3.5. Integrated Maternity & Women's Health

Dr Scullion reported on this area. NIMDTA visited DHH on the back of comments made within the NTS and a follow up visit is scheduled for 12th December

There was an increased focus on PROMPT training

It was noted that there was a plan to integrate M&M and staffing cover across both sites

3.6. Medical Education & Training

Dr Browne reported on the upcoming GMC visit to General Surgery on 6th December. It was noted that the small numbers may influence or skew the results. It was reported that the O&G feedback meeting was taking place on 12th December.

It was noted that an extra Urology post has been agreed within CAH and an extra Respiratory Registrar is being requested within DHH

It was noted that the issues relating to the doctors mess had now been resolved.

3.7. Research – Dr P Sharpe

It was noted that the regional infrastructure review was ongoing, with a centralized permission process likely to be implemented within the next year. It was noted that a Local Implementation Pack was becoming more complex.

It was reported that the funding available has been increased to £14,800 from the E&G Committee, which was to be welcomed.

Self-directing of blood tests from doctors – there has been an escalating volume of these for themselves and family members. It was noted that the GMC advises that this shouldn't be done. Dr O'Kane agreed to communicate with medical staff in relation to being responsible for their own health but not undertaking this practice
Action: Dr O'Kane/Simon Gibson

4. Governance Report from the Medical Director

4.1. Impact of Pension Changes

It was noted that if a Consultant wishes to go to less than 10PAs, a work life balance form needs to be completed

5. Revalidation/Appraisal/Responsible Officer

It was noted that this was progressing and any AMD forms should be forwarded if received.

6. GMC Issues

Locum doctors. It was noticed that the checklist for employment had been improved and induction processes were now becoming more comprehensive.

Induction

Dr O'Kane briefed the meeting on work being undertaken to modernise induction through the use of Simulation. It was noted that Ruth Carville and Eimear McCorry would be taking this forward. It was noted that the Simulation Lorry was outstanding

Action: Simon Gibson

7. Any Other Business

7.1. Proposed RCN Industrial Action

AMDs were briefed on the potential impact of the industrial action

7.2. Electronic Discharge Summary

This item was deferred

7.3. Deprivation of Liberty Safeguard Training

It was noted that we were desisting medical staff above Level 3 in relevant areas

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday 27th December 2019 – 2:00pm – 4:00pm - THQ Meeting Room, VL to Committee Room 1, DHH

Minutes of Associate Medical Directors Meeting

Friday 31st January 2020, 4.00pm-6.00pm

Present:
Dr Maria O'Kane (Chair), Dr Shahid Tariq, Mrs Trudy Reid, Dr Philip Murphy, Dr Chris Clarke, Dr Rose McCullagh, Dr Peter Sharpe, Mrs Fiona Davidson, Dr Mary Donnelly, Miss Lauren Weir (Minute Taker)
Item:
1.0 Apologies and Welcome Mr Simon Gibson, Dr Gail Browne, Dr Ahmed Khan, Dr Damian Scullion, Dr Pat McMahon, Mr Mark Haynes,
2.0 Minutes of Last Meeting 22nd November 2019 The minutes were read and agreed.
3.0 Governance Reports from Associate Medical Directors (items of common interest/concern) ***3.1 Cancer and Clinical Services – Dr S Tariq*** Dr Shahid Tariq raised the Pension issues are having a big impact on his job at the minute and this is creating a high level of stress within his service. Dr Tariq said he currently had 1 Radiologist off as they don't want a huge tax bill. He has noticed that no one wants to cover, do extra work or overtime. He has been here for 20 years in the same building and he doesn't think that better accommodation will be coming to his department. There is nowhere in Radiology to speak to patients privately. He feels that the CT Room is not fit for purpose. Another concern Dr Shahid Tariq had was that there is not enough electric power on site, he has a second scanner for the site but there isn't enough power to use them both at the same time. RQI are coming for inspections, this is the 4th inspection Radiology have had. Some documents need updated. ***3.2 Medicine & Unscheduled Care – Dr P Murphy*** Dr Philip Murphy said they are currently in the middle of Winter Pressures, there is 55 patients waiting. There are a number of issues with patients waiting for extended periods as they only become the responsibility of the medical teams when they have been admitted.

Dr Gareth Hampton is drafting up a SOP to identify the issues. Dr Philip Murphy said there have been a number of incidents with Paediatric patients as Belfast will not take them so they get taken to ED.

Dr O'Kane said that Ronan Carroll is organising a SUMP?

Dr Philip Murphy said that the patients end up sitting in ED for hours before being dealt with.

There has been a CD appointed in Daisy Hill. There are 3 applicants being interviewed for Acute posts. Dr Maria O'Kane wants to meet with these applicants. Dr Philip Murphy mentioned that the staffing pressures are ongoing in his department.

3.3 Anaesthetics, Theatres & ICU – Dr Chris Clarke

Dr Chris Clarke said there is currently 96% revalidated. There have current staffing issues, Dr Damian Scullion is interviewing for posts at the minute.

There is a hub currently in place; the décor is a bit clinical. Dr Chris Clarke said there are trying to make trainees more welcome.

3.4 Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh

Dr Mary Donnelly -

Dr Mary Donnelly said that Out of Hours is currently a concern. She also mentioned that no one wants to do overtime. Belfast Out of Hours might have to join both together.

Dr Rose McCullagh -

Dr Rose McCullagh said that there are no GP's to do the work for a form 3 in relation to the MCA. They need a regional plan, there needs to be a place of safety.

Mental Capacity Act Forms need to be filled out properly. There are issues when reading the hand writing on the forms when they are handed in. The 3 main things to look for on the form are, Behaviour, Medication and Self-harming. Dr Rose McCullagh said that this is a legal form. She mentioned that the training isn't correct and doesn't tell you how it works or how to fill out the form. There is loads of work involved regarding the Mental Capacity Act.

3.5 Research – Dr P Sharpe

Dr Peter Sharpe agreed with Dr Shahid Tariq regarding space and said that the labs don't have much space either and he feels that the whole hospital needs rebuilt.

Dr Peter Sharpe told us that the R&D office has now moved to the maples down beside Trust Headquarters. The 3 PHD Students are presenting at SMT on Tuesday 4th February.

4.0 Governance Report from the Medical Director

4.1 Managing concerns about Agency locum Doctors

The work for the Agency Locum Doctors is starting to begin. The Key thing would be the concern sheet. On the HR Checklist DOLs is on it.

Agency Locum Doctors aren't being inducted correctly before they start.

Dr Maria O'Kane said that HR, Finance and the Medical Directors Office have to have a meeting regarding this.
Action: Lauren to arrange this meeting

4.2 Open Out Patients Registrations on PAS

Dr Maria O'Kane said there needs to be paper records of wards and that it hasn't got in to outpatients yet.

Dr Chris Clarke feels it takes time to do.

Dr Maria O'Kane said that we are currently ahead of other Trusts with regards to the Registration on PAS.

4.3 Medical Education and Practice in the UK

Dr O'Kane mentioned that there has been an increase in the number of PA's. She met with Professor Louise Dubras to discuss the second medical school, AS THE Southern Trust will be getting 20% of Medical Students.

4.4 Management of Unsigned Test Results

Deferred

4.5 Med3 Reports

Dr Rose McCullagh spoke about Discharge letters and said we need an outcome for the discharge letters.

Dr Rose McCullagh said about Admin staff doing discharge letters and suggested starting with surgical departments.

5.0 Revalidation/Appraisal/ Responsible Officer – *Standing Item*

No items discussed

6.0 GMC Issues – *Standing Item*

No items discussed

7.0 Litigation/ Medical Negligence – *Standing Item*

No items discussed

8.0 Any Other Business

8.1. Deprivation of Liberty – Mental Capacity Act Non-Compliance of Form 6 by Medical Staff

Deferred

8.2. Electronic Discharge Summary

Mrs Fiona Davidson said that the Discharge summary was sent out to the GP's. Mrs Fiona Davidson went on to speak about the Electronic Discharge Summary,

- If you need to change anything on the Discharge Summary it gets reactivated at your end but it won't get updated with the GP.
- The copy that was first issued to the GP will have been removed.
- You have to reauthorise the summary so that the GP gets the updated summary sent back through.

Developers are speaking to Mark Toal regarding all of this.
Data Quality team can run a report to see what patients have been reactivated. This is to get it preauthorised.

Dr Mary Donnelly asked how the GP would know if something has been updated on the summary – as if she knows she has already read the patient summary she won't look at it again as she will think it is the same thing. There needs to be somewhere on the system that tells you which part has been updated and requires action.

8.3. NCEPOD Acute Bowel Obstruction: Delay in Transit study Executive Summary

The NCEPOD Study – 'Delayed in Transit' (acute bowel obstruction) was noted by the meeting and that it had been disseminated to operational directorates. Currently NCEPOD Ambassador role in SHSCT is vacant and will be part of the DMD role for Quality and Safety going forward. The need to develop a similar process to that for Standards and Guidelines is required to establish baseline positions and change leads for national and regional audit studies.

8.4. VTE Risk Assessment

Mrs Trudy Reid said we can't get to 95% as there are issues in some areas. Day patients are a Low Risk in this case you don't have to do a Risk Assessment. It was mentioned that all Procedures should have Risk Assessments.

9.0 Any Other Business

Discussion regarding Tax/ Pension Issue

The AMD's and Dr O'Kane discussed the Pension issue and they felt that it needed described more to everyone. It was said that that Tax is so high that no one wants to do any extra work.

Dr Peter Sharpe brought up Scheme Pays – he doesn't understand how it works.

Dr O'Kane had asked Lauren to arrange a meeting with all AMD's regarding tax.
Action: Lauren to arrange

Coronavirus

Dr Maria O'Kane said that the Coronavirus came from Bats. She thought the presentation from Emergency Planning was really interesting.
Action: Send Presentation from Dr Damani to AMD's

Mrs Trudy Reid mentioned that the IPC nurses are doing on call 9-9

10.0 Next Meeting/ Dates for your Diary

AMD Meeting: Friday 28th February 2020 at 2.00pm, THQ Meeting Room VC Tutorial Room DHH

Minutes of Associate Medical Directors Meeting

Friday 28th February 2020, 2.00pm-4.00pm

Present:
Dr Maria O'Kane (Chair), Dr Damian Scullion, Mrs Ruth Carville, Dr Mary Donnelly, Dr Rose McCullagh, Dr Gail Browne, Dr Pat McMahon, Miss Lauren Weir (Minute Taker)
Item:
1.0 Apologies and Welcome Mr Simon Gibson, Dr Ahmed Khan, Mr Mark Haynes, Dr Shahid Tariq, Mrs Fiona Davidson, Dr Peter Sharpe, Dr Philip Murphy, Mrs Trudy Reid
2.0 Minutes of Last Meeting 31st January 2020 The minutes were discussed through the group. **4.1 Managing concerns about Agency Locum Doctors** It was confirmed that work was being done regarding this and the forms have been updated. Dr O'Kane has spoken to Joanne Donnelly (ELA) about Locum Doctors. **4.3 Medical Education and Practice in the UK** Dr Gail Browne confirmed that Mae McConnell is working on this.
3.0 Governance Report from the Medical Director **3.1 Management of Unsigned Test Results** **3.2 Deprivation of Liberty – Mental Capacity Act Non-Compliance of Form 6 by Medical Staff** **3.3 Doctors report from Corporate Governance Team** **3.4 Pensions & Taxation**
4.0 Revalidation/Appraisal/ Responsible Officer – *Standing Item* Some Revalidations are outstanding <u>Appraisal for 2020</u> It was said that coming in this year you wouldn't be able to pick your Appraiser; you would be allocated with one. Dr Damian Scullion said that more positive feedback is needed from Appraisals.
5.0 Governance Reports from Associate Medical Directors (items of common interest/concern) ***5.1 Cancer and Clinical Services – Dr S Tariq*** Apology

5.2 Medicine & Unscheduled Care – Dr P Murphy

Apology

5.3 Surgery & Elective Care – Mr M Haynes

Apology

5.4 ***Anaesthetics, Theatres & ICU – Dr D Scullion***

1 Consultant has been appointed in Anaesthetics
There are ads going out all the time for consultants within our department
We are thinking of International Recruitment for DHH

ICU are currently under pressure
Damian confirmed that the hub is going really well for Trainees
There is currently a room being done in ICU – the Estates department are involved with this

5.5 ***Mental Health & Learning Disability – Dr P McMahon***

There are 3 opening for posts and there is funding for a fourth. The Job Description is going for approval. Pat advised that there is one of the trainees interested in the open post. The teams have been having team away days – there are 2 wards that haven't had their away day due to staff levels for covering their wards.
Appraisals
Bit of work to do, some are out of date

5.6 ***Children & Young People's Services – Dr A Khan***

Apology

5.7 ***Integrated Maternity & Woman's Health – Dr D Scullion***

There are some issues with Trainees in DHH
Staffing levels
1 Post – Locum has been in this position for 4 years
1 Open Post
2 Consultants not doing on call (Health Reasons)

5.8 ***Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh***

Update from Mary – Out in the Practice there are staff shortages as staff are currently off sick or off on maternity leave. Mental Capacity Act – Gerry Sloan has done the training but the forms still aren't being completed by staff.
Update from Rose – Rose said that there is a lot of time that goes into each assessment.

5.9 ***Medical Education & Training – Dr G Browne***

Gail advised that the GMC Survey needs returned by the End of March.
There are plans in place regarding the Medical Students – the Job Descriptions are ready to go out

5.10 ***Research – Dr P Sharpe***

Apology

6.0 GMC Issues – ***Standing Item***

No items were discussed

7.0 Litigation/ Medical Negligence – ***Standing Item***

Fiona has been doing work on this through Lessons Learned Forum.
X-Rays are not being done properly; X-Ray machines go out of date after 6-7 years.

8.0 Any Other Business

8.1.Care Opinion
Dr O'Kane discussed the powerpoint that is attached to February meeting.

8.2 Clinical Guidelines Update
Dr O'Kane read the update on the Clinical Guidelines sent from Fiona. Paper attached to February meeting.

8.3 ECM Update
Dr O'Kane read through the update sent in from Fiona which is attached to February meeting. There is going to be monthly updates from Fiona regarding this matter.

9.0 Any Other Business

4 Interviews have taken place for the replacement of SAS Doctor Naomi Chapman

Doctors' & Dentists' Oversight Group

Dr O'Kane discussed what the idea was behind the Oversight Group.

2020 Medical Dental Oversight TOR
Dates for DDOG Meetings 2020

Mary Donnelly asked if there would be a feedback meeting with the Doctor after the Oversight Meeting was completed.
Letter and Terms of Reference to be sent out to AMD's and Operational Directors
ACTION: Lauren to send out to AMD's and Operational Directors

Coronavirus Update
There are currently COVID-19 meetings happening with the Directors regarding this.

Governance Review
Acute Structure – Ok
CYP Structure – Ok

OPPC Structure – Some work needing done
MHLD Structure – Staffing down

Corporate Governance to help with Mental Health Department

LNC Meeting
Tuesday 28th April 2020 at 7.30pm in Armagh Surgery
ACTION: Lauren to resend email round AMD's and CD's

GP Interface Meeting – Thursday 16th April 2020 at 2.00pm THQ Boardroom
Rose mentioned that she would like to change the name of the meeting

Ruth Carville – Adept Fellow
Ruth spoke about Mental Capacity Act training that was coming up. She asked the AMD's if they felt that there was any more training needed in this area.
ACTION: AMD's to send an email to Ruth Carville with their thoughts
Damian said he thought the face to face training was better than the E-Learning training.

10.0 Next Meeting/ Dates for your Diary

Friday 24th April 2020 at 2.00pm – THQ Meeting Room VC Tutorial Room DHH

Minutes of Associate Medical Directors Meeting

Friday 27th March 2020, 2.00pm-3.00pm, via Dr O'Kane's Meeting Space

Present:
Dr Maria O'Kane (Chair), Dr Damian Scullion, Dr Gail Browne, Mr Simon Gibson, Mr Mark Haynes, Dr Shahid Tariq, Dr Peter Sharpe, Dr Philip Murphy, Dr Mary Donnelly, Dr Rose McCullagh, Dr Pat McMahon, Miss Lauren Weir (Minute Taker)
Item:
1.0 Apologies and Welcome Dr Ahmed Khan, Mrs Fiona Davidson, Mrs Trudy Reid
2.0 Minutes of Last Meeting 28th February 2020
3.0 Governance Report from the Medical Director Dr O'Kane suggested that a weekly meeting space would be good for all the AMD's Thursday's weekly 5.10pm-6.00pm via Meeting Space. **ACTION: Lauren to send invitation out to AMD's**
4.0 Revalidation/Appraisal/ Responsible Officer – *Standing Item*
5.0 Governance Reports from Associate Medical Directors (items of common interest/concern) ***5.1 Cancer and Clinical Services – Dr S Tariq*** Urgent surgery will be done in DHH Mandaville unit will stay open, staff are already used to wearing PPE Some Radiologists to work from other sites, some staff are trying to work from home ***5.2 Medicine & Unscheduled Care – Dr P Murphy*** ***5.3 Surgery & Elective Care – Mr M Haynes*** **5.4** ***Anaesthetics, Theatres & ICU – Dr D Scullion*** Damian Scullion is the Lead between Southern Trust and Belfast Trust **5.5** ***Mental Health & Learning Disability – Dr P McMahon***

5.6 ***Children & Young People's Services – Dr A Khan***

Is different on both sites
Patients will be screened and should go home after unless they have any other issues.
CAH Pathways
Non COVID will be sent to CAH and there will be signs to direct them to where they need to go.
All Paediatrics in DHH will be managed on 6th Floor of the hospital
There is a contact number to go out to patients if they may need it.
Neo-natal units on both CAH and DHH site

5.7 ***Integrated Maternity & Woman's Health – Dr D Scullion***

5.8 ***Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh***

COVID Hub
Mary confirmed that the Hub in the down area is starting on Tuesday morning
Southern Area – Up and running next week, Banbridge and South Tyrone site 8am-10pm 7 days a week. If they need to move to 24hours they will think about it in the future.

Acute Care at Home
Will see any patients over the age of 18

Rose mentioned that DNR's start at hospital doors, end at the ambulance and start again when they get to the Nursing Homes.

5.9 ***Medical Education & Training – Dr G Browne***

A lot of training has been done throughout the department
Dr Claire Brady has been helping with training
Wants date from FY1's

5.10 ***Research – Dr P Sharpe***

Offered to help if we want to set up a Trust Ethics

6.0 GMC Issues – ***Standing Item***

7.0 Litigation/ Medical Negligence – ***Standing Item***

8.0 Any Other Business

<u>COVID-19 Update</u>
North West England and London are under the most pressure
Demand for PPE and Ventilations are high demand
Patients are feeling stressful about asking for help
2pm on Saturday DHH ED closes
Social Distancing is a key point in all of this

Patients need honestly from staff
Information available for patients –there is no information out there for guidance for Patients

Dr Khan agreed that honestly is needed with the patients, and we need to tell them the truth.

