will be presented to SMT and Trust Board for approval, after which it will be uploaded to the intranet and shared with relevant staff. Wards and Departments are now being asked to develop their own evacuation and sheltering plans.

The Emergency Planner will also share the plan with multi-agency colleagues through the Southern Civil Emergency Preparedness Group.

In 2016, the acute Hospital Evacuation and Sheltering plan will be used as a template for the development of evacuation and sheltering plans for non-acute hospitals and Trust residential facilities. The plan will also be shared with independent sector providers.

#### **4.6 Incidents**

The heavy rainfall over the Christmas and New Year period caused flooding in parts of the Southern area, affecting peoples' homes in Portadown, Poyntzpass and Newry and the carpark of Portadown Health Centre. Community services to some clients were affected and staff had to implement business continuity arrangements to ensure client welfare and safety. Staff are to be commended for their efforts to maintain services during periods of severe weather conditions.

There was a huge amount of co-operation between agencies to try and mitigate the impact of Storm Frank and the subsequent rainfall and the Southern Civil Emergency Preparedness Group teleconferenced on a regular basis to ensure the provision of timely information and updates to agencies.

#### **4.7 Resourcing**

Emergency Planning has been funded for temporary Administrative support up to 31/3/16. The post holder commenced on 26 October and amongst other things has been assisting with the:

- implementation of Emergency Planning performance management arrangements
- Updating Emergency Planning action plans
- Sourcing and ordering of Emergency Planning supplies
- Ensuring Emergency internal and external contact details are updated
- Liaising with directors and Emergency Support Centre Managers to update on-call rotas

**5 Appendix A Inventory Of SHSCT Pandemic Plans at 18<sup>th</sup> January 2016**

| Directorate  | Service                                                                                             | Name of Plan                                                                                                                                                                     | Plan Owner                    | Date Created | Date of Last review | Date of Next Review |
|--------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------|---------------------|---------------------|
|              |                                                                                                     |                                                                                                                                                                                  |                               |              |                     |                     |
| <b>HROD</b>  | All HR services                                                                                     | Pandemic Flu Planning                                                                                                                                                            | Vivienne Toal                 | July 2014    | TBA                 |                     |
|              | Systems                                                                                             | E-recruitment                                                                                                                                                                    | SEE BUSINESS CONTINUITY PLANS |              | TBA                 | E-recruitment       |
|              |                                                                                                     | Nurse Bank System                                                                                                                                                                |                               |              |                     |                     |
|              |                                                                                                     | HSC E-locums                                                                                                                                                                     |                               |              |                     |                     |
| <b>MHLD</b>  | Statutory Day Care                                                                                  | Station Road Resource Centre, Armagh<br>Binnion Resource Centre, Kilkeel<br>Manor Resource Centre, Lurgan<br>Copperfields Resource Centre, Banbridge                             | Bronagh McKeown               | Feb 2012     | TBA                 |                     |
|              | Transport                                                                                           | Early Pandemic Action Plan                                                                                                                                                       | Barry Collins                 | 16/3/12      | 12/1/16             | 12/1/17             |
|              | Mental Health, Learning Disability and Physical and Sensory Disability Services and SHSCT Transport | Draft Business Continuity during Swine Flu Surge                                                                                                                                 | ?                             | 28/10/09     | TBA                 |                     |
| <b>OPPC</b>  | Statutory Day Care                                                                                  | Pandemic Flu Planning BCP and Guidance Meadows , Crozier Lodge and Edenderry day centres.<br>Lisanally,, Clogher & Keady Day centres<br>Orchard day centre and Donard day centre | Tierna Armstrong              | March 2012   | April 2015          | April 17            |
|              | Statutory Residential Homes                                                                         | Pandemic Flu Planning for Cloughreagh House ,Slieve Roe,Crozier House ,Roxborough House                                                                                          |                               | March 2012   | April 2015          | April 2017          |
|              | Trust Domiciliary Care Service                                                                      | Domiciliary Care Continuity plan                                                                                                                                                 | Claudine mc comiskey          | March 2012   | December 2015       | April 2017          |
|              | Care bureau                                                                                         | Care bureau continuity plan                                                                                                                                                      | Claudine mc comiskey          | April 2014   | April 2015          | April 2017          |
| <b>CYP</b>   | Children's Residential Homes                                                                        | Children's Residential Homes – Swine Flu Pandemic Plan.                                                                                                                          | ?                             | Mar 2012     | TBA                 |                     |
|              | AHP's                                                                                               | Child Health & Disability Division Business Contingency plan - Actions for AHP's - Preparation Stage                                                                             | Pauline Douglas               | Mar 2012     | May 2015            | May 2017            |
| <b>Acute</b> | Medicine & Unscheduled Care Surgery & Elective Care                                                 | Acute Programme of Care - PLANNING FOR PANDEMIC INFLUENZA IN:                                                                                                                    |                               | Feb 2012     | TBA                 |                     |