Dr O'Kane said that our staff are priority, we need to ensure they are fit and well to work and look after the patients that need care.

Dr Tariq agreed with Dr Khan that in the third world you have to rashin the supplies that we have. Dr Tariq had a training day on DHH site, 140 colleagues went to the training. Mental Health is important for all the colleagues and we are to ensure that we have support in place for staff if they need it.

We need to think about how we are going to support our Medical Staff
Dr O'Kane going to speak to Simon Wesley re: Support for Medical Staff
Dr Khan said that some of the team have Swartz round Training. He thinks that this training/facility is good and more staff should be able to go to do. Swartz round to come into place by April.

We need to let staff know they are supported with Mental Health Support.

Conversations with Staff about how they feel about them being the last person in contact with the patient.

Damian advised that there is a Patient passing away in his department and his staff is having to manage with the situation. We need to think about support for staff with situations like this.

Guidance regarding resus is needed for staff so that everything is clear
All arrests are different, no two are the same

CPR Resus Guidance has been issued out from David McEneany. Dr O'Kane said that in about 10 days we will be using another guidance as things will have changed.

Changes coming up this weekend
Dr Murphy updated us that ED in DHH will be closing 2pm tomorrow (Saturday 28th March)
There is going to be COVID Positive stream and a non-COVID stream
2 North is taking all Positives at the moment
Negative Patients will be sent back to DHH
Gareth Hampton said that he is currently moving staff from one ED to another. He said he isn't able to confirm time of change as of yet.

Mark Haynes updated that he has been doing urgent lists. Surgery moved to DHH from Wednesday.

Damian said that they currently have 6 patients in ICU with COVID
We are staffed for 11 ICU beds
Clarity in the Zones and the supply of PPE are an issue

Red, Amber and Green Zones on the CAH site
Testing on site is ongoing, our machine has arrived and should be up and running by

tomorrow (Saturday 28th March)
We aren't community testing at the moment
193 requests yesterday (26th March) for testing before 10am
Ring Occ Health, they give you an appointment for testing, patients have to wait on results coming back, Admin Staff is phoning out negative results and Teresa White phones out the Positive results she has been following up on the patient after telling them their results

Redeployment (Simon)
Bank of doctors so that if they are needed they can be pulled into gaps.
Gareth Hewitt working alongside Simon with redeployment
F1 Rota for Medicine and Surgery is going together.
Ruth Carville & Eimear McCorry is to go back into service week after next

8PA's starting next week they will be placed in General Medicine in DHH for 2 weeks, then 4 of them will be moving to CAH.
Medical Student Technician are being put in place
New training ongoing from 6th April 2020

Dr Tariq wants Dr O'Kane to mention to Doctors that they are appreciated with everything they do.

10.0 Next Meeting/ Dates for your Diary

Friday 24th April 2020 at 2.00pm – THQ Meeting Room VC Tutorial Room DHH

Minutes of Associate Medical Directors Meeting

Friday 22nd May 2020, 2.30pm-3.30pm, via Dr O'Kane's Meeting Space

Present:
Dr Aisling Diamond (Chair), Dr Gail Browne, Dr Damian Gormley, Mr Mark Haynes, Dr Peter Sharpe, Dr Ahmed Khan, Dr Damian Scullion, Dr Philip Murphy, Dr Pat McMahon, Dr Mary Donnelly, Dr Rose McCullagh, Miss Lauren Weir (Minute Taker)
Item:
1.0 Apologies and Welcome Mr Simon Gibson, Dr Maria O'Kane, Dr Shahid Tariq
2.0 Minutes of Last Meeting 24th April 2020
3.0 Governance Report from the Medical Director
4.0 Revalidation/Appraisal/ Responsible Officer – *Standing Item* Appraisal has been deferred for some time Have had meetings with Joanne Donnelly from the GMC If you have access to your Appraisal Folder you could continue upload to your Appraisal Folder and keep to moving. Aisling has arranged meetings with the Appraisal Team to take this forward Dr Sharpe asked if Appraisals are going to be run into next year, Aisling said she asked the question to GMC and she is awaiting confirmation. **Job Planning** Damian mentioned that this is usually done 1st April every year. Within his area this has happened this year Philip said his area have had the job planning arranged Dr Khan mentioned that there is a formal process for this, which needs approved by Line Manager. Dr Khan said that currently some of the consultants have Calendar Job Plans. Dr Khan said that there is an amount of work being carried out by staff that isn't actually in their current job plans.
5.0 Governance Reports from Associate Medical Directors (items of common interest/concern) ***5.1 Cancer and Clinical Services – Dr S Tariq*** ***5.2 Medicine & Unscheduled Care – Dr P Murphy***

5.3 Surgery & Elective Care – Mr M Haynes

5.4 ***Anaesthetics, Theatres & ICU – Dr D Scullion***

5.5 ***Mental Health & Learning Disability – Dr P McMahon***

5.6 ***Children & Young People's Services – Dr A Khan***

5.7 ***Integrated Maternity & Woman's Health – Dr D Scullion***

5.8 ***Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh***

5.9 ***Medical Education & Training – Dr G Browne***

Some trainees have been redeployed
Aisling is currently doing work on this
FIY1's
Dr Murphy thought that he that there were a good thing

5.10 ***Research – Dr P Sharpe***

6.0 GMC Issues – ***Standing Item***

7.0 Litigation/ Medical Negligence – ***Standing Item***

8.0 Any Other Business

Annual Leave
Allowance for a 2 year period will be allowed to be carried out
Documentation awaiting to confirm this

Aisling asked if Annual Leave was being taking by consultants and trainees – All AMD's confirmed that Annual was being taken

All AMD's confirmed that currently no staff is off with Stress issues

Damian Scullion mentioned that Lorraine McGurk has been doing great work with Anaesthetics Team and on Ward 2.

Clinics Restarting

Dr Khan
Urgent Care is now in Blossoms in CAH
General outpatients – limited clinics

Virtual Consultations have been taking place (last 2 months), some Patients need to be seen face to face and can't be done Virtually
No Inpatient on DHH site
Currently working along with ED Staff regarding outpatients

Dr Khan mentioned that he is looking at a Virtual Platform for CYP
Dr Khan mentioned that there is a lot of funding involved with this – had demo yesterday with Xuper. Hoping to have more developed within the next few weeks. Damian mentioned that BSO have already agreed funding for Viscon.

Dr Browne
Currently no follow up clinics within ICU

Dr Scullion
Accommodation is an issue for Chronic Pain Clinics
Some clinics can be done in DHH
Paper is being brought to SMT on Tuesday regarding this issue

Mark Haynes
Space is a 108 consultants rooms a day reduced to 33 a day
Some services have been looking for additional accommodation
Staff that where in outpatients are now manning the donning and doffing areas
Some areas have been changed to Green areas and Admin staffs have been moved in the Green areas.
Patients would be prioritised around accommodation
Systems follows Space and Staff
Stuff

Damian Gormley
Some Clinics have been done Virtually but doesn't have to do all Clinics Virtually
BSO working along-side IT with regards to Virtually Meeting
Some people are using Viscon for Clinics, others are using Whatsapp/Zoom

Dr Sharpe
Dr Sharpe raised concerns regarding getting bloods
Dr Sharpe advised that Finger Tip bloods would not be enough for Consultants
Some urgent thought needing done regarding getting bloods done

10.0 Next Meeting/ Dates for your Diary

Friday 26th June 2020 at 2.00pm – Dr O'Kane's Meeting Space

Minutes of Associate Medical Directors Meeting

Friday 26th June 2020, 2.00pm-3.00pm, via Zoom

Present:
Dr Maria O'Kane(Chair), Dr Aisling Diamond, Dr Damian Gormley, Mr Mark Haynes, Dr Peter Sharpe, Dr Ahmed Khan, Dr Damian Scullion, Dr Pat McMahon, Dr Mary Donnelly, Dr Rose McCullagh, Mr Simon Gibson, Dr Shahid Tariq , Miss Lauren Weir (Minute Taker)
Item:
1.0 Apologies and Welcome Dr Gail Browne, Dr Philip Murphy
2.0 Minutes of Last Meeting 22nd May 2020 Discussed and agreed
3.0 Governance Report from the Medical Director **ACTION: Governance report to be issued with AMD's weekly, Lauren to do.**
4.0 Revalidation/Appraisal/ Responsible Officer – *Standing Item* **CD & AMD's to be Appraisers** Dr O'Kane mentioned that in the Belfast Trust that they got SPA for taking Appraisals Dr O'Kane said that none of the AMD's Roles are the same. Experience around being and AMD and CD, Dr O'Kane to meet with everyone to discuss this. **Oversight for Appraisals** Feedback to AMD or CD isn't there Appraisals shouldn't be signed off until feedback is completed **Dr Khan** Mentioned that when he was a Responsible Officer, there is disconnection between Appraiser and Appraisee AMD's are managed by Medical Director and Operational Director There needs to be a clear structure line from AMD's to the Medical Director **Dr Tariq** He agreed that we need clearer line of responsibility **ACTION: Dr O'Kane to discuss with AMD's at their 1-1's regarding what each AMD does**

within their role, Appraisals.

Rose
All GP's have their Appraisals up to date

Aisling
External training being organised to provide training for Appraisers, middle of August

5.0 Governance Reports from Associate Medical Directors (items of common interest/concern)

5.1 Cancer and Clinical Services – Dr S Tariq

5.2 Medicine & Unscheduled Care – Dr P Murphy

5.3 Surgery & Elective Care – Mr M Haynes

5.4 ***Anaesthetics, Theatres & ICU – Dr D Scullion***

5.5 ***Mental Health & Learning Disability – Dr P McMahon***

5.6 ***Children & Young People's Services – Dr A Khan***

5.7 ***Integrated Maternity & Woman's Health – Dr D Scullion***

5.8 ***Older People & Primary Care – Dr M Donnelly/ Dr R McCullagh***

5.9 ***Medical Education & Training – Dr G Browne***

5.10 ***Research – Dr P Sharpe***

6.0 GMC Issues – ***Standing Item***

None

7.0 Litigation/ Medical Negligence – ***Standing Item***

None

8.0 Any Other Business

Virtually Meetings
Dr Tariq – more meetings are happening over zoom and there aren't the licenses for this. Meeting only last 40 minutes then there is difficulty getting back on. **Dr Tariq to email Siobhan regarding**

getting a license and longer than 40 minutes.

Virtual Regional Policy, Damian mentioned that there is Guidance on this, Siobhan has this. Could circulate this to the group. AHP Guidance is out there, Damian checked if we could circulate this.

Dr Khan mentioned that Siobhan has guidance and he had to comment on this.

Damian to pull together Guidance and send to Dr O'Kane to let Joanne Donnelly GMC know what they are planning on doing. And then it is issued out to the Doctors as they are using Virtual Clinics more often.

Rose to send Handbook to Damian Gormley.

Death Certificates
Damian Gormley mentioned that there is a new process for Death Certificates
COVID going on the Certificate and sometimes the family doesn't know, this is lost communication within Clinics.
ACTION: Damian Gormley to issue memo to Medical Staff re: Death Certificates

Regional Medical Examiner, look at having someone within the Trust for this.

Annual Leave
We are trying to encourage staff to take some leave, they all need a break for their safety. If leave isn't managed to be taken you can spend it throughout a 2 year period. There is flexibility built into the current guidance regarding Annual Leave.

ACTION: Dr O'Kane to go back to Vivienne regarding guidance for Annual Leave and circulate to AMD's

GP's aren't wanted to take Annual Leave as there is nowhere to go.
A lot more GP's are being put into Out of Hours; Rosemary is looking at the payment for OOH working. Rose meeting with Rosemary and others about this.

Dr Tariq
Overseas Doctor, depending on which department you work you
Bigger team – More support
Induction is not enough for overseas Doctors, more effort is needed

Aisling commented, it has been recognised, developing a programme for International Doctors starting within the Trust. How the learning works within the Southern Trust.

Microbiologists and IPC are under pressure, big stress on the department. Martin Brown is leaving in a few months. Dr Tariq advised that we should only be using IPC/Microbiologists when it is URGENT.

A call was received that Craigavon is the hardest place to get a body released, and there is hold ups with Death Certificates.

IPC
Additional support funding for IPC and Microbiologists. Number of retirements coming up this year and next.

It needs to be encouraged across all of the AMD's areas, that Junior Doctors can talk out loud if

they are stressed.

Dr Khan mentioned there is a lot of resources available for Health & Wellbeing. Should have a place where we can point staff towards.
Aisling mentioned that there is a place on Sharepoint for this.
ACTION: Lauren to send link to AMD's

Dr Khan
Amber areas in COVID
Ground floor in DHH is Amber PPE
Public is coming through front area of DHH which is Amber PPE
Trudy mentioned that Central Doning and Doffing areas will be kept but discrete

If Medical Staff wear 883 mask they need to go get fit tested. Stock running low.

10.0 Next Meeting/ Dates for your Diary

Friday 24th July 2020 at 2.00pm – Dr O'Kane's Meeting Space / Zoom

Southern Health and Social Care Trust

Associate Medical Directors Meeting

Friday 28th August 2020

ACTION NOTES

Present:

Dr Maria O'Kane
Dr Mary Donnelly
Dr Gail Browne
Dr Shahid Tariq
Dr Aisling Diamond
Dr Damian Scullion
Mr Simon Gibson

1. **Apologies**
   Peter Sharpe

2. **Minutes of the last meeting July 2020**

It was agreed to circulate these for all to consider

3. **Governance Report from the Medical Director**

4. **Revalidation/Appraisal/Responsible Officer – Standing Item**

Appraisal
It was noted that the volumes of 2018 Appraisals outstanding was getting smaller, as more doctors were being signed off. All AMDs were reminded to get these concluded as soon as possible
Action: All AMDs

Whole of practice appraisal.

The governance structure of private practice was discussed, particularly in relation to private practice carried out in their own home. It was agreed to consider the current psychotherapy guidance, to see whether there were lessons which could be learned.

Dr Scullion provided an update on the contents of the 2020 appraisal and the revalidation timetable

5. **Governance Reports from Associate Medical Directors [Items of common interest/concern]**

5.1. **Cancer and Clinical Services – Dr S Tariq**

Dr Tariq updated on the process for regional Oncology M&M activities, and the process of considering Radiological discrepancies as an alternative to M&M. If there was learning relevant to other specialties, this learning was passed across to these specialties.

It was agreed to consider whether there was benefit in linking in the Litigation Department, for them to highlight any issues which arose as a result of litigation

Haematology. There was a discussion regarding the current outbreak within the Haematology Ward

5.2. **Anaesthetics, Theatres & ICU – Dr D Scullion**

It was noted that two posts were being interviewed for ICU next week
Dr Sculion raised the use of IR1's which seemed to be used inappropriately as a way of raising grievances, and Dr Diamond agreed to consider previous IR1's with a view to use these as a teaching tool
Action: Dr Diamond

Protected time for Patient Safety meetings was raised – it was agreed to reinstate these in a similar way as before

5.3. **Medicine and unscheduled care – Dr P Murphy**

Dr Murphy outlined the workload pressures within Medicine, and considered the ability to flow doctors in training between sites to balance training opportunities and workload

5.4. **Integrated Maternity & Women's Health - Dr D Scullion**

It was noted that a number of consultant appointments had been made to the O&G service in DHH, which would support the DHH site

5.5. **Older People & Primary Care – Dr M Donnelly**

It was noted that there had been three resignations within Bannview Medical Practice this week. Dr Donnelly described the various options for sustaining this practice.

Dr Donnelly also noted that there had been good engagement with GPs as part of their role in the "No More Silos" workstreams. Dr Scullion outlined from an ATICS persective the work being undertaken from workstreams he was involved in.

5.6. **Medical Education & Training – Dr G Browne**

Dr Browne briefed on the process of restarting undergraduate teaching. It was noted that there were a number of challenges in relation to delivering this teaching, but there was a high number of options being considered to ensure teaching was delivered

Postgraduate teaching. It was noted that induction had been completed and was felt to be successful. There were continuing challenges in some areas as a result of workload

Dr Murphy outlined the challenges in getting all doctors in training the volume of activity. It was agreed to write to NIMDTA to seek clarity on what proportion of activites could be undertaken virtually
Action: Mr Gibson

Any Other Business

Medical Leadership programme – it was noted that this would be progressing

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday 25th Spetember 2020 at 2.00pm, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors Meeting

Friday 23rd October 2020

ACTION NOTES

Present:

Aisling Diamond	Robin Brown	Gail Browne	Shahid Tariq
Rose McCullagh	Ahmed Khan	Peter Sharpe	Pat McMahon
Simon Gibson	Damian Gormley		

1. **Apologies**
   Dr Maria O'Kane

2. **Minutes of the last meeting August 2020**

The minutes of the last meeting were agreed

3. **Governance Report from the Medical Director**
   Dr O'Kane was not in attendance

4. **Revalidation/Appraisal/Responsible Officer – Standing Item**
   Dr Robin Brown delivered a presentation on Appraisal and Performance MGT
   From the survey monkey the comments regarding appraisal were mostly negative but there were a few positive responses whose feedback was useful. Dr Brown discussed that appraisal is changing to try and move it away from the perceived "box ticking exercise" that some feel it is. The plan that is being worked on would streamline the appraisal by separating the performance review , appraisal and sign off. If performance review is undertaken first, then the appraisee is given time to address any issues before their appraisal, resulting in the appraisal becoming a more positive experience. Dr Brown also noted that reducing the volume of paperwork would make the process simpler and more manageable, the appraisal becomes a more positive peocess that Doctors actually want to engage with. This will create a culture of support and encouragement.

5. **Governance Reports from Associate Medical Directors [Items of common interest/concern]**

5.1. **Cancer and Clinical Services – Dr S Tariq**

Particular issues in haematology regarding available space and the stress of the SAI, staff are feeling under pressure in both cancer and haematology. No members of staff off with covid. One radiologist has broken his arm and is off work due to this. On the oncology side, they have a new member of staff who started on the 12th October but has some training in the cancer centre

to undertake. They have no accommodation and Dr Shahid is chasing up with HR – Dr McCullagh advised that there is a contact for an estate agents via Dr Frances O'Hagan (her husband)

5.2. **Anaesthetics, Theatres & ICU – Dr D Scullion**

Only one person off isolating who was back today. Have had some trainees off unwell, one of whom had been admitted to hospital – Dr Brown and Dr Scullion will follow up to check how they are.

There is capacity in ATICS to support critical care colleagues if necessary and have capacity to redeploy to help respiratory colleagues. The consultants are now covering weekends as well. They have now employed two new intensivists

5.3. **Medicine and unscheduled care – Dr P Murphy**

No report – Dr Murphy not in attendance

5.4. **Integrated Maternity & Women's Health - Dr D Scullion**

There are two substantial rotas on both sites and also making progress on sorting out part time doctors. Middle grade doctors would be the next recruitment issue to deal with to lessen the use of locums.

5.5. **Older People & Primary Care – Dr R McCullagh**

Urgent Treatment centre pilot ran and figures were good and it will be up and running from 27th October. The Bannview practice is under extreme staffing pressure, one doctor is off sick and the other doctor is unhappy to be working if by herself. Its proving difficult to secure locums to help and the rescue team wont come in because there is no permanent doctor.

5.6. **Medical Education & Training – Dr G Browne**

Email has gone out to all educational supervisors and trainees to let them know redeployment will be for two week maximum. They are being given the choice of which specialty they would like to be redeployed to. General Surgery Deanery visit is next week on the 30th October with a pre meeting scheduled for 27th October. Met with NIMDTA last week to go over the quality report and try to close off any outstanding issues. Histopathology and Haematology visits have happened but no feedback has been received yet.

There are a number of trainees self isolating across the specialties and there are 2 working within intensive care who are currently off (non covid related)

5.7. **Research and Development – Dr Peter Sharpe**

No workforce issues to report, Dr Sharpe updated on the various projects that are currently ongoing such as the recovery trial which led to the discovery of dexamethasone. Dr Sharpe is currently also involved in two Ulster University studies, one called the pandemic study and one called the covres study which looks into the genomics of how covid affect people differently and the genetic links that might predispose people to various outcomes.

A number of research nurses are involved in the vaccination study.

With nurses commiteed to these phase 3 trials this leaves them a little short staffed.

5.8. Mental Health – Dr Pat McMahon

No urgent workforce pressure due to covid – 2 doctors off after having tested positive, both reasonably well and both coming back. One long term locum going off today due to being symptomatic. One of the medical students requires testing due to car sharing and is symptomatic. 3 out of 4 vacancies were filled at the beginning of the month. Still have a few vacanices which cant go out again until January so will be reliant on locums for a while longer. Currently at 100% capacity with beds, everyone is being swabbed when they come in but have only had one positive so far so it would seem that patients are adhering well to ppe in the community. Manic patients struggle with the isolation but are being managed well. The single rooms in Bluestone help and patients are wearing masks if they leave the room. Some storage containers have been set up for additional staff space, just waiting on water and electric to be fitted but these are a big help with supplying staff with space to have breaks.

Any Other Business

Dr Browne queried if there is a specific staff support system for staff and students etc. if they have to self isolate to ensure they have support – Dr Diamond agreed that a pastoral care system to address this would be useful and should be looked into

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors Meeting

Friday 27th November 2020

ACTION NOTES

Present:

Aisling Diamond	Gail Browne	Shahid Tariq	Mary Donnelly
Rose McCullagh	Ahmed Khan	Gail Brown	Damian Gormley
Dr Maria O'Kane	Pat McMahon	Simon Gibson	Philip Murphy
Peter Sharpe	Emma Campbell (Minutes)		

1. **Apologies**
   Dr Mark Haynes,

2. **Minutes of the last meeting October 2020**

The minutes of the last meeting were agreed.

3. **Governance Report from the Medical Director**

4. **Update regarding the Independent Inquiry**

5. **Revalidation/Appraisal/Responsible Officer – Standing Item**

Need to push on with changes regarding revalidation and appraisal. Appraisal will need to be separate and we cannot choose our appraiser. Need to look at how we can separate the operational side regarding clinics and performance management. Through a collective leadership approach need to thinkn how we look at performance management separately. Will need to look at professional governance, performance management and appraisal and bring these into three separate areas. In terms of the hwole revalidation process, we will have to design some sort of descriptor of how we capture any other work outside of the NHS such as private or legal work.

We need to develop systems to protect doctors who are doing a good job. In relation to other activities we have no way of capturing this work and this goes for GP as well. Special interest roles will need to be appraised by someone in the specialty. All 3 elements ned to come together and they will need to feed into eachother and feed into revalidation.

Aisling suggested that the appraasier should be random, no longer able to choose appraiser within the SHSCT.

In GPs services you keep your appraiser for 3 years.

Working in Multi disciplinary teams provides an openness among teams, this is a new learning process.

Perfomance management should be against you job plan in an conrtuctive conversation in relation to what you are achieving, this should not be included in the appraisal. If this is all done beforehand with CD then when it comes to appraisal everything is there and ready to review and can discuss what can be done to improve services.

Appraisal should be about you as a professional and the job should be measured through another channel.

Need to look at what a good appraisal system would look like and deliver. Dr McMahonadvised the challenge is around how we pick up bad practice in a one off appraisal. Harder pick up bad practice unless you break down their decision making and patients and if it is what we expect from them.

Need to look at the proxys whether people are in difficulties or not. If we started to build up what a better system would look like.

Rose asked if there is an opportunity or value in asking Primary care for honest feedback. This process has to be purely about patient safety. Dr Gormley advised this is more about performace support and looking for signals if they are striuggling and are out of their control, performance being reviewed needs to be put in a positive perspective as this may not be due to negative actions. Social workers have a different approach, they do case reviews every month with senior social workers and review cases and if they bring forward issues then they will have to review 2 cases the following month which will lead to a case review. Multidiscilplinary aspect is very important. Dr Khan suggested would there be value in collating FAQs into the PALs line to get an opportunity to share with GPs. Need to take a group th

6. Governance Reports from Associate Medical Directors [Items of common interest/concern]

6.1. **Cancer and Clinical Services – Dr S Tariq**

6.2. **Anesthetics, Theatres & ICU – Dr D Scullion**

6.3. **Medicine and unscheduled care – Dr P Murphy**

6.4. Pediatrics – Dr A Khan

No new staffing issues, have reduced bed capacity from 13 to 9 beds. At full bed capacity but managing this. NMS work is still ongoing with other workincluding UTCs and progessing on with care pathways from GPs to hospitals. Working to support short stay paediatric unit.
Covid has decreased morale in staff across the board including both mental andphysical fatigue. There have been a few cases were staff have had to isolate.

6.5. **Integrated Maternity & Women's Health - Dr D Scullion**

6.6. **Older People & Primary Care – Dr R McCullagh**

6.7. **Medical Education & Training – Dr G Browne**

6.8. **Research and Development – Dr Peter Sharpe**

6.9. Mental Health – Dr Pat McMahon

Any Other Business

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday 18th December, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 22nd January 2021

ACTION NOTES

Present:

Dr Maria O'Kane, Dr Shahid Tariq, Philip Murphy, Gail Browne, Damian Scullion, Patrick McMahon, Ahmed Khan, Simon Gibson, Damian Gormley, Aisling Diamond, Peter Sharpe, Mark Haynes, Rose McCullagh, Emma Campbell (Minutes)

1. Apologies

2. Minutes of the last meeting December 2020

The minutes of the last meeting were agreed.

3. Covid Update

Total numbers of Covid are decreasing in all areas; however there are concerns that this may not be the case for the Southern Trust as there are still a high number of people testing positive.

Mr. Gibson asked if genotyping would be available for the Southern Area to see if we could get an idea on what strains are within the community. Dr O'Kane advised that IPC have been linking in to see if this possible.

Dr Gormley presented on the current Covid figures.

Admissions have dipped, this is predominantly due to the divert that was in place; however the discharges have helped this number decrease further. The number does seem to be plateauing now but we are not seeing the decrease in number which other Trusts are seeing.

Community Transmissions within the community within the ABC are still the highest numbers regionally. Separately Newry, Mourne and Down and Mid Ulster are seeing a linear decline, however Armagh, Banbridge and Craigavon is not seeing as much of a decline to the other areas within the Southern Trust.

The Median length of stay is between 8-9 days; however this will be affected by the age of the patient. This does vary and it will have an impact on the amount of beds that will need. Length of stay has a direct effect on the occupancy of the hospital.

Depending on the community transmission, if this decreases then our hospital numbers will also decrease, however if the community transmission stays at the numbers they are then our occupancy will stay at high numbers.

Dr O'Kane asked if it would be beneficial to escalate up through Silver to see if they would consider a tougher local lockdown in areas which are still seeing higher levels of Covid.

Dr O'Kane also suggested we could suggest stepping up vaccinations for people such as Teachers etc. as this will help lower the numbers.

Staff fatigue is increasing throughout the hospitals, staff are exhausted and under a lot of pressure.

Meeting went ahead today with staff today and they are now working 3 to 1, with possible redeployment this has deeply affected staff morale. The pay structure has not been sorted out regionally which has been challenging and adding to staff becoming demoralized.

In terms of Acute Care at Home, they have played a crucial part in discharging patients and keeping them out of hospital.

Dr O'Kane advised that out estate is not fit for purpose for modern day health care, if we can pull together with Belfast in relation to outbreaks and also MHD there would be a lot of benfit to come from this. With regards to the SAI within urology, the staffing team have been left bereft by this and this has affected them massively. Dr O'Kane to look at ways to be more robust about messaging and support available to staff.

Mr Haynes advised that we predicted that this situationin realtion to cancer surgeries, that this has got worse and worse over the last few months. This is a big regional piece of work to match were the highest level of demand is, we have asked for guidance from the Federation althougth before Christmas they were keen not to issues this guidance. One of the challenges over the next number of months that patients will move Trusts as we may find that patients waiting surgery in other Trusts who are not offering this surgery but we are, this will impact on other services and patients who are not of the same priority. There will be some areas that will not have the skilled staff to do this.
Dr Diamond advised that they have been told that if staff have not been doing their specialty for a year then they will need to retrain in that specialty. Dr O'Kane asked if we could get a mobile simulation suite to allow the surgeons to use if they are not able to do surgeries. Dr Diamond advised that we have a bid in for two new simulators , these come as piece that can be used static in a building or be made mobile. Dr Diamond advised that these would £80,000 per each m,achine, Dr Diamond to send this over to Mr Haynes to review that they are fit for purpose. We also have trainees who are suffering significantly and will need access to the simulator as well.
There is more indepenetent sector operating, in regards to this there will need to be a comintued pressure to allow the trainees to attend and be aprt of the patiemt care.
Dr O'Kane ask Mr Gibson to into E&G to fund this, Dr Diamond and Mr Haynes to meet next week to discuss this further.
Dr Murphy thanked everyone for the redeployement of staff as this has helped massively.
In terms of elective surgery, we have done incredibly well to maintain a clean service to those who have needed it.
Dr O'Kane and Dr Sharope advised that the phlebotomy drive through service will need to be stepped up.
Dr Daimond thaned everyone for the sdafe redeployement of staff to help support Covid patients.
Gail advised we have been focusing on the inducyion for Febrary and this is ready to go ahead.
Dr Diamond advised that medical techians

4. Revalidation/Appraisal/Responsible Officer – Standing Item

5. Governance Reports from Associate Medical Directors [Items of common interest/concern]

5.1. **Cancer and Clinical Services – Dr S Tariq**
Not in Attendance.

5.2. **Anesthetics, Theatres & ICU – Dr D Scullion**

5.3. **Medicine and unscheduled care – Dr P Murphy**

5.4. **Integrated Maternity & Women's Health - Dr D Scullion**

5.5. **Older People & Primary Care – Dr R McCullagh**

5.6. **Medical Education & Training – Dr G Browne**

5.7. **Research and Development – Dr Peter Sharpe**

5.8. Mental Health – Dr Pat McMahon

6.9 **Pediatrics – Dr Ahmed Khan**

7.0 **Independent Medical Examiner – Dr Gormley**
And

Any Other Business

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 26th February 2021

ACTION NOTES

Present:
Dr Maria O'Kane, Dr Shahid Tariq, Dr Philip Murphy, Gail Browne, Dr Damian Gormley, Dr Peter Sharpe, Stephen Wallace, Dr Shahid Tariq, Dr Ahmed Khan, Dr Pat McMahon, Dr Aisling Diamond, Dr Rose McCullagh, Dr Mary Donnelly Ruth Montgomery (Minutes)

1. **Apologies**

2. **Minutes of the last meeting January 2021**
   The minutes of the last meeting were agreed.

3. **Modernising Revalidation and Appraisal**
   The governance processes around appraisals need to be clarified, Dr O'Kane noted that Stephen Wallace and Dr Robin Brown have been working on this
   Dr O'Kane discussed a proposal to modernise aspects of revalidation and appraisal which would include decoupling certain aspects and identifying the AMD roles going forward in relation to this – see point 4.
   Dr O'Kane requested that the papers regarding 2020 appraisal information is sent out to advise medical staff what they are supposed to be doing for this year – **action:** Simon Gibson to speak to Katie Shields.

4. **Divisional Medical Directors**
   There is a variation in the AMD posts, with not all getting paid the same PAs or having the same expectations within their roles. Dr O'Kane discussed renaming the role of AMD to Divisional Medical Director in line with the description the Northern Trust use and more in line with the collective leadership approach in England.
   The draft job description circulated was discussed with the group and Dr O'Kane noted that the appropriate clinical structures also need to be in place with robust Medical Management structures to ensure the system works appropriately. Patient Safety and quality will be at the centre of all of this.
   There should be between 1-3 Clinical Directors reporting to the DMDs so this will need to be taken into condsideration as well given the variation in these roles too.
   The biggest challenges are potentially going to be within Acute but Dr O'Kane would like to take this job description to SMT on Tuesday for discussion so would appreciate any feedback from AMDs prior to this.

The AMD role in OPPC also needs to be reviewed given the scope of the job and the time required for the post. Dr O'Kane would like this role revised to include an advisory aspect to it rather than a heavy focus on OPPC only.
Dr O'Kane also suggested that Dr Aisling Diamond reinforce with new recruits that the additional 0.5 PA offered to consultants is to make connections with GPs and they should potentially be reminded of this.

5. Governance Reports from Associate Medical Directors [Items of common interest/concern]

5.1. **Cancer and Clinical Services – Dr S Tariq**

Laboratory is suffering due to lack of staffing, particularly biomedical scientists. Similar staffing issues on the haematology side. Cancer has suffered throughout COVID due to not being able to undertake surgeries. Radiology has no current issues, interviewing for a position next month.

5.2. **Anaesthetics, Theatres & ICU – Dr D Scullion**

Not in Attendance.

5.3. **Medicine and unscheduled care – Dr P Murphy**

Dr Murphy updated that COVID numbers are down to less than a third of what we were at the peak. The large number of beds which were taken over from surgery during the peak have resulted in medicine having more beds than they had previously been used to so discussions are ongoing to arrange if these can be converted to medical wards and obtain staffing.
M&M Chair for medicine is an ongoing issue due to the large numbers of deaths to be presented at meetings and the length of the meetings as a result of this.
Dr Murphy also discussed options going forward with regards to consultants retiring. Is there an option to come off the on-call rota and continue with a full time job? Dr Khan noted that Zoe Parks had been working on a paper regarding this and believes that flexibility in this respect is discussed within this.
Action: Dr Murphy to request a copy of this and share with group

5.4. **Integrated Maternity & Women's Health - Dr D Scullion**

Not in Attendance.

5.5. **Older People & Primary Care – Dr R McCullagh/ Dr Mary Donnelly**

Primary care issues which are being sent to Dr McCullagh and Dr Donnelly – can a system be put in place for these to be dealt with as there are sometimes GPs chasing results of a patient etc.

5.6. **Medical Education & Training – Dr G Browne**

Dr Browne updated that there is good news within Medical Education as there are 2 COE training posts approved and 3 IMT3 posts approved for advertising.

5.7. **Research and Development – Dr Peter Sharpe**

R&D going well, have recruited more patients than other Trusts for SIREN and other COVID-19 priority studies within the Trust. Dr Sharpe gave particular credit to Irene Knox and the researchers and clinicians who have been working tirelessly to recruit staff into the studies.
With regards to biomedical science, there has only been one person covering so bringing in more people would be beneficial.

Dr Sharpe noted that in relation to consultants retiring, coming off on call and continuing to work, there are other issues to factor in including those who have reached their life time allowance on their pensions as they could be inclined to take their retirement earlier to avoid going beyond that as they will incur further taxes

5.8. Mental Health – Dr Pat McMahon

Pressures with workforce but have a few pots advertised at the minute. Legacy cases being addressed currently.

5.9 **Pediatrics – Dr Ahmed Khan**

Ongoing staffing issues in CYP

Any Other Business

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 26th March 2021

ACTION NOTES

Present:
Dr Maria O'Kane, Dr Shahid Tariq, Dr Philip Murphy, Gail Browne, Dr Damian Gormley, Dr Peter Sharpe, Stephen Wallace, Dr Shahid Tariq, Dr Ahmed Khan, Dr Pat McMahon, Dr Aisling Diamond, Dr Rose McCullagh, Dr Mary Donnelly, Emma Campbell (Minutes)

1. **Apologies**

2. **Minutes of the last meeting February 2021**
   The minutes of the last meeting were agreed.

3. **Modernising Revalidation and Appraisal**

4. **Divisional Medical Directors**

5. **Governance Reports from Associate Medical Directors [Items of common interest/concern]**

   5.1. **Cancer and Clinical Services – Dr S Tariq**

   5.2. **Anesthetics, Theatres & ICU – Dr D Scullion**

   5.3. **Medicine and unscheduled care – Dr P Murphy**

   5.4. **Integrated Maternity & Women's Health - Dr D Scullion**

   5.5. **Older People & Primary Care – Dr R McCullagh/ Dr Mary Donnelly**

   5.6. **Medical Education & Training – Dr G Browne**

   5.7. **Research and Development – Dr Peter Sharpe**

   5.8. Mental Health – Dr Pat McMahon

5.9 **Pediatrics – Dr Ahmed Khan**
Ongoing staffing issues in CYP

Any Other Business

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday, Dr O'Kane's Meeting Space/ Zoom

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 23rd April 2021

ACTION NOTES

Present:
Dr Maria O'Kane, Stephen Morrison, Nicole Bell, Dr Damian Scullion, Dr Mary Donnelly, Dr Philip Murphy, Dr Pat McMahon, Dr Ahmed Khan, Trudy Reid, Dr Peter Sharpe, Dr Rose McCullagh, Aisling Diamond, Emma Campbell (Minutes)

Apologies
Dr Shahid Tariq
Simon Gibson
Dr Gail Browne

1. **Minutes of the last meeting**
   The minutes of the last meeting were agreed.

2. **Stephen Morrison – Presentation on Job Planning**
   Stephen Morrison Presented on Job Planning and moving forward on this.

   Dr Khan asked if need for earlier job planning in the annual cycle. Stephen advised that this has changed and that issuesor concerns are being highlighted and caught in time.
   There are concerns that some staff are not going through the sign-off process and this has not been escalated- this will be reviewed. Action : Zoe Parks/ Stephen WallaceDr Scullion advised that within ATTICSs this is addressed. Stephen advised that when undertaken in a timely fashion Drs are not having to be paid a back log due to their PA's or repaying due to job planning not being correct. This will provide a safety net for staff.