|  |                                                                                                                  |                                                                                                                                                             |                                  |             |           |               |
|--|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------|-----------|---------------|
|  | Integrated Maternity & Women's Health<br>Cancer & Clinical Care<br>Pharmacy<br>Functional Support<br>Social Work | Medicine & Unscheduled Care<br>Surgery & Elective Care<br>Integrated Maternity & Women's Health<br>Cancer & Clinical Care<br>Pharmacy<br>Functional Support |                                  | Sept 2012   |           | November 2015 |
|  | <b>Support Services</b>                                                                                          | AFC Terms and Conditions & Payment Arrangements for 7 day Working - Pandemic Flu Plan                                                                       |                                  |             |           |               |
|  |                                                                                                                  | Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure, Bluestone & Coffee Bars)                                                        |                                  |             |           |               |
|  |                                                                                                                  | Laundry Services Contingency Plan                                                                                                                           | Kate Corley                      | 2008        | Annual    | Nov 2016      |
|  |                                                                                                                  | Sterile Services Contingency Plan                                                                                                                           |                                  |             |           |               |
|  |                                                                                                                  | Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)                                  | Anne Forbes                      | Sep 2011    | Annual    | Oct 2016      |
|  |                                                                                                                  | Escalation Plan for Domestic Services in Non In-patient Community Facilities                                                                                | Sandra McLoughlin                | Jul 2012    | Annual    | Oct 2016      |
|  |                                                                                                                  | Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)                    | Kate Corley                      | May 2009    | Annual    | Nov 2016      |
|  |                                                                                                                  | Escalation Plan for Switchboard, CAH Contingency Plan in Event of Total Failure of Referral & Booking Centre                                                | Kate Corley                      | Sep 2011    | Annual    | Nov 2016      |
|  |                                                                                                                  | Contingency Plan for Health Records in SHSCT                                                                                                                | Kate Corley                      | Sep 2011    | Annual    | Nov 2016      |
|  |                                                                                                                  | Contingency Plan for Admin Services in ED                                                                                                                   |                                  |             |           |               |
|  |                                                                                                                  |                                                                                                                                                             | Anne Forbes                      | Sep 2011    | Annual    | Oct 2016      |
|  |                                                                                                                  |                                                                                                                                                             | Anita Carroll/Katherine Robinson | August 2012 | Bi-annual | Oct 2016      |
|  |                                                                                                                  |                                                                                                                                                             | Helen Forde                      | August 2010 | Annual    | Aug 2016      |
|  |                                                                                                                  |                                                                                                                                                             | Helen Forde                      | Jan 2015    | Annual    | Jan 2016      |

## 6 Appendix B Inventory Of Business Continuity Plans For Trust Services at 18<sup>th</sup> January 2016

| DIRECTORATE | SERVICE                         | NAME OF PLAN                                                                                                                             | PLAN OWNER                       | CREATED     | REVIEW SCHEDULE | LAST REVIEWED | NEXT REVIEW   | LAST TESTED |
|-------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|-------------|-----------------|---------------|---------------|-------------|
| ACUTE       | Support Services                | Acute Catering Services Contingency Plan (CAH, DHH, Lurgan, STH, Mullinure, Bluestone & Coffee Bars)                                     | Kate Corley                      | 2008        | Annual          | Nov 2015      | Nov 2016      | June 2015   |
|             | Support Services                | Laundry Services Contingency Plan                                                                                                        | Anne Forbes                      | Sept 2011   | Annual          | Oct 2015      | Oct 2016      | March 2015  |
|             | Support Services                | Sterile Services Contingency Plan                                                                                                        | Sandra McLoughlin                | Jul 2012    | Annual          | Oct 2015      | Oct 2016      | March 2015  |
|             | Support Services                | Escalation Plan for Domestic Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone)               | Kate Corley                      | May 2009    | Annual          | Nov 2015      | Nov 2016      | March 2015  |
|             | Support Services                | Escalation Plan for Domestic Services in Non In-patient Community Facilities                                                             | Kate Corley                      | Sept 2011   | Annual          | Nov 2015      | Nov 2016      | March 2015  |
|             | Support Services                | Escalation Plan for Security and Portering Services in Acute and Non-Acute Hospitals (CAH, DHH, Lurgan, STH, St Luke's site & Bluestone) | Kate Corley                      | Sept 2011   | Annual          | Nov 2015      | Nov 2016      | March 2015  |
|             | Support Services                | Escalation Plan for Switchboard, CAH                                                                                                     | Anne Forbes                      | Sept 2011   | Annual          | Oct 2015      | Oct 2016      | March 2015  |
|             | Support Services                | Contingency Plan in Event of Total Failure of Referral & Booking Centre                                                                  | Anita Carroll/Katherine Robinson | August 2012 | Bi-annual       | October 2014  | October 2016  | March 2015  |
|             | Support Services                | Contingency Plan for Health Records in SHSCT                                                                                             | Helen Forde                      | August 2010 | Annual          | August 2015   | August 2016   |             |
|             | Support Services                | Contingency Plan for Admin Services in ED                                                                                                | Helen Forde                      | Jan 2015    | Annual          |               | Jan 2016      |             |
|             | Unscheduled Care                | Emergency Department                                                                                                                     | Barry Conway                     |             | Bi-annual       | October 2014  | October 2016  |             |
|             | Cancer & Clinical Services      | Cath Lab                                                                                                                                 | Simon Gibson                     |             | Bi-annual       | October 2014  | October 2016  |             |
|             | Pharmacy                        | Asceptic Unit                                                                                                                            | Tracey Boyce                     |             | Bi-annual       | August 2014   | August 2016   |             |
|             | Pharmacy                        | Pharmacy – Medical Gas Testing                                                                                                           | Tracey Boyce                     |             | Bi-annual       | August 2014   | August 2016   |             |
|             | Pharmacy                        | Pharmacy – Cold Storage                                                                                                                  | Tracey Boyce                     |             | Bi-annual       | August 2014   | August 2016   |             |
|             | Pharmacy                        | Pharmacy Automated Dispensing                                                                                                            | Tracey Boyce                     |             | Bi-annual       | August 2014   | August 2016   |             |
|             | Pathology & Laboratory Services | Laboratory Services:                                                                                                                     | Brian Magee                      |             | Bi-annual       | August 2014   | August 2016   |             |
|             |                                 | Blood Shortages                                                                                                                          | Tom McFarland                    |             | 3 yearly        | June 2013     | June 2016     |             |
|             |                                 | Bio computer Failure                                                                                                                     | Kevin Duffin                     |             | Bi-annual       | July 2014     | July 2016     |             |
|             | Cancer & Clinical Services      | Imaging                                                                                                                                  | Jeanette Robinson                |             | Bi-annual       | November 2014 | November 2016 |             |
|             | Cancer & Clinical Services      | Audiology                                                                                                                                | Jeanette Robinson                |             | 3 yearly        | November 2014 | November 2016 |             |
|             | Cancer & Clinical Services      | Neurophysiology                                                                                                                          | Jeanette Robinson                |             | 3 yearly        | November 2014 | November 2016 |             |