3. **NEWS2 Implementation**
   We have now signed this off and aiming to move forward with this from May..

4. **Medical Management Update**

Ongoing concerns regarding pension problems. Previously the management allowance was pensionable, however now due to pension taxation over the last year this has caused spme issues. In

relation to formal feedback we have found this would be better given via PA's instead of pension especially in relation to the Divisional Medical Driectors role. This would allow staff to adjust this in terms of clinical work etc. This is holding up the Divisional Medical Directors Advertisement.

Dr O'Kane advised options.Dr McMahon asked if there has been discussion in relation to this with other Trusts and what their thoughts are on this. .
Dr O'Kane to bring this up with other Medical Directors at next meeting.

5. Revalidation/Appraisal/Responsible Officer – Standing Item

Are now moving forward with theRevalidation oversight process.

6. Governance Reports from Associate Medical Directors [Items of common interest/concern]

6.1. **Cancer and Clinical Services – Dr S Tariq**

Not in Attendance

6.2. **Anesthetics, Theatres & ICU – Dr D Scullion**

Starting to get back into normal working and recruiting more nursing staff but challenging.

6.3. **Medicine & Unscheduled Care – Dr P Murphy**

6.4. **Surgery & Elective Care – Urology Update**

Discussion re impact on professional governance , management processes and MDMs..
Vulnerabilities recognized in relation to Appraisal processes being addressed including similar grade appraisal and appraiser allocation.

6.5. **Integrated Maternity & Women's Health - Dr D Scullion**

Resuming some activities stood down during Covid.

6.6. **Older People & Primary Care – Dr R McCullagh/ Dr Mary Donnelly**

Primary Care doctors had a supportive appraisal this year 2020. has an appraisal every year, this year is more of a supportive appraisal this year due to covid etc.

6.7. **Medical Education & Training – Dr G Browne**

Not in Attendance

6.8. **Research and Development – Dr Peter Sharpe**

Dr Sharpe advised that a lot of the other non-covid studies have fallen significantly. The funding for these have fell into difficulty and this will be presented to the Governance Committee next month. Dr Shape adbised that the shortfall is down to around 50%.
Dr Sharpe to update Dr O'Kane .

6.9. **Mental Health – Dr Pat McMahon**

5.9 **Paediatrics – Dr Ahmed Khan**

Not in Attendance

7. GMC

DLS have issed a letter in relation to MCA to say that we will be criminally liable from the 30th April 2021. Mr Devlin will raise this with the CX's on Wednesday, The legislation had not been changed but the criminal liability had not been highlighted previously.

Any Other Business

Next Meetings / Dates for your Diary:

- AMD Meeting: insert

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 28th May 2021

ACTION NOTES

Present:
Dr Maria O'Kane, Dr Damian Scullion, Dr Mary Donnelly, Dr Rose McCullough, Dr Pat McMahon, Dr Ahmed Khan , Dr Aisling Diamond, Nicole Bell (Minutes)

1. **Apologies**

   Dr Gail Browne, Simon Gibson, Dr Damian Gormley, Dr Philip Murphy

2. **Minutes of the last meeting**

   Aisling reviewed minutes from previous meeting and they were agreed.

3. Medical Management Update

   It was agreed that Aisling would action the medical management.

Revalidation/Appraisal/Responsible Officer – Standing Item

Dr Aisling Diamond advised that feedback from the SAS doctors has highlighted low staff morale and that staff feel excluded. They would like to have the opportunity to complete appraisals for consultants and CD's. Discussion around the paper from the Academy which has been reviewed and used to support the new way of working and completing appraisals. The New Appraisal system cascades down through AMD's, CD's and AD's. Concern was highlight in relation to other Trust using different structures for appraisal. Dr Diamond attended BMA Meeting and was advised UK wide Trusts were following same structures.

Dr Scullion advised the AD's need to get the information about the appraisals in good timing so we can assure the Medical Director at meeting like this.
MHS England are using this same process, this will also allow for the separation between performance management and appraisal. However was agreed that when completing revalidation this will include elements of both.
Job planning has been discussed with staff and they were advised if they don't engage in this process it will be escalated immediately to highlight as an early sign of concern, other areas of UK use same processes.

Dr O'Kane advised as we roll out the changes in the medical structure there would be a focus on professional governance and job planning, new processes will need to be in place for escalation if no job planning is in place. We will need to review previous processes and review these to what will be needed.

4. ACP Policy Update – [Letter Attached] – not discussed.

5. AMD Updates

6.1 Cancer and Clinical Services – Dr S Tariq

Dr Tariq highlighted concerns regarding his service, such as staffing issues related to the stress of the Public Inquiry. Ongoing investigation within Microbiology has raised challenges throughout the service e.g. staff turnover, issues with older contracts for staff, weekend cover. Unions advised the staff not to complete actions if not agreed in contracts, this is leading to difficulty within HR discussing the T&C's which has led to the service becoming unsafe.

Samples are now not being sent on a Friday due to the ongoing pressures.

Mrs. Melanie McClements has been made aware of the situation, a further conversation Between Mrs. McClements Mr. Devlin to take place. Lab services are having an effect on patient care as they are short staffed which resulted in SHSCT having the least number of staff within this area.

Radiology workload is increasing especially within OOH services. We are at top of the rank of the number of inpatients, this is roughly 10/15 MRIS for a single person. This is currently unattainable and unsustainable. Recruitment has become difficult due to one trainer being available; concerns have also been raised in relation to staff not completing job planning. There are also Regional Issues which is not allowing for support to SHSCT.

HOS and AD are off on sick. Dr Tariq advised he is feeling low and morale is also low. Incident within DHH - it was noticed that the blood fridge was not working and the alarm system didn't trigger. He advised estates had a look at this and it was then noticed that everything was on the same circuit.

Dr O'Kane that this was worrying there have been significant challenges over the past year although 3 blood fridge's on one circuit were not acceptable. Further conversation to be had between Dr O'Kane and Dr Tariq in relation to ongoing concerns. Litigation issues are stopping Dr Tariq pulling from agencies for staff.

6.2 Anesthetics, Theatres & ICU – Dr D Scullion

Moving forward we are increasing capacity, from the third week in June there will be 9 extra lists operation out of DHH once the site is COVID compliant. Staff are trying their best in regards to the waiting lists and we are beginning to see movement. We are behind other trusts but the progress will be evident. There is an element of burnout and stress starting to be shown, we asked for all staff members to be vigilant of all their staff.

Dr O'Kane agreed with this and spoke about Mental Health First Aid, we need to look out for the signs and try to identify what we need for staff support other, dr O'Kane to lok into. Huge changes in staff have been highlighted, however we have come a very long way. She believes we are getting much better about identifying patient safety processes, and staff are looking forward to getting back to their usual working patterns.

6.3 Mental Health & Learning Disability – Dr P McMahon

Ongoing staffing issues and waiting list issues, concerns raised about the change in the management structure. Dr O'Kane advised this has slowed down due to HR processes, JD's for DMD's are ready to go out and will get an update from HR on where these are at.

6.4 Children & Young People's Services – Dr A Khan

Not Present

6.5 Older People & Primary Care – Dr M Donnelly/ Dr Rose McCullagh

Dr McCullagh attended a meeting with RMBF, she advised that the escalations they are receiving are mental health issues from younger doctors.

Dr Donnelly raised issues with communication with Primary Care. One form of communication was using EDT, the other being paper process (letter). Only a small amount of staff are trained in looking at EDT which has led to some requests from departments that others would like to communicate via email. This has been advised that it was not acceptable.

Gynae highlighted risk involved in using CCG as a form of communication; Dr McCullagh and Dr Donnelly have agreed to meet with Gynae and will involve LNC to make sure the process is correct. Dr O'Kane asked can secondary care use CCG to get the information out for the patient, Dr Donnelly advised there would need to be something that pops up to advise there user that has been a change in advice.
Dr O'Kane asked Dr Donnelly what forms of communication does GPs use to communicate with Primary and Secondary care. Dr Donnelly advised it EDT/CCG is used. Dr Donnelly advised faults are common and it is easily missed due to the sheer volume of communication coming from Primary and Secondary care.
Dr O'Kane advised she can see how frustrating it is for secondary care. Dr Donnelly agreed and advised they are still able to ring and explore the option. Most GP practices have number that consultants can ring as the problem was getting through to the GP. It was agreed that Dr McCullagh will get the number which is on the GP intranet through LNC.

6. AOB

Next Meetings / Dates for your Diary: Friday 28th May 2021, 1-2pm

Southern Health and Social Care Trust

Associate Medical Directors Meeting

Action Notes

Friday 22nd June

Attendees:
Dr Damian Scullion, Dr Mary Donnelly, Dr Damian Gormley, Trudy Reid, Dr Philip Murphy, Dr Aisling Diamond, Simon Gibson, Dr Gail Browne, Dr Peter Sharpe

1. **Apologies**

Dr Pat McMahon, Dr Shahid Tariq, Dr Rose McCullagh, Stephen Wallace, Dr Maria O'Kane

2. **Minutes of the last meeting May 2021**
The group approved the minutes.

3. **Divisional Medical Directors Update**
It was noted that the first round of applications have now closed. Awaiting dates for the next stage regarding this. Second round of application has yet to go out.

Duty of Candour Consultation
Duty of Candour consultation is available and everyone will have the opportunity to respond to this. Deadline for responses is 2nd August. Responses can come from individual or as an organisation.

Actions:

- Dr Gormley to circulate information, key events and links directing staff to the Duty of Candour consultation for staff and asked for staff to have look at the information and share if necessary.
- Dr Scullion to speak to Dr Campbell to see if there was any reply/outcome from the directorate meeting for Anaesthetics on this consultation.

4. **Revalidation/Appraisal/Responsible Officer – Standing Item**
It was noted that good progress on the backlog of appraisals has been made, although some appraisers are withdrawing from completing appraisals. Dr Scullion advised there has been a lot of complaints' regarding appraisals which he has collated and will send to Dr O'Kane.

It was noted that performance support meetings need to be robust. Simon Gibson advised there are challenges with the new revalidation process such as gathering new information that Dr O'Kane has requesting from governance information, litigation information, SAI information and if the doctor is involved in any HR process. The information for revalidation and appraisal needs to be with the AMDs in good time.

Dr Scullion advised that numbers of monthly revalidations should be more consistent and manageable going forward.

5. AMD Updates

5.1. **Anesthetics, Theatres & ICU – Dr D Scullion**

- Dr Scullion advised there is a new post commencing in August, which is a pre –CCT post. He is hopeful that this will attract staff to SHSCT, this will be funded centrally. The new staff member will act as a consultant.
- Workload in theatres is increasing slowly however he stated that there are ongoing discussions about pressures for waiting list incentives.

5.2. **Integrated Maternity & Women's Health - Dr D Scullion**

- Dr Scullion advised there is consultant post going out for advertisement in DHH.

5.3. **Older People & Primary Care – Dr M Donnelly**

- Dr Donnelly reported that GPs would like a 2nd lab collection each day, it was noted the proposal was going back to HSCB to apply for joint funding. Dr Sharpe supported the need for another lab collection as samples shouldn't be sitting for more than 24hrs.
- Primary care trying to run clinics for those not vaccinated yet, they are targeting over 40 age group. Numbers are increasing in the phlebotomy drive thru; Dr Sharpe advised he would rather use this than send a patient to GP.

5.4. **Medical Education & Training – Dr G Browne**

- Dr Browne advised they are currently planning for changeover in August. It was noted there is a big focus is FY1 curriculum and getting community placements organised. There has been great support from the community teams.
- It was advised that there will be challenges on wards as they will have less staff due to community placements for the FY1.
-
- It was noted that there are 2 SimMans, one in CAH and one in DHH to increase simulation options for training.

5.5. **Research – Dr P Sharpe**

- The DOH looking to restart the wider research project that was paused due to COVID. The SHSCT are keen to promote research fellowship. PHA fellowships have been advertised recently.
- SHSCT have been ranked 2nd highly research trust after Belfast.

6. **GMC Issues – Standing Item**
   Nothing to escalate

7. **Litigation / Medical Negligence Issues – Standing Items**
   Simon Gibson advised the group that the coronial services are starting to get busy again post COVID. It was noted that there are a number of trainees and staff members involved.

8. **AOB**
   It was noted that the IME pilot has been ongoing for some time. The process changed to allow the mortuary service to send death certificates as this is more accurate and consistent.

Next Meetings / Dates for your Diary:

- AMD Meeting: Friday 25th July 2021, 1-2pm

Minutes of Associate Medical Directors Meeting

Friday 28th June 2019

Present:
Dr Maria O'Kane (Chair), Mrs Ruth Montgomery, Dr Ahmed Khan, Dr Shahid Tariq, Dr Peter Sharpe, Dr Martina Hogan, Dr Neville Rutherfoord-Jones, Mr Mark Haynes, Mrs Fiona Davidson, Mrs Trudy Reid, Mr Stephen Wallace, Miss Lauren Weir
Item:
1.0 Apologies and Welcome • Mr Simon Gibson, Dr Philip Murphy, Dr Pat McMahon, Dr Damian Scullion, Dr Mary Donnelly, Dr Rose McCullagh, Dr Gail Browne
2.0 Minutes of Last Meeting The minutes of the last meeting 24th May 2019 were discussed and agreed.
3.0 Reflection on AMD Development Days Constructive feedback was given.
4.0 Chairs Business Dr Maria O'Kane briefly updated on the following items: **4.1 F1s and discharge letters** NIMDTA have developed a twelve point plan following the report from Michael Davis, ADEPT Fellow. One of the points noted that FY1s are not to do any more than 5 letters per day. Dr O'Kane also advised that a project was currently being undertaken by summer students focusing on this topic. (Attached) **4.2 Flexible Job Plans** Deferred to be discussed during AMDs' individual 1-1 meetings **4.3 Sickness and Absence Policy** Dr O'Kane asked AMDs to consider the current policy for feedback. **Action: All AMDs to consider and respond by 19th July to Lauren Weir.** **4.4 Management and Leadership Training for AMDs and CDs** Dr O'Kane noted that she understands this has been done on a case by case basis in previous years but felt that this needs to be reviewed and has asked that AMDs consider for discussion in their individual 1-1 meetings. **Action: All AMDs to consider and respond with suggestions to Lauren Weir by 19th July.**

5.0 Agenda Items for discussion

Dr Maria O'Kane briefly updated on the items for discussion:

5.1 Patient Safety Meetings

Dr O'Kane discussed M&M Meetings and if they currently have any impact in terms of patient safety. It was noted that changes to the current model were necessary to allow people to concentrate more in depth on issues and develop learning from these.

Action: Dr O'Kane and MDO SMT in development

5.2 Work Shadowing between GPS

Dr O'Kane asked AMDs to read the paper provided by Dr Rose McCullagh and advised that GPs were keen to be involved. Dr O'Kane advised that feedback would be requested from Dr Rose McCullagh and Dr Mary Donnelly.

Action: Mrs Ruth Montgomery to contact Dr McCullagh and Dr Donnelly for feedback and respond by 19th July.

Update from Dr Rose McCullagh:

"Using our contacts with LMC if we have a list of Consultants who wish to avail of a session in primary care we can pair them up. I have a GP in Coalisland who would like to have a consultant out. We could start the ball rolling with Dr Frances O'Hagan in Armagh and McKenna in Coalisland and Dr Dorman in Kilkeel."

5.3 Update from GP/Trust Meeting on 18th June

Deferred to next meeting

5.4 Medical Leadership Paper

Discussed under item 5.9

5.5 Regional Appraisal System

Dr O'Kane advised that the system was up and running asked AMDs to encourage staff to use it, noting that there has been a hesitancy in the use of the new system but that those not using it could face delays in revalidating.

5.6 Volumes of Unsigned x-rays ad bloods

Dr O'Kane acknowledged this was an ongoing issue which required further discussion.

Action: AMDs to respond with comments request to Dr O'Kane by 19th July.

5.7 Major Trauma Repatriation to SHSCT

Dr O'Kane advised that to ensure SHSCT are involved, this has been escalated to the Acute Director for sign off. Mr Mark Haynes noted that he considered the current circulated guidelines to be insufficient and that protocols need clarity on the expectations for both parts – call & send and return. It was noted that issues have been communicated

back to the Trauma Network and also that there is currently no paediatric trauma network or guidelines on dealing with paediatric trauma cases.
Action: Mr Haynes to communicate requests to Ms Susan Young Trauma Lead and update AMD group next meeting.

5.8 SPEED
Dr O'Kane briefly updated on the collective leadership paper surrounding unscheduled care and asked that the AMDs think about how to manage USC in a different way to help progression.
Action: All AMDs to consider the paper
Presentation on this 4th July to Trust Staff.

5.9 Medical Leaders Forum
Dr O'Kane noted that the AMD role will need to change to a more involved role with the Senior Management Team and the steps currently being taken to facilitate this which include the two new Deputy Medical Director posts which will support the new structure. Dr O'Kane asked the AMDs to review the paper for discussion at the next meeting.
Action: All AMDs to review paper for next meeting. Comments to Lauren Weir by 19th July.

6. AMDs Reports

- Dr Shahid Tariq updated on effect of Pensions, Taxation on Radiology and Labs. DCC.

- Dr Ahmed Khan updated on current issues within CYP which were affecting mainly DHH and community. A reduction in staffing levels was noted to be causing concern. Dr Khan advised that Clinical Guidelines are up to date and uploaded and advised that the recent Quality and Safety Conference was a great success with approx. 150 delegates internally, 30 talks over the day and 55 posters on show.

- Dr Hogan advised that there were current issues surrounding two consultants unable to do the on call rota but that this was being worked on. Dr Hogan advised that IMWH were having staff unwilling to apply for roles and asking for a reduction in PAs as a result of the pension issue.

- Mr Mark Haynes updated regarding staffing issues due to the pensions issue, advising that within ENT, staff were dropping to 7.5 or 8 PAs affecting the whole department which would equate to 1/3 reduction, T&O are looking at a reduction to 10 PAs, General Surgery are looking at some not reducing and a willingness to still undertake WLI work, and Urology will have1 potential reduction. Mr Haynes also noted that there were current on call rota issues for CAH due to four consultants on sick leave.
  Mr Haynes also noted that he would like to have a further discussion surrounding WLI processing issues and ways to deal with current problems with the claim forms.

- Dr Philip Murphy updated via email that MUSC has offered four new consultant posts for DHH and will know the uptake numbers following UHD Interviews within the next few days. One candidate was recently interviewed for three elderly care posts and has been offered a position. The candidate is currently considering which of the three posts he would like to take – one is Stroke, one is in DHH and one in Acute Care at Home.