|                                                         |                                                                 |                                                                                                                                                      |                                                          |           |                                                                                                                                  |                                                                              |                       |                           |
|---------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------|---------------------------|
|                                                         |                                                                 |                                                                                                                                                      |                                                          |           |                                                                                                                                  |                                                                              |                       |                           |
|                                                         |                                                                 | Acute Allied Health Provision – respiratory call outs                                                                                                | Cathie McLroy                                            |           | Annual                                                                                                                           | November 2014                                                                | November 2015 (2015)? | November 2015?            |
|                                                         | Maternity                                                       | Maternity Services – theatres CAH and DHH                                                                                                            | Anne McVey<br>Patricia McStay                            |           | Annual                                                                                                                           | November 2014                                                                | November 2015         | 2014 but no plan in place |
|                                                         | Cancer & Clinical Services                                      | Intensive Care - CAH                                                                                                                                 | Mary McGeough                                            |           | Annual                                                                                                                           | November 2014                                                                | November 2015         |                           |
|                                                         | Cancer & Clinical Services                                      | Emergency Theatres - CAH and Daisy Hill                                                                                                              | Mary McGeough                                            |           | Annual                                                                                                                           | November 2014                                                                | November 2015         |                           |
|                                                         |                                                                 |                                                                                                                                                      |                                                          |           |                                                                                                                                  |                                                                              |                       |                           |
| <b>HUMAN RESOURCES &amp; ORGANISATIONAL DEVELOPMENT</b> | HCR System Failure                                              | HCR System Failure e– Local Operating Procedures                                                                                                     | Karyn Patterson                                          | 18/2/11   | HCR has now ceased use for general operational activity and remains live only to facilitate remaining use of live waiting lists' | September 2013<br>Out of Operational Use – Read only Access until April 2016 |                       |                           |
|                                                         | E-recruitment                                                   | E-recruitment System Failure Operating Procedures                                                                                                    | Karyn Patterson                                          |           | In Development – system introduced April 2015                                                                                    |                                                                              |                       |                           |
|                                                         | Nurse Bank System                                               | Nurse Bank System Failure Operating Procedures                                                                                                       | Karyn Patterson / Mary Averall                           |           | In Development – system upgraded May 2015                                                                                        |                                                                              |                       |                           |
|                                                         | HSC E-locums                                                    | HSC E-locums System Failure Operating Procedures                                                                                                     | For SHSCT – Karyn Patterson / Karen McConville           |           | In Development – system upgraded May 2015                                                                                        |                                                                              |                       |                           |
|                                                         | Estates                                                         | Draft Estates Business Continuity Plan                                                                                                               | Alan Metcalfe                                            | Jan 2012  |                                                                                                                                  | Feb 2015                                                                     |                       | As per Trust test in 2014 |
| <b>PERFORMANCE &amp; REFORM</b>                         | Informatics                                                     | Business Contingency / Continuity Plan (Information Management, Information Systems, ICT, Informatics, Corporate Records, ITS Programme Managements) | Siobhan Hanna                                            | Jan 2011  | Annual                                                                                                                           | January 2015                                                                 |                       | -                         |
|                                                         | Informatics                                                     | Business Continuity Plan for Managed Print Services                                                                                                  | Stephen Hylands                                          | Feb 2012  | Annual                                                                                                                           | December 2014                                                                |                       | -                         |
|                                                         | Informatics                                                     | ICT Business Continuity Plan                                                                                                                         | Andrew Patterson                                         | Nov 2009  |                                                                                                                                  | January 2015                                                                 |                       | November 2014             |
|                                                         | Performance & Improvement                                       | Business Continuity Plan including flu pandemic contingency arrangements                                                                             | Lesley Leeman                                            | Mar 2012  | Annual                                                                                                                           | Oct 2014                                                                     |                       |                           |
|                                                         |                                                                 |                                                                                                                                                      |                                                          |           |                                                                                                                                  |                                                                              |                       |                           |
| <b>OLDER PEOPLE &amp; PRIMARY CARE</b>                  | Domiciliary Care                                                | CB, AD, N&M Domiciliary Care Continuity Plan V2                                                                                                      | CB Mel Byrne<br>AD Geraldine Rushe<br>NM Valerie Magowan | Sept 2011 | Annual                                                                                                                           | December 2015                                                                | March 2017            | February 2015             |
|                                                         | Intermediate Care, stroke and Specialist Primary Care Services. | Continuity plan and support procedures in event of a major disruption to services. . 5998766                                                         | Catherine Sheeran                                        | Nov 2011  | Annual                                                                                                                           |                                                                              |                       |                           |

|                                                                                                                                                                                                                                                                                                                  |                             |                                                                                                                    |                                                                                                        |            |           |                                                        |            |                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------|-----------|--------------------------------------------------------|------------|-----------------------------|
|                                                                                                                                                                                                                                                                                                                  | Promoting Well Being        | Business Continuity Plan for Promoting Well being                                                                  | Gerard Rocks<br>Lynne Smart<br>Carolyn Agnew                                                           | March 2013 | Annual    | February 2015                                          |            |                             |
|                                                                                                                                                                                                                                                                                                                  | Non-Acute and Day Hospitals | Non-Acute hospitals/Day Hospitals Business Continuity Plan                                                         | Pat Nugent/Catherine Sheeran                                                                           | Nov 2011   |           | Nov 2012                                               |            |                             |
|                                                                                                                                                                                                                                                                                                                  | GP Out of Hours             | GP Out of Hours Business Continuity Plan VI                                                                        | Cathrine Reid                                                                                          | Mar 2011   | Annual    | Mar 2012<br>Reviewed September 2015, and being updated |            |                             |
|                                                                                                                                                                                                                                                                                                                  | Adastra                     | GP Out of Hours Contingency Protocol if there is no Access to Adastra in the Call Centre                           | Cathrine Reid                                                                                          |            | Annual    | June 2013<br>Reviewed September 2015                   |            | June 2013<br>September 2015 |
| <b>The separate Continuity Plan &amp; Support Procedures in the event of a Major Disruption to Services for OPPC</b><br><b>OT.DN and Social Work are currently under review as a combined OPPC Primary Care Integrated Care Team Continuity Plan. This work is being led by Nuala Gorman Head of Service ICT</b> | Occupational Therapy        | Occupational Therapy Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services | Nuala Gorman<br>James Todd<br>Miceal McParland<br>Alicia Dickson<br>Patrick Robinson<br>Siobhan Macari | Nov 2011   | Jan 2015. | Ongoing.<br>Review to be completed by 30.06.15         |            |                             |
|                                                                                                                                                                                                                                                                                                                  | Memory Service              | Memory Service- Continuity Plan & Support Procedures in the event of a major disruption to services V3             | C&B Shane Caldwell<br>A&D Siobhan Donaghy<br>N&M                                                       | Nov 2011   |           |                                                        |            |                             |
|                                                                                                                                                                                                                                                                                                                  | Physiotherapy Service       | Physiotherapy Service continuity plan & Support Procedures in the event of a major disruption to services          | Teresa Ross                                                                                            | July 2012  |           |                                                        | May 2015   |                             |
|                                                                                                                                                                                                                                                                                                                  | Care Bureau                 | Care Bureau Service – Continuity Plan & Support                                                                    | Claudine                                                                                               | March 2014 |           | April 2015                                             | April 2017 |                             |

|            |                                                    |                                                                                                                       |                                                                                                        |                                                       |           |                                                |          |                        |
|------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------|------------------------------------------------|----------|------------------------|
|            |                                                    | Procedures in the event of a major disruption                                                                         | McComiskey                                                                                             |                                                       |           |                                                |          |                        |
|            | Residential Care Homes                             | BCP for Crozier House, Roxborough House, Slieve Roe, Cloughreagh                                                      |                                                                                                        | Jan 2012<br>Jan 2011                                  | annual    | April 2015                                     |          | Desk top test 11/12/13 |
|            | Access & Information Service                       | Access & Information Contingency Plan                                                                                 | Mairead Kirk                                                                                           | March 2012                                            | Annual    | Nov 2015                                       | May 2016 | 18/11/2015             |
|            | Daycare Centre Service Continuity Plan             | BCP Meadows, Crozier Lodge & Edenderry Lisanally, Keady & Clogher, Donard & Orchard                                   | Tierna Armstrong                                                                                       | April 2011                                            | Annual    | April 2015                                     |          | Desk top test 11/12/13 |
|            | Nutrition & Dietetic Service                       | Nutrition & Dietetic Service – Continuity Plan & Support Procedures in the event of a Major Disruption to Services V3 | Mandy Gilmore                                                                                          | Nov 2011                                              |           | Dec 2014                                       |          |                        |
|            | District Nursing Service                           | District Nursing Service – continuity Plan & Support Procedures in the event of a major disruption to services V3     | Nuala Gorman<br>James Todd<br>Miceal McParland<br>Alicia Dickson<br>Patrick Robinson<br>Siobhan Macari | Nov 2011                                              | Jan 15    | Ongoing.<br>Review to be completed by 30.06.15 |          |                        |
|            | Social Work/Care                                   | Social Work/Care - continuity Plan & Support Procedures in the event of a major disruption to services V3             | Nuala Gorman<br>James Todd<br>Miceal McParland<br>Alicia Dickson<br>Patrick Robinson<br>Siobhan Macari | Nov 2011                                              | Jan 15    | Ongoing.<br>Review to be completed by 30.06.15 |          |                        |
|            | Podiatry                                           | Podiatry Service - continuity Plan & Support Procedures in the event of a major disruption to services                | C&B Denise Russell                                                                                     | Nov 2011                                              |           | Nov 2014                                       | May 2015 | TBC                    |
| <b>CYP</b> | Children's & Young People's Services               | Children's & Young People's Services                                                                                  | <b>TBA</b>                                                                                             |                                                       |           | Feb 2012                                       |          |                        |
|            |                                                    |                                                                                                                       |                                                                                                        |                                                       |           |                                                |          |                        |
|            | Community Dental Services                          | Community Dental Services                                                                                             | Michelle Oliver                                                                                        | Sept 2008                                             | Bi-annual | May 2015                                       | May 2017 | May 2017               |
|            |                                                    |                                                                                                                       |                                                                                                        |                                                       |           |                                                |          |                        |
|            | Executive Director of Social Work Responsibilities | Executive Director of Social Work Responsibilities                                                                    | <b>Paul Morgan</b>                                                                                     | <b>Should be reflected in all PoC Emergency Plans</b> |           |                                                |          |                        |
|            |                                                    |                                                                                                                       |                                                                                                        |                                                       |           |                                                |          |                        |
|            | Social Work Out of Hours Service (Trust Wide)      | RESWS (region al emergency social work service)                                                                       | Regional service 02895049000                                                                           | May 2013                                              | N/A       | N/A                                            | N/A      | N/A                    |