- Dr Peter Sharpe gave a brief update on the three PhD students funded through the ECME Project. It was advised that there were current funding authorisation issues with trying to obtain a cardiac probe for one of the students. Dr Sharpe also raised an issue for point of care testing and staff using ultrasound equipment. Staff who are appropriately trained are given a barcode to allow them to use the equipment but issues have arose where the barcodes are being shared with those not trained. Dr O'Kane asked that the issue be further explored by Dr Sharpe and discussed at the next 1-1 meeting.
  Action: Miss Lauren Weir to schedule 1-1 for Dr Sharpe

- Dr Rutherfoord Jones updated on behalf of Dr Damian Scullion noting that they will be losing a staff grade in DHH in July and have a new start potentially beginning in July from the International Recruitment drive. Dr Rutherfoord Jones also advised that interview for staff grades would be taking place in July.

  There were no other AMD report updates

9 Any Other Business

Pensions issue
Following discussion, it was summarised by Dr O'Kane that there could be a potential 10% reduction across all specialties if staff reduce to 10 PAs and advised that the Chief Executive is taking a paper to the Department next week to try and come up with a solution to the tax issue. Dr O'Kane advised that once the paper was complete, it would be circulated to all AMDs.
Action: Dr Maria O'Kane

AMD Meeting frequency and duration
Dr O'Kane noted that there had been discussion during the AMD away days surrounding the frequency and duration of the AMD meetings and the benefit of changing to shorter, fortnightly meetings. It was requested that the AMDs consider for the next meeting.
Action: All AMDs with responses by 19th July to Lauren Weir.

10 Date of next Meeting for your diary:

- **AMD Meeting 26th July, 2pm – 4pm, Trust HQ Meeting Room, VC Committee Room 1, DHH**

Southern Health and Social Care Trust

Associate Medical Directors' Meeting

Friday 23rd July 2021 1-2pm

ACTION NOTES

Present: Dr Maria O'Kane, Dr Rose McCullagh, Stephen Wallace, Dr Gail Browne, Dr Pat McMahon, Dr Damian Gormley, Dr Damian Scullion, Dr Aisling Diamond, Emma Campbell (minutes)

1. **Apologies:** Dr Philip Murphy, Dr Peter Sharpe, Dr Shahid Tariq, Dr Mary Donnelly, Mr Simon Gibson.

2. **Minutes of Last Meeting – June 2021 (Attached)**

3. **Divisional Medical Directors Update**

We have appointed Mr Mark Haynes, Dr Pat McCaffrey and Dr Beverley Adams as Divisional Medical Director for their specific areas. In addition to this we will be advertising another Deputy Medical Director Post for 2 years initially; this will be based around Revalidation and Private Practice. The appointed person will also act as the Deputy RO formally in terms of Revalidation. This post will be out for advertisement on Monday / Tuesday.

The Public Inquiries have exposed the amount development we have to do around this and putting g protection around medical staff to allow them to practice safely. This will allow us to identify at an early stage any problems that may arise. Dr McCullagh advised that in relation to Private Practice, letters are not being updated on to ECR which is becoming problematic. Dr O'Kane asked Stephen Wallace to take this into consideration whilst working on the Private Practice Policy with the appointed Deputy Medical Director for Revalidation.

4. **Revalidation / Appraisal / Responsible Officer – Standing Item**

Dr O'Kane and Dr Diamond met with Stephen Morrison to discuss developing job planning and around appraisal and revalidation. There are a lot of doctors throughout the Trust that have a lot of job planning to do, there are concerns that this will cause them to fall behind in appraisal and revalidation. This will pout doctors under an enormous amount of pressure, including those doctors in roles such as Clinical Directors.

Revalidation Oversight Group is starting to take shape and are currently working through and identifying any signals that we need to pay attention to. Dr O'Kane has asked for full participation in the Revalidation Oversight Group from AMD's and Div MD's and if they cannot attend then a Clinical Director will need to attend on their behalf. We will need to further develop processes in relation to Private Practice to ensure this is done safely; this is likely to be a main focus on the back of the Public Inquiry. CD's have expressed concerns on attending on behalf of their AMD as they are unsure what the expectation of them is and what the role includes.

Southern Health and Social Care Trust

5. AMD Updates –

5.1 Cancer and Clinical Service – Dr S Tariq

Not Present

5.2 Medicine & Unscheduled Care – Dr P Murphy

Not Present

5.3 Surgery & Elective Care – Mr M Haynes

Mr Haynes suggested offering vaccines out to teenagers of staff members to help reduce staff sickness. There are also concerns around standing down surgeries due to the possibility of temporary redeployment of staff due to Covid. Dr O'Kane advised if we can't get staffing steadied up in areas such as ED then we may need to ask for help from staff and ask them to be redeployed. There were 208 beds available within the care home sector has been reduced down to around 50 as Care homes do not have the staff to look after new residents.

There currently is no community mitigation at the moment, we need to try and manage this over the incoming weeks to mitigate the spread of Covid, which means there will be very limited time for surgery. From a surgical perspective we are very aware of where the risk lies within this department, the regional review is due to have one public consultation with a local public consultation. Mr Haynes advised it is unclear as to what we can and cannot do in the meantime.

5.4 Anaesthetics, Theatres & ICU – Dr D Scullion

One resignation within Attics and will be going out for replacement post for this.

We need to encourage staff to engage with the appraisal process or there will be issues in getting staff appraised and revalidated in the longer term.

5.5 Mental Health & Learning Disability – Dr P McMahon

Under pressure in relation to staffing with some vacant posts needing filled. We are back up to full capacity but running over 100% occupancy most of the time, this is happening on a regional basis.

Dr McMahon expressed his concern in relation to backlog of patients from Muckamore, Dr McMahon has asked for direction from the Board on operating at over 100% within LD.

Action: Dr O'Kane to raise this with other Mental Health Directors.

5.6 Children & Young People's Services – Dr A Khan

Not Present.

5.7 Integrated Maternity & Women's Health – Dr D Scullion

Dr Beverley Adams has been appointed Divisional Medical Director and Dr Scullion will continue to work with Dr Adams.

Dr O'Kane suggested for the AMDs to sit down with their teams to discuss job planning to move forward with this.

Southern Health and Social Care Trust

5.8 Older People & Primary Care – Dr M Donnelly & Dr R McCullagh

Bannview is very short of doctors, staff are doing their best and patients are being as patient as they can be. Bannview will no longer be under the Southern Trust as of 31st August. Dr McCullagh advised there are a lot of patients moving across to private healthcare.

5.9 Medical Education & Training – Dr G Browne

Dr Adams advised that changeover is going ahead from Monday.

5.10 Research and Development – Dr P Sharpe

Not Present

6 GMC Issues – Standing Item

7 Litigation / Medical Negligence Issues – Standing Item

8 AOB

Was agreed to move these meetings to fortnightly meetings and will include the Divisional Medical Directors.

9 Next Meeting / Dates For Your Diary :

- AMD Meeting: Friday 28th August 2021 1-2pm Via Zoom.

Southern Health and Social Care Trust

Divisional Medical Directors/AMD Meeting

Friday 22nd October 12:00-1:00pm

Those in attendance: Dr Maria O'Kane (chair), Dr Mark Haynes, Rose McCullagh; Damian Scullion; Dr Aisling Diamond; Shahid Tariq; Mary Donnelly; Trudy Reed ;Dr Damian Gormley; Dr Pat McMahon; Gareth Hampton; Anna McGovern; Nicole Bell, James King (minutes)
Apologies: Dr Patricia McCaffery
Minutes from the last meeting:
Structural Reform and Feedback:
Maria will try to chat with the Chief today about the structural reform that is taking place
Medical Leadership- Developments:
Appointments Gareth is DivMD of Emergency Medicine Anna is DivMD of CYP Mark Haynes is DivMD of surgery, although we have him seconded to urology as well. Currently working our way through mental health and ATICS. Clinical Directors- Maria will approach SMT about appointments of clinical directors, Winter planning is important and will be taken into consideration HR have suggested to move towards having 'Thank you Thursdays' between now and Christmas, Dr O'Kane stresses that if this is done authentically that it could be great for team morale and as a suitable mark of appreciation for each team.
Professional Governance Developments; Revalidation and Appraisal; Private Practice:
Started to put in place monthly 1:1s with an additional induction once everyone is in place. Really trying to work out what everyone's developmental needs are, what the ongoing training is. Eventually Dr O'Kane would like to get to a point where each DivMD has a dashboard so that they can clearly identify a problem within their division and it can be escalated. Urology inquiry training has taken up a significant amount of time, one of the questions that has come up is whether we understand if systems are safe or not. Private practice, working our way through revalidation oversight. Monday evening meeting for medical leaders discussed the revalidation and appraisal forms and forms for doctors who are practicing privately. Dr O'Kane proposes that each area with support should introduce a thematic review of previous serious adverse incidents of the last five years, as this will guide learning within everyone's own directorates. By looking at these incidents, we can develop themes of their own directorate, and make sure that the same mistakes aren't repeated. Governance oversights: traditionally done by medical directorates office, but more useful in addition to weekly governance meetings. Maria will also set up a fortnightly governance meetings looking at

SAIs and professionally helping the system. Shahid notices that we have a lot to learn about how to do SAIs properly and that historically he has seen staff come up with recommendations that are undeliverable or will not work, how do we make recommendations that are doable? Dr O'Kane states that the Director of Social Work, Director of Nursing and herself will have oversight of SAIs to ensure its effectiveness. Aisling- operationalising recommendations, function on the wards, might be worth bringing nursing staff in to see if the recommendations are followed through as they can accurately tell if there have been changes on the ward.
DivMD/AMD Updates:

Cancer and Clinical Services – Dr Shahid Tariq

- Haematology finding it difficult to hire, one doctor leaving next month, continued to do a day for us and now is doing two. Locum will be away and new doctor has broken wrist.
- Belfast Trust will charge us for the new doctor's services but her paediatric expertise will be appreciated in CAH.
- Accreditation process could happen in November/December, but significant staffing issues mean that this might slip.

Anaesthetics, Theatres & ICU – Dr Damian Scullion

- 1 anaesthetist has left and another intensivist leaving, post up for the anaesthetist job, intensivist leaving I February anyway
- 1 post for general theatre staff being developed currently
- Aisling: could anaesthetists be transferred into intensivists to deal with province wide staff shortage? Dr O'Kane also advises that if there is any room for flexibility where training from one position to the other could take place in CAH that that should take place, as it is a more pragmatic approach to the staff shortage. Damian has said that staff are sometimes reluctant to do this in the past but that he will consult with Chris and Raymond to examine the possibilities of this

Mental Health & Learning Disability – Dr Pat McMahon

- Recruited 2 in general ward staff, 1 person for home treatment, and another appointed ID consultant today.
- Mental Health has a number of vacancies in the region, we are trying to improve trainee allocations in the region, but Pat stresses that there is just not enough higher trainees. Pat suggests writing a joint letter from the medics with their concerns for the allocations of trainees, and asks if everyone could include their amount of trainees for their department so that the difference would be apparent to NIMDTA, and they would have a more accurate map of the allocations. Pat notes that a core number of trainees is adequate, which he says around five would be beneficial, but also notes that higher trainees means that more staff will stay with us.
- Vacancy level in the region is about 25% currently; Dr O'Kane will discuss options with Pat offline privately. Aisling has also drawn up clinical fellow posts for Mental Health that could be useful in this process.

Children & Young People's Services – Dr Anna McGovern

- No staffing changes in 3 weeks, main issues are the preparation for the winter pressures and the number of children presenting at Out Of Hours and Emergency Department. Dr McGovern and the department are trying to get safe systems to make sure we meet the surging demand and propose meetings about what can be done about that.

Older People & Primary Care – Dr Mary Donnelly/ Dr Rose McCullagh

Older People: Rose and Mary have conceived a new idea to converse with different specialties to get information out to primary care and vice versa as there is a GP echo but it is once a month in the Southern area, and Rose and Mary are trying to get consultants on the agenda for that. They have deliberated a plan to do short videos to send to GPs who can access the video. Consultants are eager but we will see if it accesses enough people in primary care and if we could send it to nursing. The benefits of these videos are that they eradicate the problem of having to tell GP's an onslaught of information. Video clips for GPs will show people and have a face to their names, need a list of GPs working across the trust, so an 'in conversation with' session could perhaps take place. Zoe will have a list suggests Dr O'Kane, and these conversations could begin to take form.

Medical Education & Training – Dr Aisling Diamond

- No updates, just progressing, developed some areas running OSCE's for third years and around Easter there will be more, first in the region to achieve this. Proximi will be edited for postgraduates, trying to introduce augmented reality for the trainees particularly in surgery as they do not get the exposure. Another way to train this is to develop wet labs. Kevin McIlvenna has completed the first film, that will be edited and trainees will be introduced to this. Trainees can see in surgical field, use camera on progress, trainer can see what trainee is doing and you can see their knowledge or skills before they actually see a patient in person. Wet lab has won a national prize, and it will be expanded out to gynaecology.

ED– Dr Gareth Hampton

- Doing 5 year plan as ED consultants will be qualified over the few years. Aisling suggests to Gareth that it might be worth sitting and thinking if there are any areas that you could recruit consultants into, for example AC@H, to increase the scope of what the ED consultants can do. The flow can move and then it will help Gareth at the front.

GMC Issues – Standing Item:

Trying to gather these up in relation to individual doctors, hopefully everyone attending with assistant directors so we can support doctors

Litigation / Medical Negligence Issues – Standing Items

Struggling to see how learning can get out with this. We will do internal learning, will be overlap with SAIs.

AOB

- National Audit Assurance Report for November 2021 Governance Committee
    - 31 requests for submission updates issued to Clinical Audit leads, cc'd DivMDs on 29/09/2021 for return by 22/10/2021
    - Further 15 reminders issued 14/10/2021
    - Received to date:
        - 2 progress updates
        - 9 nil returns (Can we encourage audit leads to carry this out?)
        - 3 – no national report available (RCEM / ED)

This is developing and Dr O'Kane is keen to use this as a vehicle of improvement. Audit has been side-lined by quality improvement but Maria notes the two should be done side by side.
Maria is putting together a template to identify within your area the different leads (audit, litigation etc.), this will ensure that there will be a support network underneath everyone to give a steady stream of information. Information therefore is accessible for whenever it's needed and medical directors are knowledgeable about their own areas. Dr O'Kane offers to help anyone who is struggling with this. Urology inquiry has highlighted that we need this in place.

Interface between primary and secondary care- April will introduce integrated care, the pilot will be the Northern Trust prototype, Dr O'Kane looked at the plan and there's a suggestion that the interface changes in relation to decision making and how primary care is engaged. Tim Neill, Mary and Rose have met about interface between primary and secondary care, Dr O'Kane suggests bringing that to the meeting that her Rose and Mary will have.
Trying to do this fortnightly as opposed to monthly.

Date of next meeting: Friday 26th November 2021, 12-1pm.

Southern Health and Social Care Trust

Divisional Medical Directors/AMD Meeting

Friday 19th November 2021 4.00pm-5.30pm

Those in attendance: Dr Maria O'Kane (chair), Dr Damian Gormley; Dr Damian Scullion; Dr Peter Sharpe; Dr Shahid Tariq, Dr Patricia McCaffery; Beverley Adams; Mark Haynes Stephen Wallace; Seamus Murphy; Anna McGovern; Dr Gareth Hampton; James King (minutes)

Apologies: Philip Murphy, Pat McMahon

1. Developing Medical Leaderships within the Southern Trust.

Dr O'Kane formally congratulates the new medical leaders in their new positions. Try to make these jobs a bit easier. Managing doctors, rationale being if doctors are clearly appraised and shown what their expectations are then they know what their parameters are, and allows them to develop a strategically planned service with other staff behind them. Urology inquiry has sharpened our focus, there will be a strong emphasis on all aspects of governance. Aspects of professional governance such as job planning, appraisals, patient safety, M+M, Datex, how we reflect. In relation to the appraisal piece, the GMC is very clear about this, this will be a focus in relation to both inquiries. Developing assurance systems approach to this, Stephen has been working with us to shape the framework for this. Trying the most out of the 1:1s, MOK also emphasises if new DivMD's need her then please contact her on the phone between these meetings. Stephen shows us the draft of DIVMD review. Template lifts from the JD and would drive the discussions that the monthly 1:1s would consist of. Something sent out in advance to the DIVMD's. Divided in sections, first one being professional governance.

1. Job planning- we hope to give a picture from medical HR with job planning within everyone's individual services. Staff absences, [redacted], can't get recruitments. Both parties can take template away and follow these things up bt the next meeting.
2. Medical appraisal- breakdown of the staff each department has
3. Revalidation, total numbers would need revalidating in each year, anything pertinent to each persons division and other supplementary pieces.
4. 4. Professional Performance Management- we will be working towars performance management and how we will measure this in each team. People in either of those extremes we have to worry about. In terms of 100 people waiting for mental health assessment would be helpful to know but would not be a responsibility of DIVMD , more operational responsibility, for example. Aspirational piece over time.
5. Medical workforce- Posts in recruitment in process, locum posts in process, many have multiple specialties, delays to recruitment, retirements coming up, efforts to make posts substantive
6. Doctors and Dentists oversight- anything coming up such as issues identified from DDOG meeting

Clinical governance second section

1. Adverse incidents- Datexes, number of signed off, not signed off, incidents that have been reviewed and have they been closed with action plan or if there is no action required. A lot of this information is to drive discussion.
2. Serious Adverse Incidents- this will tell us about number of adverse incidents and do we know about it rather than what are you doing about it.

3. Litigation and Claims Management- this team is working through divisional report on this.
4. Coronial Matters- litifation team will populate this.
5. Standards and Guidelines- what standards and guidelines are in the area. Difficult appointing a change lead in these areas. Is there an issue identifying it, no one is willing to take it on.
6. Complaints- mirror what will happen, what complaints are outstanding. Patterns can be picked up with this. Generally the level of complaint youre getting from your directorate but complaints about specific doctors. An individual complaint doesn't give enough information but multiple will become important.
7. Morbidity and Mortality- reforming this to represent a divisional piece. Not easy to extract from one piece.
8. Clinical Audit and Quality Improvement- there will be a list of clinical audits, what needs complete and where theyre at status wise.
9. Patient Safety- each division will have specifics that would fit in here- pull that info in here and see what is in the system. Antimicrobial prescribing it will be in your inbox but you will probably not get to see it alongside other pieces unless you print it out
10. Sign Off or Test Results- some challenges, what denominator is there here Damian. Is there unsigned results, perhaps due to locum cover for example? Puts closure on this and work out what our sign off is. We will have mechanism to see if theres anything we can do to improve.
11. 11. Medical Education-
12. Research and Development- section here for each division, do we need to involve other trusts?
13. Quality improvement- we have split out this on its own. Formal or involvement- DIVMD can bring in what is the most successful this month.
14. DIVMD issues identified for discussion this month- this can go to top of the form or anywhere. Where we expect that you as a DIVMD would identify any issues that you may want to raise, even something as trivial as car parking. Perhaps relevant but not covered by the metrics above.