|  |                                  |                                  |                 |  |             |          |          |          |
|--|----------------------------------|----------------------------------|-----------------|--|-------------|----------|----------|----------|
|  |                                  |                                  |                 |  |             |          |          |          |
|  | Business Continuity Plan for AHP | Business Continuity Plan for AHP | Pauline Douglas |  | Bi-annually | May 2015 | May 2017 | May 2017 |

**Wright, Elaine**

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**From:** Clarke, Paula [Personal Information redacted by the USI]  
**Sent:** 15 June 2015 22:05  
**To:** O'Brien, Aidan  
**Subject:** Re: Wait for Surgery

Thanks Aidan I appreciate the challenges despite all the good work you and the team are doing to reform to increase capacity. We are lobbying hard for regional action to address the backlog. Paula

Sent from my iPad

On 15 Jun 2015, at 21:36, O'Brien, Aidan [Personal Information redacted by the USI] wrote:

Hello Paula,

The only reason for [Personal Information redacted by the USI] long wait is that I have patients awaiting admission since October 2013, never mind October 2014.

In any case, I have been in contact with her, and she is very pleased to be admitted on Tuesday 23 June 2015 for surgery the following morning,

Aidan.

---

**From:** Clarke, Paula  
**Sent:** 08 June 2015 21:19  
**To:** [Personal Information redacted by the USI] O'Brien, Aidan; [dolores.kelly](#) [Personal Information redacted by the USI]  
**Cc:** Wright, Elaine; Elliott, Noleen  
**Subject:** RE: Wait for Surgery

[Personal Information redacted by the USI] thankyou for highlighting your concerns and giving us the opportunity to address them and I will ensure your case is looked into and we will respond to you as soon as possible.

Thanks

Paula Clarke  
 SHSCT Chief Executive (Interim)

[Personal Information redacted by the USI]  
 You can follow us on [Facebook](#) and [Twitter](#)

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**From:** [Personal Information redacted by the USI]  
**Sent:** 08 June 2015 19:56  
**To:** Clarke, Paula; O'Brien, Aidan; [dolores.kelly](#) [Personal Information redacted by the USI]  
**Cc:** Wright, Elaine; Elliott, Noleen  
**Subject:** Wait for Surgery

Dear Mrs Clarke, Mr O'Brien and Mrs Kelly,

I am writing to express my concern with my extended wait for surgery in Craigavon Area Hospital.

In October 2014 I was admitted to hospital suffering severe pain due to a large kidney stone. Unfortunately, surgery to retrieve the stone was unsuccessful, so a stent was put in place and I was discharged. Some time later, I received ESWL treatment which was also unsuccessful. On review following this treatment Mr Young (Consultant Urologist) advised

that I would need further surgery, and to expedite the process, he would maintain my place on Mr O'Brien's surgical list, while also adding me to his own surgical list.

It is now over 7 months since my original surgery and I still have no indication of when i will be called for surgery. On follow up with the Urology secretary, I was advised that I was only on Mr O'Brien's surgical list and had been listed as 'routine' despite Mr Young indicating to me that he felt I needed to be seen urgently.

Both my GP and I have been in regular contact with the Urology department but without success. I am in pain daily, I am suffering from recurrent infections and the situation is having a great impact on my life as a busy mum to 4 very young children. My husband is self employed and works away from home Monday to Friday each week, I have no family support as my mum suffers from early onset dementia and requires 24 hour care. I have tried to persevere with the situation but am currently struggling to do so and would greatly appreciate any assistance you could offer in this matter.

Yours Sincerely

Personal Information redacted by the USI

D.O.B.

Personal Information redacted by the USI

NHS No.

Personal Information redacted by the USI

Hospital No.

Personal Information redacted by the USI

Home:

Personal Information redacted by the USI

Mobile:

Personal Information redacted by the USI

**Wright, Elaine**

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**From:** Wright, Elaine [Personal Information redacted by the USI]  
**Sent:** 11 August 2015 09:26  
**To:** 'Dobson, Jo-Anne'  
**Cc:** Complaints; Burns, Deborah; Stinson, Emma M; Wright, Elaine; Clarke, Paula  
**Subject:** RE: Surgical Appointment - [Personal Information redacted by the USI]  
 [Personal Information redacted by the USI]

Dear Jo-Anne

Thank you for your email below re [Personal Information redacted by the USI]. I have forwarded onto the relevant Directorate and asked that contact is made.