This is a draft- we don't feel all this has been put on one page to have a full discussion around it. Will have a chance to work through this as the weeks and months go on.
Aspiration is that this will be populated in advance to you before the meeting.
Seamus- this would be incredible if I had all that information to me. If there was admin support to pull this information it would be very beneficial.
To take this as a template for a doctor in difficulty.
Pat would need data for geriatric and stroke would perhaps . Extremely comprehensive but it is very large. Challenging but always been on the to do list.
Individuals instead of the headings? Do you have complaints is your performance outside of the normal. People who have issues they would have surely fallen into some of these boxes in a big way. Good tool for developing support structures in the areas that clearly need it. Definitely a work in progress. Stphen do you have an admin team to source this info? Its various teams, all of marias teams, everyone doing their small part and its being brought together.
We have now got to the stage in terms of trust structures is governance committee, always concerns about governance committee. Took us full day to get thru reports. What we have done now is to put in a layer bellows that . Significant challenges with SAI's,never quite sure if they get implemented. A regular fortnightly meeting between MOK Director of Nursing and Director of Social Work to examine these SAI's. Trying to see what went wrong but also if any reports have been produced then who has been actioned and who is involved. Chair of the SAI panel or someone that they

nominate, this should be revisited to make sure its actually done. W e will have to generate an awful lot less sstuff. Smart objectives that we can work on. We would like to convert the system to SJR, learning out a lot faster and anyone involved is involved from the outset. John simpson in the process of replacing this but we haven't got it over the line. Complaints is an interesting one. Education- Stephen pulled down the list of the top 20 doctors who are complained about. When you drill into them, the vast majority are not about the doctors at all. More powerful than 360 degree feedback. People volunteer information themselves for this. SAI system- are we totally in favour of moving away from this. Prelimiary work John has done says SAI's level 1 and level 2 they seem to be as good if not better. MWHR, SAI lack of opportunities to implement early learning. A lot of time spent learning, if we can identify SAI's with definite need for learning then we can benefit.
Should we approach internal audit about auditing the SAI process. Lots of time in energy put into a not very good systems. RQAI could maybe see that this is a fairly redundant tool. RQAI review of SAI's hasn't been published. Cetainly duggests major changes need to be made. Put on list for internal audit.
Beverley looking at recommendations from SAI's and SJR'S to demonstrate learning and shorten the cycle of learning. The people involved are often very anxious. Tried this a couple of time, needs tested more, Aislings vision is that automatically the recommendations could go from SAI, litigation back to medical education, sim leads and ultimately harder to make recommendations that aren't feasible a they can be road tested
Learning from experience meeting followed by the being open meeting, working out how we approach these things. MOK was interested in the conversation around insulin incidents- we repeatedly know that if we can sort out insulin then we would save lives. Regardless of speciality, and yet we grapple with it. How we address that, end up in a dituation where nurses are disciplined due to missing appointments. System problem, human factors involved, then we can learn and redesign in the system. Great scope in this and we can take smaller examples and work on them would be really powerful.

Fatigue Charter – BMA - https://www.bma.org.uk/media/4447/bma-ni-fatigue-and-facilities-charter-aug-2021.pdf

2. 1:1 Divisional Medical Director Updates

DivMD/AMD Updates:

2.1. Cancer and Clinical Services – Dr S Tariq

Clinical services- Labs has been under significant pressure since start of pandemic, difficulties in recruiting, especially recruiting those with specialist knowledge. Trying to give them support from admin side. Particularly difficult in Daisy Hill. Trying to get someone knowledgeable in haematology and biochemistry is extremely difficult. radiology has many sub specialities, every mini department has three or four specialists. Impossible to make sure that there is attendance from various radiologists.

Cancer- Where do we stand as ___ as a national tool. Some things we don't have in place. More about admin support around MDT. Looking back at data in terms of audits is proving to be difficult. Ongoing work related to inquiry and urology. Recommendations from SAI's a frequent . MDT compliance will make us compliant with most of those recommendations. Lots of regional work happening concurrently. Some things we didn't have in place such as no specific job description for MDT chairs. Making sure those are running are given the time which is in their job plans. The need to take part in the MDT makes the best use of this. Trying to find a counterpart in England, managed to find counterpart in Liverpool to see

Emergency Medicine & Unscheduled Care – Dr G Hampton

2.2. Medicine (Governance) – Dr P Murphy

2.3. Medicine (Workforce) – Dr S Murphy – new appointment .

2.4. Surgery & Elective Care & Urology – Mr M Haynes

2.5. Anaesthetics, Theatres & ICU – Dr D Scullion

2.6. Mental Health & Learning Disability – Dr P McMahon

2.7. Children & Young People's Services – Dr A McGovern

2.8. Integrated Maternity & Women's Health - Dr B Adams

2.9. Primary Care – Dr M Donnelly/ Dr Rose McCullagh

2.10. OPPC – Dr P McCaffrey

2.11. Medical Education & Training – Dr A Diamond

5.10 Research – Dr P Sharpe

Incredible rise of POCT since the pandemic. Biomedical scientist staff have joined, one staff member lost to the public inquiry and urology. Other issue is LIAT instruments, used for testing three viruses RSV COVID and Flu, ROSH has said global supply issue with the kits. What we were promised we are actually getting 35% of what we were promised. R&D has proven its worth during pandemic. One of the difficulties we have is limited number of research nurses, one deployed to ICU on a number of occasions. Very difficult for us to object to us. This means however is that we can't do critical research as she is full time clinical and ICU. Can we discuss importance of critical research? Long term staffing of ICU at a higher level than their baseline. Surgically it is a dire situation, capacity across NI doesn't meet, not met priority 3 for the entire pandemic. Over 6 hours of patients on priority 2 waiting list. Patients have been waiting over a year. Difficult to get thru that. Ethics meeting on 23rd regionally to discuss this. On elective, we have this week been asking what the infrastructure plans are considering this is a new normal. Needs to be a clear plan across the region A NEW NORMAL BASELINE ICU capacity. Where do we focus our limited resource? On sickest or who will use the least resources. Difficult conversation. Ethical framework meeting on 23rd, we will take this forward. Circulate to Damian, Mark and Maria to bring that line of thinking into the group. Referred this matter to the regional forum a few months ago. Who makes the decision? We can expand a regional centre in Lagan Valley you have to draw the staff from one place which stops the staff doing something somewhere else. What should ethical decision making look like? Department could receive a letter with a consensus, but this could be difficult. Individuals think we should be doing the most for the most. Strongly believe the most at risk should be treated, others think.

A just culture guide- showed by Damian- applied to patient safety incidents. When we review any incident we look through this framework. Trying to remove step 1a, nobody goes out to intentionally cause harm. Substitution test- nothing to do with individual . When we review adverse incidents, we often do try to find the individual , it feels as if the problem is solved when that's not realistic. CD roles- individual conversations planned. CD paper brought to SMT, weren't worried about money but whether releasing PA's would topple the system. MOK- genuinely concerned considering manpower issues. Also what we should be doing is thinking about distributing leadership models. Identifying who you have as a lead. Who leads in education, audit, teaching. Do we need to give PA allocation to them? Even if we start to use the template as a base, we might look at heading on DIVMD JD and send it to everybody so they see how many PA's they need for their own division. That will shape exactly what the CD posts start to look like as there is a variation in terms of the number of doctors. Core work needs to be done whether youre a CD or not. Complexity of the area, on top of all of that we know some of these posts are demanding in time. Admin support- we would provide, and put together a proposal, to get admin support. 10pa job you get ten pa worth of secretarial support. What we will do for the next few weeks, populate it, and we will meet with you quickly and individually of what we need, quickly go back to SMT and say this is how we will proceed and we will build up towards it. Strcutures review Shane leaving, might be tweaked, within all of that we need to make sure these structures are aligned with new structures. CD's and areas covered gives a clear steer away from that. Is appraisal built into CD roles- ideally yes, but if we have people who can only do 1.5PA's as CD, then we would be looking to put ina line of appraisars beside them. Max number of appraisals anyone can do is 10 and minimum is 8. Job plan appropriately if others in the team would like to do it. Some directorates will be ready to move in that a bit more quickly than others. Interrim we could put EOI to see if anyone wants to do it in DHH . Someone could be interested in this, for Seamus CD role. 27 waits , Gareth in same sitch, somebody for Gareth up for the role. Temporary for a few months, Shahid- how to manage email traffic; induction for new posts, induction about our new roles, some of us clinical commitment iin daisy hill but managerial in CAH. Don't know answer to second bit, thought about induction. As we add to this group, the opportunity in relation to learning is immense, probably a few things on an immediate list that needs addressed. We still have divmd on admin floor, floating office. Secretarial support will be sorted out. Appreciate a lot to be done in relation to inquiry, we need to fire on with this in ancitipation of other people . Difficult conversations, chairing meetings, useful work being done that could help new directors. Induction needs discussed. Time dedicated to this. MOK- action learning sets- some may have experience but some may not. Stephen and MOK can have immersive sessionafter Christmas and a couple of half days training with experts with end to end, people distanced, could be done reasonably quickly. SHhaid- not to Stephen Hyland to give us reasonable IT equipment so we do not struggle with IT equipment.
AOB

Date of next meeting: Friday 7th December 2021

Southern Health and Social Care Trust

Deputy and Divisional Medical Director's Meeting

Friday 3rd December, 4.00pm

Present	Apologies
Dr Damian Gormley (Chair), Rose McCullagh, Raymond McKee, Beverley Adams, Philip Murphy, Simon Gibson, Peter Sharpe, Mark Haynes, Ted McNaboe, Patricia McCaffrey, Mary Donnelly, James King (minutes)	Seamus Murphy, Anna McGovern (late), Damian Scullion, Aisling Diamond

Items	Actions
1. Developing Medical Leadership within the Southern Trust. • New introductions • Ted McNaboe new DivMD of Surgery and Elective Care • Raymond McKee- new DivMD for Anaesthetics Development of Clinical Director is ongoing. Dr O'Kane would prefer this to remain a fortnightly meeting. Last time Stephen shared a presentation on supplying the new Directors with information to carry out these roles to the best of their ability. Beverly shares experience of first 1:1 meeting with Dr O'Kane, says it was successful but needs slightly better structure. Dr Gormley assures that each successive meeting will be better. Pat asks if we can see individual consultant's workloads in this pro forma. Damian says no but this information will be available on the performance review or job plans for each individual consultant.	
2. 1:1 Divisional Medical Director Updates 2.1. Medicine (Governance) – Dr P Murphy Governance in medicine- difficulty in recruiting and retaining M&M chairs.. Huge numbers of deaths in medicine. Whole process of them getting signed off is tedious, each patient takes five minutes. Trying to make this useful while still carrying out what we have been asked. EOI's sent out, not much activity. Clinical input is needed re NIECR- ultimately somebody else may not have the power to sign M&M. Bigger meetings have corporate governance support to minute meetings for Medicine. Lacking good process for discussing morbidity in the surgical specialties. Lots of deaths are inevitable, what about things that went wrong but didn't kill someone? Every patient safety meeting has an agenda that discusses morbidity, SAI's etc. SJR process from England could be brought to NI. Vast majority of deaths happen in general medicine. 2.2. Surgery & Elective Care – Mr T McNaboe Not the same volume of deaths as in Medical, parts of this are	

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combatted through the sub specialty patient safety meetings. Trying to deal with surgical expediency. Tend to get overview picture and we can feed back to departments to try and balance it up with our trust.

2.3. Urology – Mr M Haynes

Mark and Ted working out the specifics of their roles and how they will interlink.

2.4. Anesthetics, Theatres & ICU – Dr R McKee

Difficult to get through meetings on deaths. ICU learning experience will come from the near misses and many deaths they experience are inevitable deaths ultimately. Damian suggests a smaller group analyzing deaths, picking most important out and bringing them to a larger group to save time for the majority of staff.

2.5. Children & Young People's Services – Dr A McGovern

Governance in place, electronic sign offs on blood, job plans in order. Pediatrics shifts from busy to not busy. Busy but managing currently. Nothing additional that needs to be discussed here and now.

2.6. Integrated Maternity & Women's Health - Dr Beverley Adams

Review of deaths- stillbirth and neonatal deaths where we have to answer to coroner. National inquiry, Beverly found she couldn't do it with old M&M system. Is there an ambulatory unit across the trust to link into? Gynae service running with one nurse. No more silo work should have been looking at that and funding was going to go towards that. Ambulatory specific work stream. Aisling had been chairing that group, no NMS work going on. ED group and UC group doing same thing so merged. Aisling and Mary Burke good people to contact regarding this.

2.7. Primary Care – Dr M Donnelly/ Dr Rose McCullagh

22,000 contacts a week. Protocols are in place,
Usual winter pressures, vaccines. GPs want to do the right thing. Education and helping hand via email or phone call where a GP hasn't started someone on a medication. Desire for a patient user waiting list where patients can take themselves off if symptoms have disappeared. HRT clinic in Mater does regional advice line, sending queries many times a week. Next step is to publish FAQ's so that GP's can search for answers rather than ask us for answers.
Working on discreet self-referral for doctors with difficulty. Sent out five questions in a questionnaire from the BMA about setting up a wellbeing service. Barriers to healthcare, confidentiality, decisions for career among problems staff had mentioned in their replies. Large number of responses. Appetite for combating low morale.
Nominate GP for SAI David Gilpin is doing. Someone outside Southern Trust is one of the qualifications. Unsure if we can get a GP who doesn't know doctor involved.

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2.8. OPPC – Dr P McCaffrey 50% of beds are occupied by patients ready for discharge. ACAH was working reasonably well until the end of this week; this has changed due to staffing absences. Pat is concerned about pressures in CAH. Pat asks if we should bring in a modular build or strategic plan about where these people go. Whole site has been scoped for what could be a bed and what could be brought on from a modular basis. Estates are looking at areas to put additional resources into. However we do not have the staff to fill the wards, need another way to think of this. Trust is doing what it can within the bounds of its responsibilities. Supply and demand issue, do not have supply to deal with demand. Simon has raised it formally, and supports raising it again so that the medics are aware of the pressures on this service. 5.10 Research – Dr P Sharpe Redeployment of some of our staff. UCAS accreditation- both biochemistry and haematology both passed. Concerns about staffing issues. Daisy Hill lab is under critical issues with staffing. Samples taken to CAH or manned by other staff. This vulnerable service sometimes does not have a GP available. Biochem and haematology under pressure due to this. Point of care testing- expansion. Problem with untrained staff using new instruments. Internal quality control and external quality assurance. OOH stuff on daily basis. Clinical decision making should be fed back to the actual service. Peter has raised some as SAI's and fed it back at senior level. UCAS will scrutinise again in six months as they were concerned about absences, they will be checking we have additional staffing.	
AOB •	
• **Date of next meeting: 17th December 2021, 4:00pm**	

Stinson, Emma M

From: OKane, Maria
Sent: 26 June 2022 20:04
To: Stinson, Emma M
Subject: FW: HOT clinics

Please upload

From: Corrigan, Martina <[redacted]>
Sent: 26 June 2022 13:34
To: OKane, Maria <[redacted]>
Subject: HOT clinics

Maria

As discussed please see below attendances at Urology HOT Clinics from April 2015-June 2020 (I have not included locum consultants or Matthew Tyson as he was only in post from 26 Feb 2019-June 2019 before he went on his fellowship – he seen 70 patients in these 4 months)

Urology Hot Clinic attendances
1 April 2015 - 30 June 2020

Consultant	Attendances
Mr Glackin	311
Mr O'Brien	142
Mr O'Donoghue	249
Mr Haynes	585
Mr Young	591

Anything further please let me know
Kind regards

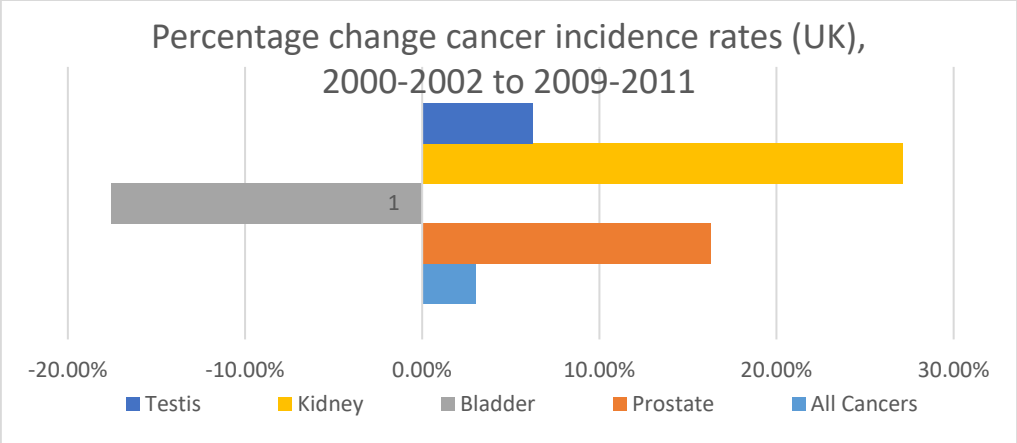
Martina

Martina Corrigan
Assistant Director – Public Inquiry and Trust Liaison
Mobile: [redacted]

Background

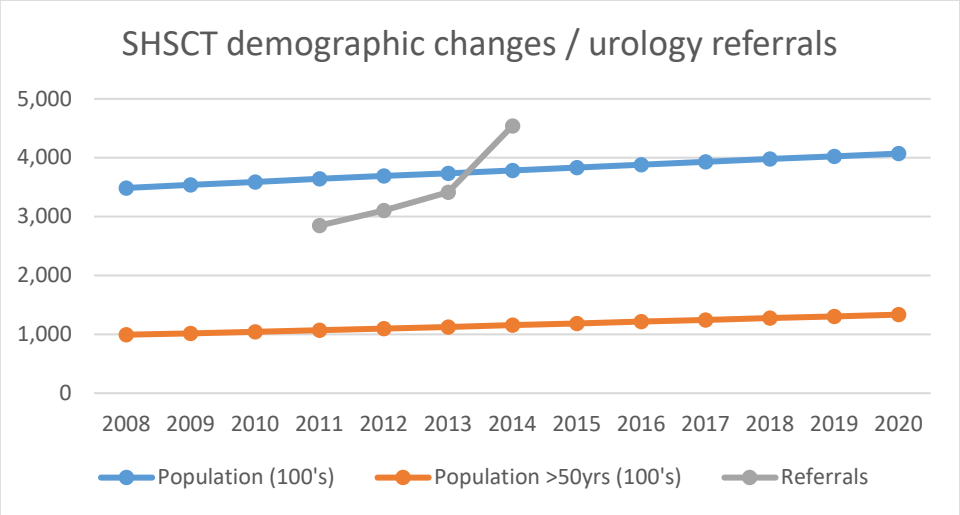
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015. Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team). For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question ‘what can be done differently to reduce our consultant capacity requirement?’. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals have been delayed rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral. All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be 'what speciality do you wish to refer the patient to?' which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral. These systems are used in other areas of the NHS and to a limited extent in specific conditions within

NI (eg post menopausal bleed clinic referral). Unfortunately this ideal is a considerable distance from being available within the NI 'gateway'. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms) and in our meetings we have the impression of considerable reluctance with regards mandating any aspect of the process.

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use considerable consultant time and in order to maximise efficiency of consultant time we would envisage this as a 'stop gap' measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the trust and wider NHS is that while they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects. In order to deliver a sustainable service there is recognition that the number of

Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. I was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. This increase in theatre sessions will commence in October 2014. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on CAH site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.
- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12 months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379
June	395
July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10

min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres. As discussed in the service plan, utilisation of off site theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously. Work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work. We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this demand. However it is noted that in order to get to the benchmark timings, the Benchmark trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new OP consultations the haematuria and diagnostic / LUTS assessment patuients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers

for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

ESWL

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requiremnt for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, , this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. FU demand for 2013-2014 was 5050 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients

where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been prerformed prior to the fist outpatients attendance. Where investigations are arranged, writing with results and if required telphone follow-up. Those patients who do need to attend for FU will be seen either by CNS or consultant. A significant proportion of this required FU will be consultant led and nurse delivered (in particular oncology FU), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood. A separate plan is required fro reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing FU while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requiremnts are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session (including admin time)	Weekly sessions required	Weekly Hours	Weekly PA's
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	10	47.5	11.875
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			310.5	77.625

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service wihtin SHSCT and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and

reduce this consultant input but presently we believe this aspiration is some considerable time away.

All “concerns or complaints relating to Mr Aidan O’Brien” from 2009

The table below provides the ID reference and location as follows. Relevant to Acute, Evidence after 10 December, Document No 29 and 34 Relevant to Acute, Evidence Added After 08 02 2022, Governance Office.

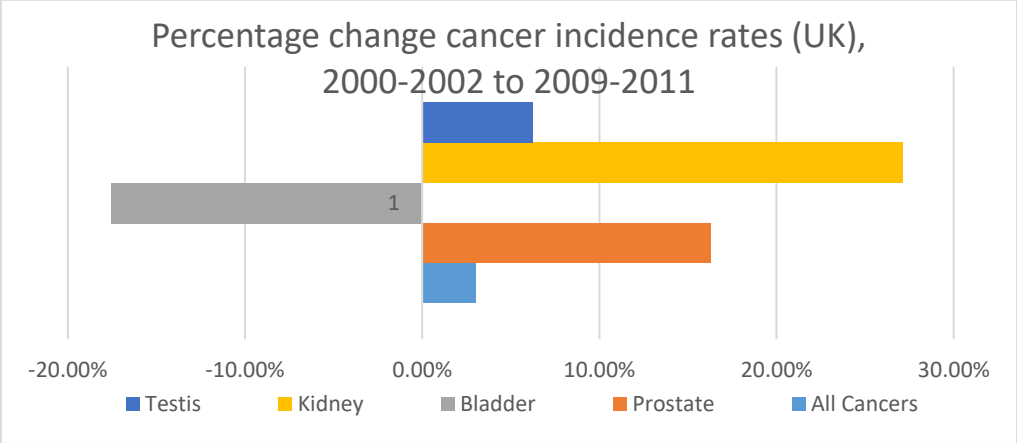
Location	**ID Reference.**
Enquiries 2012	Personal Information
Enquiries 2014	Personal Information, Personal Information, Personal Information (20141121), Personal Information, Personal Information, Perso nal , (20140414 Enquiry + 20140419 Trust Response)
Enquiries 2016	Personal Information
Formal Complaint 2009-2010	Personal Information, Personal Information redacted by the USI, Personal Information
Formal Complaint 2011-2012	Personal Information, Personal Information (Personal Information redacted by the USI), Personal Information, Personal Information, Personal Information, Personal Information
Formal Complaint 2012-2013	Personal Information
Formal Complaint 2013-2014	Personal Information redacted by the USI, Personal Information, Personal Information, Personal Information, Personal Information
Formal Complaint 2014-2015	Personal Information, Personal Information, Personal Information redacted by the USI, Personal Information, Personal Information, Personal Information, Personal Information, Personal Information, Personal Information, Personal Information
Formal Complaint 2015-2016	Personal Information, Personal Information
Formal Complaint 2016-2017	Personal Information, Personal Information redacted by the USI, Personal Information, Personal Information
Formal Complaint 2017-2018	Personal Information redacted by the USI
Formal Complaint 2019-2020	Personal Information
Formal Complaint 2020-2021	Personal Information redacted by the USI, Personal Information

The Vision for Urology Services
Southern Health and Social Care Trust

Background

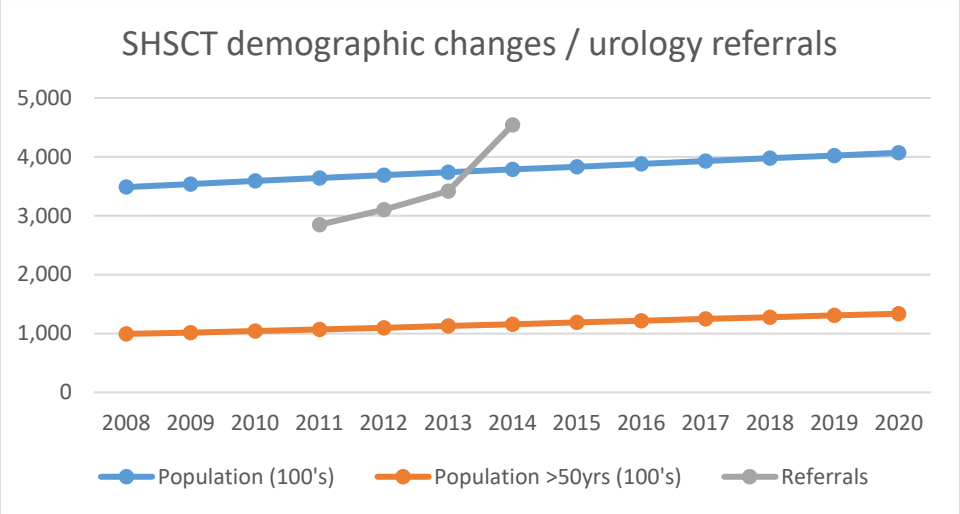
One of the biggest challenges facing the NHS is matching capacity to demand. Demand for secondary and tertiary healthcare services is rising faster than would be expected from population demographic change alone and is driven by a combination of this demographic change, increases in disease incidence, increases in available interventions, increased patient awareness and expectations and capacity constraints of primary care services.

Within urology the incidence rates of disease are rising. Published data is available regarding incidence rates of cancers. The table below shows percentage changes in incidence of the 20 most common cancer in the UK.



Corresponding figures for Northern Ireland are an increase in prostate cancer incidence of 39.9% (UK figure 16%), kidney cancer incidence of 31.4% (UK figure 27%), testes cancer incidence of 6.5% (UK figure 6.2%) and a reduction in bladder cancer incidence of 3.4% (UK figure -18%). These changes in incidence rate equate in increases in case numbers across Northern Ireland of 67.4%, 57.1%, 12.5% and 11.4% for prostate cancer, kidney cancer, bladder cancer and testes cancer respectively over the same time period. A similar pattern would be observed for benign disease but this incidence data is not as readily available as cancer incidence statistics.

Looking specifically at SHSCT, the graph below shows population demographics vs Urology outpatients referrals (nb the demographics information does not include Fermanagh which is part of the SHSCT Urology catchment). The incorporation of Fermanagh (65000 population, 17% rise in population served) into SHSCT urology catchment accounts for some of the big increase seen in 2014, prior to this year on year referral increases were at approximately 10% per year.



The result of this increasing demand for urological services in SHSCT and across the NI Healthcare system is that patients are waiting too long for their care. The SHSCT urology service received 4541 outpatient referrals between 1st July 2013 and 30th June 2014 while over the same time period 2557 of these new referrals were seen. Consultant numbers have now increased which has increased the available clinics to see new patients (to a maximum of 4100) but this does not meet demand or the expected 10% increase in demand in 2014-2015.

Additionally, in order to maximise theatre utilisation above the profiled 41 weeks, SHSCT urology has cross covered theatre lists such that the profile currently being utilised runs at 47 weeks and as a result dropped some outpatient activity. This has meant that while there were 2262 available new outpatient appointments based on a 41 week profile, 1935 were actually delivered (this is based on capacity delivered for the full year and does not include sessions delivered by members of the team who started or left during this 12 month period, 622 new outpatients were seen over this period by these additional members of the team).

For Inpatient / Day Case surgery an average of 140 hours of operating per month over the last twelve months has been listed for theatre within a capacity of 120 hours of operating per week. The result of this demand vs capacity mismatch is a growing waiting list across every aspect of our service, the current waiting lists are;

- New outpatients – 1586 (1250 > 9 weeks, 880 > 15 weeks)
- Follow-up outpatients – 3385 (longest waiter due OP review Feb 2011)
- Inpatient / day case surgery – 973 (115 > 52 weeks)
- Flexible cystoscopy – 185 (includes planned patients)
- Urodynamics – 117 (80 > 9weeks)

In light of this SHSCT urology has worked towards creating a vision for delivery of urological services which;

- Delivers a sustainable service.
- Is based on efficient models of care.
- Maximises available capacity.
- Maintains acceptable, equitable waiting times.
- Incorporates planning for delivery of increasing demand.
- Identifies what additional resource is required to deliver this service.
- Identifies risks which pose a threat to delivery of the vision.

Experience of previous attempts to tackle the demand vs capacity mismatch are that focus on one or two elements has resulted in short term improvement and subsequent return to the previous situation. We agreed therefore that in order to deliver this vision we would re-examine the entire urology service and redesign the entire process. For each aspect of the patient pathway we posed the question 'what can be done differently to reduce our consultant capacity requirement?'. The output from this can be split into three aspects, demand management, capacity planning and management and service delivery which will be discussed in further detail.

1. Demand management

This is a key element in delivering a sustainable service, with the focus being an increase in primary care investigation and management prior to referral into secondary care. To assess the possible impact of managing demand a sample of routine outpatient referrals were reviewed and from these, with expectations for primary care investigation and management prior to urological referral approximately 50% of these referrals could have been avoided. The overall impact of demand management would be expected to be less than 50% as this review did not include urgent or red flag referrals, also some of these patients that did not require referral at that point will require referral after completion of additional investigation / management in primary care. A suggested reasonable expectation for demand management would be a reduction in referrals of 20%.

Existing referral systems that are utilised within NI primary care have been explored. The central vision for referrals into secondary care is to move to all referrals occurring electronically via the CCG. This Gateway currently provides a standardised referral form providing key demographic information and with a free text section for clinical information. From a demand management perspective, key limitations of this gateway is an absence of any mandatory, condition specific requirements for referral with the 'gateway' acting effectively, as an open door; GPs can refer any patient to secondary care without any expectation placed upon them of initial management, investigation or provision of clinical information. A number of different demand management interventions have been utilised in other areas of the NHS. Many of these have been led by primary care and have resulted in an initial fall in referral numbers and this has been followed by a return to previous referral levels – referrals have been delayed

rather than prevented. In order to be successful and sustained we believe demand management systems require;

- To be led by Secondary care.
- Simple safe guidance for primary care management and investigation.
- Timely primary care access to necessary investigations (eg radiology).
- Mandated clinical information at referral specific to each condition.
- Effective policing of referrals and rejection of those that do not meet mandated requirements.

The ideal demand management process would therefore consist of comprehensive guidance for primary care investigation and management of urological conditions which is readily accessible, simple to use and written by the secondary care team. The referral itself needs to include specified mandatory information, specific to the condition being referred for. The referrals need to be reviewed against the mandated requirements and returned to the referrer if they do not meet the requirements. Alongside this there is a requirement for secondary care to provide primary care access to the diagnostic investigations specified in the guidance for primary care management and investigation and a need for access for advice from secondary care without generating a secondary care referral.

All of these requirements could be met by a comprehensive electronic referral process with dynamic forms which mandate provision of specific information and do not allow referral without provision of this information. Design of these forms could be such that they are simple to use (from a primary care perspective) and indeed could cover all specialities from an initial entry point (first question could be ‘what speciality do you wish to refer the patient to?’ which would then lead to subsequent speciality specific questions). Incorporation of secondary care guidance would enable this electronic referral process to categorise the urgency of the referral (e.g. those that meet red flag criteria would be automatically graded as red flag). Most importantly, without completion of all specified mandatory information the electronic form could automatically reject the referral.

These systems are used in other areas of the NHS and to a limited extent in specific conditions within NI (e.g. post-menopausal bleed clinic referral). Unfortunately we are advised that this ideal is a considerable distance from being available within the NI ‘gateway’. Presently referral via the electronic gateway stands at 26%, dynamic protocols are not currently developed within the software (required for dynamic forms).

Having explored the existing / available referral processes available in NI it is clear that presently we cannot move immediately to the ideal mechanism of mandated electronic referral for a number of reasons. Therefore, in order to commence a mechanism of demand management the process will need to be based upon primary care guidance and education, consultant review and triage of all referrals against the agreed primary care guidance and rejection of referrals which do not meet the specified referral criteria. Over time and with training we envisage that some of this work will be performed by clinical nurse specialists. This process will use considerable consultant time and in order to maximise efficiency of consultant time we would

envisage this as a ‘stop gap’ measure until a suitable electronic referral process is available.

2. Service delivery Model

The service delivery model was divided into elective and emergency care with a separate model of delivery for each. Across both models specific consideration is required with regards infrastructure and staffing requirements.

Elective

The Guys model of new patient outpatient service delivery model has been considered as the preferred model of initial secondary care contact for the patient. This model delivers outpatient care such that at the end of the single visit patients are either discharged back to primary care or listed for a urological intervention. The Guys model is delivered with a capacity of 18 patients seen in a session with medical staffing at 2 consultants and a trainee. In addition to the positive service aspects of this model it also had significant positive impact on training and supervision for the SPRs. It was agreed that this model should be pursued as a basic model of outpatient service delivery. The number of these sessions required will be guided by capacity requirements (see below). There needs to be agreement in planning the patient pathways on;

- Do all patients need to be seen in OP?
  Patients referred for a vasectomy can be placed directly on a waiting list rather than coming to an outpatient clinic first.
  Patients referred from the continence team can be listed directly for urodynamics.
- What will be done before the OP visit?
  Ideally all radiological investigations should be done and available at the time of the OP visit. Each referral pathway will require consideration of how appropriate investigation will be arranged.
- What will be done at the time of the OP visit?
  Ideally all investigations required to make a treatment decision will be performed at this OP visit. For each investigation have considered what will be needed to deliver this at the time of the OP visit (ie infrastructure, equipment, staff).
- Who will be followed up?
  Ideally patients will be either discharged or listed and so follow-up requirements will be minimal. Where follow-up is required does this need to be delivered by a consultant in person? Could it be delivered by a nurse in person or over the phone? Can it be delivered by letter? For example TRUS biopsy patients with cancer on biopsy need an in person follow-up with their pathology results but do patients with negative results? Published data from Guys suggests a follow-up rate of 30%.

Specific consideration of models of care and capacity planning needs to include the requirements of active surveillance TRUS biopsies of prostate (utilise radiology provision of TRUS for this group?), TCC surveillance (protocol guided, nurse delivered?), Urodynamics (direct access following continence team referral for female LUTS?) and the specific needs of the stone service which bridges acute and elective care (ESWL capacity and delivery, stent removal).

In order to deliver the demand there needs to be considerable expansion in delivery of aspects of care by non-consultant staff. Staff grade post recruitment is an issue across Northern Ireland and GPwSI models have been utilised but the experience of the Trust and wider NHS is that whilst they provide additional capacity when posts are filled, once a post is vacated they leave a gap in service delivery and recruitment to fill again is difficult. It was agreed that the delivery of care will be broadly based upon a consultant delivered service with SPR delivery (supervised) and CNS delivery of specific aspects.

In order to deliver a sustainable service there is recognition that the number of Clinical Nurse Specialists and scope of practice needs to increase above that which is currently provided. It is recognised that at inception the model will involve consultant delivery of aspects which over time, following likely recruitment and training will become CNS delivered. This training requirement will mean that at inception the capacity of the service will be reduced but this will increase as competencies are acquired. Some aspects of service will remain consultant delivered while others will be consultant led. Examples of these are below;

Consultant Delivered (provided by medical team)	Consultant Led (provided by CNS and medical staff as a team)
New OP appointments	Flexible cystoscopy
Inpatient / Daycase surgery	Urodynamics
Acute care	Intravesical treatments
	Follow-up OP appointments
	TRUS Biopsy of prostate

Specific deficiencies in the current patient pathway with regards fitness for surgery and assessment of holistic patients' needs were identified. These create specific issues in elective list planning, worsen the waiting list position with patients not fit for anaesthetic being on the waiting list and currently result in significant utilisation of consultant time. It was agreed that for elective surgery the waiting list should only include patients deemed fit for surgery. A model was agreed whereby patients listed for elective surgery will receive an initial pre-admission assessment at the time of their listing. This will include holistic needs assessment (care needs, notice requirements, transport issues, post procedure care requirements etc) in addition to an initial anaesthetic assessment. The anaesthetic assessment will identify two groups of

patient, those with no major comorbidity who are fit and able to be placed directly on the waiting list, and those who require further anaesthetic assessment and will only be placed on the waiting list when deemed fit for their planned elective surgery.

There is agreement to the creation of a pooled waiting list for common urological procedures. This would bring advantages in terms of capacity planning, delivery of equitable waiting times and off site operating (see below). It was accepted that individual patients may wish to 'opt out' of this but should be made aware that this will result in longer waiting times for their procedure and that across the team capacity for delivering procedures from this list will differ.

It was acknowledged that delivery of capacity for operating theatre centred care is a major challenge. On Craigavon Area Hospital site Inpatient theatre capacity is fixed and at a premium while the location of the day surgery unit, availability of day unit recovery beds and timing of the urology allocated sessions constrains what procedures can be delivered through day case theatres. Having calculated capacity requirements for theatres we have increased the available urology theatre sessions from 8 per week to 12 per week. This increase has been achieved with current infrastructure by extending the working day across 3 surgical specialities and anaesthetics / nursing. Theatre productivity will be addressed by working with theatres in order to maximise the efficiency of these sessions, specifically addressing turnaround times, start times and ensuring that the lists finish on time by identifying issues which directly impact on these factors (eg porter availability).

There was discussion around procedures which are currently delivered as inpatient care which could be delivered as day cases. In order to increase our scope of delivery of day unit procedures there is a requirement for infrastructure work on Craigavon Area Hospital site. An alternative that is being explored is delivery of day case urological surgery off site with Daisy Hill Hospital and South West Acute Hospital being identified as potential sites. All consultants would be happy to deliver certain procedures on these sites which would offer significant advantages to the service and bring care closer to home for patients requiring suitable procedures. There are specific requirements in order to deliver off site operating which include;

- Theatre equipment.
- Theatre and ward staff training.
- Junior doctor support both in and out of hours (although intended as day case procedures, a proportion of procedures may require subsequent overnight admission).
- Provision of consultant out of hours cover.