Kind regards

Jennifer (on behalf of Elaine Wright)

-----Original Message-----

From: Dobson, Jo-Anne [<mailto:jo-anne.dobson>] [Personal Information redacted by the USI]  
 Sent: 10 August 2015 22:36  
 To: Clarke, Paula  
 Cc: Wright, Elaine  
 Subject: Surgical Appointment - [Personal Information redacted by the USI]

Dear Paula,

I have been contacted by [Personal Information redacted by the USI] on behalf of her husband [Personal Information redacted by the USI] of [Personal Information redacted by the USI].

[Personal Information redacted by the USI] has told me that her husband has been under the care of Mr O'Brien Urology in Craigavon. He has kidney stones and has been waiting for surgery since July 2014. He had a stent fitted as the stones were too large to pass and this was to attempt to break them down however this hasn't worked!

He has been told that his surgery to remove the stent is a priority case and while he was told it was likely to take place in February he has not received a date yet. He is currently taking 28 tablets per day and I would appreciate your assistance in securing a date for surgery.

I have sent a consent form for [Personal Information redacted by the USI] to complete and will forward to you upon receipt.

Kind regards

Jo-Anne

**Corrigan, Martina**

---

**From:** Clarke, Paula [Personal Information redacted by the USI]  
**Sent:** 02 November 2015 07:48  
**To:** Wright, Elaine  
**Subject:** Re: \*FOR RESPONSE\* [Personal Information redacted by the USI]  
**Attachments:** image001\_4kblhpnwa2m.png

Yes please Elaine and maybe ring Martina first

Sent from my iPad

On 28 Oct 2015, at 16:40, Wright, Elaine [Personal Information redacted by the USI] wrote:

Paula – out of courtesy should we ring [Personal Information redacted by the USI] and just advise we know that his mums case is being progressed, and any concerns/issues to please let us know.....?  
 e

---

**From:** Stinson, Emma M  
**Sent:** 27 October 2015 13:53  
**To:** Wright, Elaine  
**Subject:** RE: \*FOR RESPONSE\* [Personal Information redacted by the USI]

Hi Elaine

[Personal Information redacted by the USI] is already in the Urology system under Mr O'Brien - Martina Corrigan is Head of Urology and has escalated to Mr O'Brien for response – complaints have been kept in the loop

Many Thanks  
 Emma

*Emma Stinson*

PA to Mrs Esther Gishkori  
 Director of Acute Services  
 SHSCT, Admin Floor, Craigavon Area Hospital



**Direct Line:** [Personal Information redacted by the USI]

**Direct Fax:** [Personal Information redacted by the USI]

<image002.png> [Personal Information redacted by the USI]



Please consider the environment before printing this email

Click on the link to access the [Acute Services Page](#)



<image004.png>




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**From:** Wright, Elaine  
**Sent:** 27 October 2015 13:43



**To:** Stinson, Emma M

**Subject:** \*FOR RESPONSE\* [Personal Information redacted by the USI]

Can I just check then if [Personal Information redacted by the USI] needs referred now to Urology and would this be through her GP? Just to know what advise to give.  
Thanks elaine

---

**From:** Reddick, Fiona

**Sent:** 23 October 2015 09:54

**To:** Stinson, Emma M; Carroll, Ronan

**Cc:** Complaints; Wright, Elaine

**Subject:** RE: \*FOR RESPONSE\* [Personal Information redacted by the USI]

Emma,

I have checked with the stoma nurses – they tell me that the Mitrofanoff stoma is an internal stoma which is a procedure carried out by the Urology team.

This lady would need to be reviewed by the Urology team for further management. The stoma nurses are happy to be involved to advise if her skin is excoriated or painful.

Regards

Fiona

*Fiona Reddick*

Head of Cancer Services

Southern Health and Social Care Trust

Macmillan Building

Tel: [Personal Information redacted by the USI]

Mobile: [Personal Information redacted by the USI]

---

**From:** Stinson, Emma M

**Sent:** 20 October 2015 09:42

**To:** Reddick, Fiona; Carroll, Ronan

**Cc:** Complaints; Wright, Elaine

**Subject:** \*FOR RESPONSE\* [Personal Information redacted by the USI]

Dear Fiona

Please see below – could you advise if you could follow up with the Stoma nursing team? I have already forwarded this complaint to Martina Corrigan to address urology issues.

Many Thanks  
Emma

*Emma Stinson*

**PA to Mrs Esther Gishkori**

**Director of Acute Services**

**Southern Health and Social Care Trust**

**Admin Floor**

## Craigavon Area Hospital

**Direct Line:****Direct Fax:**

&lt;image002.png&gt;

Personal Information redacted by the USI



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[Click on the link to access the Acute Services Page](#)‘You can follow us on [Facebook](#) and [Twitter](#)’

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**From:** Wright, Elaine  
**Sent:** 20 October 2015 09:26  
**To:** Stinson, Emma M  
**Cc:** Complaints  
**Subject:** Personal Information redacted by the USI

Emma – please see advice from OPPC below. Can you please progress via the Stoma Nurse and advise.  
 Thanks Elaine

---

**From:** Toner, Roisin  
**Sent:** 19 October 2015 19:40  
**To:** Wright, Elaine  
**Subject:** Fwd: Personal Information redacted by the USI

Elaine  
 Martina has advised that  
 Mitrofanoff is a stoma product therefore this would be best referred to Stoma nurse through Acute.  
 Many thanks  
 Roisin

Sent from my iPad

Begin forwarded message:

**From:** "McVeigh, Angela" Personal Information redacted by the USI  
**Date:** 19 October 2015 at 18:10:51 BST  
**To:** "Toner, Roisin" Personal Information redacted by the USI, "Thompson, Martina" Personal Information redacted by the USI  
**Subject: FW:** Personal Information redacted by the USI

Roisin and Martina  
 see request for help with continence.  
 this patient may already be known to you.  
 can you follow up and advise.  
 thanks  
 Angela

-----Original Message-----

From: Wright, Elaine  
 Sent: 19 October 2015 16:43

To: Gishkori, Esther; McVeigh, Angela  
Cc: Stinson, Emma M; Complaints; Taylor, Karen  
Subject: [Personal Information redacted by the USI]

Please find as below regarding [Personal Information redacted by the USI].

Esther - can you please provide an update on [Personal Information redacted by the USI] position with regard to surgery.

Angela - can you please take forward to refer [Personal Information redacted by the USI] to the Trust's continence service.

Thanks Elaine

-----Original Message-----

From: [Personal Information redacted by the USI]  
[Personal Information redacted by the USI]

Sent: 19 October 2015 15:37

To: Wright, Elaine

Subject: [Personal Information redacted by the USI]

Elaine

Thank you for sorting this out for me,

On another point I spoke to Paula Clarke on Friday evening and she suggested I email you.

Back in January/February time Mairead helped me out with some issues relating to my mother, from memory Irene from David Simpsons office was involved in this too.

At that time my mum visited the ED and was seen by a Jr Dr and he examined the Mitrofanoff site on her stomach which had and continues to cause incontinence, pain and bleeding subsequently she was give a temporary bag to help with the matter.

Following that she had seen Mr O'Brien (23rd Feb 15) he then put mum on the list for surgery to try resolve the matter on a longer term basis, this was marked as urgent.

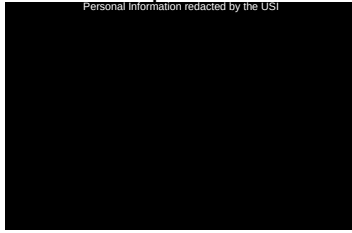
To date there has been no communication between Mr O'Brien my mum or her GP (Dr Claire Evans, Portadown health centre) although Dr Evans has written to Mr O'Brien urging that he do the surgery.

In the meantime my mum has found that the temporary bags have been pretty much useless for a number of reasons which has left her continuously incontinent, her bed clothes are continuously being ruined and she is having to change her clothes 2 and three times in a good day.

As my mum also suffers with I'll mental health I feel that it is very important that this matter is dealt with as soon as possible to avoid further deterioration in both her physical and mental conditions.

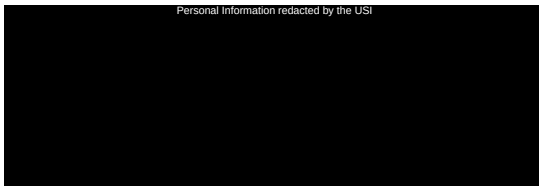
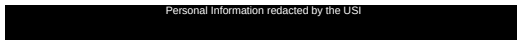
Whilst I know that your Drs are extremely busy and under pressure I would appreciate if you could request an update in relation to this issue, I would further ask that you would look at possibly referring my mum to the appropriate people to help address the incontinence issue in the short term.

Details for patient:



Many thanks for your help in advance and if you require any further information please let me know

Kind regards



<mime-attachment>