Non-Elective

Non elective care presents specific challenges due to variation in demand and a need for prompt access. Significant numbers of referrals for outpatients originate from accident and emergency attendances. A model of non-elective care was presented and agreed which is consultant delivered. This model would entail;

- Consultant led morning ward rounds Mon-Fri.

- Hot clinic – A&E referrals plus non-elective GP referrals which don't require inpatient admission. This will entail appropriate management and investigation of these patients with some seen in an outpatient setting and others managed remotely.
- Non-elective operating (regular 1 hour morning slot on the emergency theatre list).
- GP advice and triage of referrals (demand management).
- Consultant led afternoon ward rounds Mon-Fri (of patients who had investigations so as to review results and make further plans).

3. Capacity management

The Demand / Capacity calculations described below include a number of assumptions and estimates. As a result of these assumptions / estimates, although we are confident in the accuracy of the data presented, the projected capacity requirements / capacity delivery and backlog reduction may upon delivery of the service be wrong (are based upon an 80% upper confidence level therefore 20% risk of true referral numbers being higher than planned for, equally a risk of numbers being lower than planned for). Staffing numbers have been considered based upon what is required to deliver the service as described but in some cases will require recruitment and training before the full capacity can be delivered.

Demand / capacity for the urology service has been calculated based upon the preceeding 12 months demand information. Projected demand for outpatients activity has been based upon an anticipated impact of demand management of a 20% reduction in referrals alongside an expected 10% annual increase in referrals. The demand projections cover a 3 year period with capacity planned at the same level for all three years (based on current demand minus 20% (demand reduction), plus 10% each year for demand increases). This will allow for some backlog reduction during years one (backlog reduction of 17% of overall capacity) and year two (backlog reduction of 8% of overall capacity) with demand matching capacity in year three. All demand projections are based upon an upper confidence level of 80% (as recommended by the NHS institute). The demand calculations are therefore;

Current demand = 80% upper confidence limit of mean demand for April 2013 – March 2014

Projected demand Year 1 = current demand – 20% (demand management impact)

Projected demand Year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

Where projected numbers of sessions are calculated, these are based on delivery over a 41 week profile. It is recognised that as the department has worked to cross cover annual leave in order to maximise inpatient theatre utilisation over the past 12 months (resulting in a 47 week profile of theatres covered) this had meant the cancellation of

a number of other sessions, most of which have been outpatients activity. The net impact of this cross cover was a loss of 232 new outpatients appointment slots across the service over a 12 month period.

Regarding inpatient / daycase theatre capacity this is calculated in a similar manner however there is no element of demand management reducing required capacity (as it is anticipated that the same numbers of patients will be listed for surgery as at present). Average theatre times for procedures undertaken over the 12 month period from July 2013 – July 2014 were obtained from TMS with an addition of a turnaround time (time between anaesthetic finishing on one case to starting on the next case). These timings were then applied to all new additions to the waiting list over this period. The capacity calculations include an anticipated 10% increase in referrals each year with capacity being set at the same level for the 3 years to allow for some backlog reduction (21% of available capacity year 1, 10% of available capacity year 2). Additional backlog reduction is expected as a result of theatre productivity / efficiency work but this has not been factored into the capacity planning. Projected capacity requirements are calculated as;

Current demand = 80% upper confidence limit of mean demand for July 2013 – July 2014

Projected demand year 1 = Current demand

Projected demand year 2 = Projected demand year 1 + 10%

Projected demand Year 3 = Projected demand year 2 + 10%

Capacity plan = Projected demand Year 3.

New Referrals

The Data for April 2013 – March 2014 as described above is below. The capacity plan is therefore set at delivering 407 new outpatients slots per month. As described in the service delivery plan the majority of these will be seen in the new patient service modelled on the Guys clinic. A proportion will be managed via the Acute clinic by the consultant of the week. We have estimated this at 5 new referrals per day (25 per week, with the acute clinic running 50 weeks of the year as the only aspect of service running 5 days a week all year round with no service on bank holidays and weekends, resulting in 1250 being managed via this service per year). The New general outpatient clinic will therefore have an annual capacity requirement of 3634 patients per year. Based upon the guys model number of 18 appointments delivered by 2 consultants plus a trainee, modelled at 41 weeks this will require 202 of these clinics to be delivered over the year, equating to 5 clinics per week. This capacity will enable reduction in the current backlog of new referrals by 1291 patients over the first 2 years of delivery of the service.

New referrals 2013 - 2014	
April	410
May	379
June	395

July	426
August	360
September	442
October	459
November	438
December	395
January	380
February	443
March	345
Total referrals	**4872**
Monthly Mean	**406**
80% CI Upper limit	**420**
Projected Monthly Demand Year 1	**336**
Projected Monthly Demand Year 2	**370**
Projected Monthly Demand Year 3	**407**
Projected Backlog reduction (over 3 year period)	**1291**

Inpatient / Daycase Theatres

Theatre time calculations have been collated from twelve months data of waiting list additions and theatre data systems information on theatre case length (time from patient entering theatre to being in recovery), unfortunately information on turnarounds (time between patient being in recovery and next patient being in theatre) was not readily available and has been estimated at 10 min. The table below shows the monthly minutes of theatre listings over a twelve month period July 2013-2014 (including the 10 min turnaround). An additional analysis of cases that could be delivered in a daycase setting has also been performed which has demonstrated that expansion in current capacity for inpatient / daycase theatres is required for inpatient theatres with adequate current capacity within daycase theatres.

As discussed in the service plan, utilisation of offsite theatres is being explored. Theatre capacity will therefore be planned at 2101 hours per year which profiled over a 41 week period equates to 13 theatre lists per week. As discussed previously, work is already underway to enable delivery of this required theatre capacity in the near future. The calculations here do not include the increase in numbers of cases listed that would be expected as a result of the increase in new patient appointments delivered. It is anticipated that this increase in numbers of patients placed on the waiting list will be met to a significant degree by theatre productivity / efficiency work.

We have benchmarked our required operating minutes against theatre time requirements for a large NHS Foundation Trust in England which has been through a number of cycles of theatre productivity / efficiency work. If our theatre timings are brought level with these timings this will result in a further capacity of 6 hours theatre capacity per week (based upon current timings) which we anticipate will meet this demand. However, it is noted that in order to get to the benchmark timings, the

Benchmark Trust had been through 6 year period of multiple cycles of productivity and efficiency work and therefore there is significant risk that this productivity increase does not meet the demand increase and therefore backlog reduction is reduced. Given this significant risk, backlog reduction prediction figures have not been calculated.

	Total minutes operating listed
July	8614
Aug	8845
Sept	6792
Oct	10402
Nov	7998
Dec	7245
Jan	8145
Feb	8416
Mar	7537
Apr	8741
May	8070
June	8971
Total Minutes operating listed	**99776**
Monthly Mean Operating listed	**8315**
80% confidence upper limit	**8682**
Projected Monthly Demand Year 1	**8682**
Projected Monthly Demand Year 2	**9551**
Projected Monthly Demand Year 3	**10506**

Flexible cystoscopy

As part of the 'Guys model' of new outpatient consultations the haematuria and diagnostic / Lower Urinary Tract Symptoms (LUTS) assessment patients will undergo their flexible cystoscopy during their Outpatient attendance. Patients undergoing TCC surveilance flexible cystoscopies and flexible cystoscopy and removal of stent will continue to need this service otside of the 'Guys model'. Between 12 – 16 patients per month undergo a planned flexible cystoscopy (TCC surveilance). We have not got patient numbers for flexible cystoscopy and removal of stent. For planning if we assume that half of all emergency cases get a stent that requires removing (other half have stent and subsequent further procedure) and 2 elective cases per week, this will give an estimate of 16 procedures required each month. This would mean a service need of one flexible cystoscopy list per week. The elective flexible cystoscopy service is planned to be deliverred as a consultant led service delivered by clinical nurse specialist and occuring alongside elective consultant outpatient activity.

TRUS biopsy of the prostate

As with the flexible cystoscopy service most will be provided at the time of the initial consultation. Long term it is anticipated that this will be provided by clinical nurse specialists within this clinic but this will require CNS training and recruitment. Some will not be suitable for providing through this clinic (patients on anticoagulation, active surveilance as specific examples). These will be provided within the capacity currently provided by radiology consultants. It has not been possible to obtain accurate data on these numbers and the demand / capacity for this service will require close monitoring and possible adjustment during the initial months of introduction of the service.

Urodynamics

This will not be provided as part of the 'Guys model' clinic due to time and space requirements. This investigation is planned to be a consultant led, CNS delivered service with specific consultant delivered sessions for complex clinical conditions (estimated 2 CNS delivered : 1 Consultant delivered). Our initial estimate is that we will require 3 sessions per week (9 patients). However, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Extracorporeal shock wave lithotripsy (ESWL- Stones)

Based upon current demand 444 treatments are required per year. The year on year increase for this service is affected by both within Trust referrals and referrals from other NI trusts. We have not obtained information on the last 5 years listing numbers for this tretament in order to estimate the year on year demand increases and as such have not modeled this. We treated 276 patients in the last 12 months. The service will therefore need to deliver additional treatment sessions to meet this unmet demand. Additionally there is a requirement for capacity to utilise this treatment modality in the acute management of ureteric colic which is currently not available. We estimate that this service will require 3/4 sessions per week to deliver the required capacity running 50 weeks per year. Again, this is an estimate and the demand / capacity for this service will require close monitoring and adjustment during the initial period.

Follow-up appointments

Estimating future follow-up capacity is extremely complex and would be based upon large numbers of assumptions / estimates. Follow-up demand for 2013-2014 was 4994 appointments, additionally there would have been further demand if we had seen the patients currently awaiting new appointments. The change in service delivery as described will reduce demand for follow-up appointments. Additionally there is a large current backlog. We anticipate patients only attending outpatients where absolutely necessary. This will be achieved by the triage ensuring that all necessary investigations have been performed prior to the first outpatients attendance. Where investigations are arranged, writing with results and if required telephone follow-up. Those patients who do need to attend for follow-up will be seen either by CNS or consultant. A significant proportion of this required follow-up will be consultant led and nurse delivered (in particular oncology follow-up), thus reducing the consultant time requirement to deliver the demand. We propose to provide available capacity to meet demand for the past 12 months and this capacity will be delivered in a consultant led

service with approximately 50% of the capacity provided by the consultant and 50% provided by the CNS team. Ongoing capacity for follow-up will need close monitoring and adjustment once true demand within the new service is understood.

A separate plan is required for reduction of the follow-up backlog. We propose to manage this as a team working through the 3385 overdue follow-up appointments, initially by case review and discharge as appropriate and then by provision of additional capacity (outside of proposed service) which will require funding. We would be opposed to this work being outsourced to private providers as experience of this is that significant numbers are referred back for ongoing follow-up while our aim in reviewing this backlog is to achieve a very high discharge rate.

Staffing requirements

Staffing requirements in order to deliver the service to meet demand as illustrated have been calculated. In the Thorndale Unit (urology outpatients), in order to provide the services we will require expansion of the team of Clinic Nurse Specialists. There will need to be 4 members of this team 'on the ground' for each half day session plus support workers. In our current service significant amounts of CNS time are utilised managing the outpatients department. To free up this time we propose the creation of new outpatients administrative roles which will enable the clinical staff to spend more time delivering patient care. These staffing requirements are shown below, some of the gap is funded but currently unfilled;

Band	In Post (WTE)	Proposed (WTE)	Gap (WTE)
7	1.86	3.4	1.54
5/6	2.72	4.4	1.68
2/3	0.8	3.4	2.6
4 Admin Support	0	1	1
2 Admin Support	0	1	1

The CNS team is anticipated to provide opportunity for progression and development and as such we would anticipate that as the individuals acquire skills and educational requirements to deliver service at a higher band they will be afforded this opportunity in-house. Without this we would be a significant risk of providing training / development to members of staff who then leave the Trust to progress their careers. Funding and subsequent appointment to these posts is essential in order to deliver the service as described.

At consultant level numbers of PA's have been calculated based upon capacity requirements as above and the following hours calculations;

Session	Consultant Hours per session	Weekly sessions required	Weekly Hours	Weekly PA's

	(including admin time)			
Theatres (Inpatient and daycase)	5	14	70	17.5
Outpatients clinics (New, FU, Off site)	5	17.6	88	22
Urodynamics	5	1	5	1.25
ESWL	1	4	4	1
Multidisciplinary team meetings (oncology and non oncology)	5	6	30	7.5
Acute care	4.75	12.2	57.9	14.5
Unpredictable out of hours work	4	6	24	6
Supporting Professional Activities	6	7	42	10.5
Total			320.9	80.25

In order to deliver the anticipated demand the service will therefore require funding for 7 consultants (11.4 PA's) in addition to the expansion in the outpatients nursing team. Without this we will not be able to meet projected demand as consultant capacity would be reduced.

Summary

We have reviewed the Urology service within Southern Health and Social Care Board and examined every aspect from the perspective of aiming to provide a sustainable service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of consultant time. In order to do this there is a need for expansion of the clinical nurse specialists within the team. This expansion will require training and funding, without this the service cannot be provided in a sustainable manner. However, even with this expansion and maximisal efficiency of consultant time there is no currently sufficient consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction.

Demand reduction will be a major aspect of delivery of the service. This requires support in our engagement with primary care and in the principle of secondary care defining the criteria for referral and rejection of referral which have not followed agreed primary care investigation and management guidance. The currently available mechanisms for this process will require significant consultant input. The proposed electronic mechanism for this process would be preferable and reduce this consultant input but presently we believe this aspiration is some considerable time away.

Southern Health and Social Care Trust

Urology Service

Benchmarking of Current Service (v0.1) –
Updated Information 6/7/2022 (red font)

The guidance relating to the implementation plan for the urology review included a requirement to benchmark the current urology service. The following pages provide some benchmarking information.

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

	2006/07	2007/08	2008/09	2009/10	15/16	18/19	21/22	22/23 *
All Trusts	1.96	2.03	1.79	1.68				

	2006/07	2007/08	2008/09	2009/10	15/16	18/19	21/22	22/23 *
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				
Southern Trust	4.04	3.27	3.28	2.09	1.5	1.08	2.99	3.14
Western Trust	2.65	2.32	2.49	1.73				

*** 22/23 is April and May only**

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

Note: The national new to review ratio is 1:2.1. It is accepted that there will be some variation due to case mix/complexity. The plan should explain the actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5

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	15/16	18/19	21/22	22/23*
All Trusts	Day Cases	3793	3733	4255	3492				
	Elective	3780	3963	4293	3710				

	Admissions								
	DCs+ElecAdm	7,573	7,696	8,548	7,202				
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**				
Belfast Trust	Daycases	1737	1584	1896	1615				
	Elective Admissions	1938	2092	2015	1873				
	Total	**3,675**	**3,676**	**3,911**	**3,488**				
	DC Rates	47.3	43.1	48.5	46.3				
Northern Trust	Daycases	211	209	241	372				
	Elective Admissions	465	430	582	448				
	Total	**676**	**639**	**823**	**820**				
	DC Rates	31.2	32.7	29.3	45.4				
South Eastern Trust	Daycases	930	912	940	751				
	Elective Admissions	257	325	369	328				
	Total	**1,187**	**1,237**	**1,309**	**1,079**				
	DC Rates	78.3	73.7	71.8	69.6				
Southern Trust	Daycases	579	576	770	433	3210	3827	2737	463
	Elective Admissions	742	691	807	650	934	893	432	97
	Total	**1,321**	**1,267**	**1,577**	**1,083**	4144	4720	3169	559
	DC Rates	43.8	45.5	48.8	40.0	77%	81%	86%	83%
	CHKS Rates	72%	72.2%	74.3%	74.8%				
Western Trust	Daycases	336	452	408	321				
	Elective Admissions	378	425	520	411				
	Total	**714**	**877**	**928**	**732**				
	DC Rates	47.1	51.5	44.0	43.9				

*** 22/23 is April and May only**

DC rate does not exclude any operative codes – all are included

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10	15/16	18/19	21/22	22/23*
All Trusts	3.7	3.5	3.4	2.9				

	2006/07	2007/08	2008/09	2009/10				
Belfast Trust	3.9	3.5	3.5	3.3				
Northern Trust	2.3	2.9	2.4	1.9				
South Eastern Trust	3.8	4.0	3.4	3.2				
Southern Trust	3.7	4.3	3.9	2.7		2.9	2	
Western Trust	3.6	2.9	3.2	2.9				

Non Elective

	2006/07	2007/08	2008/09	2009/10				
All Trusts	4.8	4.7	4.6	4.4				

	2006/07	2007/08	2008/09	2009/10	15/16	18/19	21/22	22/23*
Belfast Trust	5.5	4.9	5.4	5.0				
Northern Trust	4.3	5.4	4.9	3.7				
South Eastern Trust	3.9	4.4	3.5	3.8				
Southern Trust	4.5	4.8	4.6	4.7		5.1	4.9	
Western Trust	3.9	3.8	4.1	3.4				

British Association of Day Surgery (BADS) – CHKS – 1/4/2021 – 31/3/2022

British Assoc Day Surgery » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
BADS: Correction of hydrocele (Adult)	13	-	13	0		4070	20	43	
BADS: Correction of hydrocele (Paediatric)	0	-	0	0		358	*	*	
BADS: Cystostomy and insertion of suprapubic tube into bladder	2	-	2	0		2031	10	22	
BADS: Dacryocystorhinostomy including insertion of tube	0	-	0	0		1880	8	26	
BADS: Diagnostic laparoscopy	8	-	8	4	100%	8683	37	95	
BADS: Endoscopic examination of urethra +/- biopsy	5	-	5	4	25%	1153	*	9	
BADS: Endoscopic extraction of calculus of bladder	16	-	16	9	78%	4138	21	45	
BADS: Endoscopic incision of outlet of male bladder	0	-	0	2	-100%	762	*	9	
BADS: Endoscopic insertion of prosthesis into ureter	69	-	69	74	-6.8%	12292	56	133	
BADS: Endoscopic insertion of prosthesis to compress lobe of prostate	0	-	0	0		858	*	14	
BADS: Endoscopic laser fragmentation of calculus of kidney	18	-	18	6	200%	3161	*	38	
BADS: Endoscopic resection of prostate (TUR)	12	-	12	20	-40%	11713	66	134	
BADS: Endoscopic resection/ destruction of lesion of bladder	144	-	144	105	37%	33979	182	339	

British Assoc Day Surgery » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
destruction of lesion of bladder									
BADS: Excision of epididymal lesion	2	-	2	0		1762	*	19	
BADS: Excision of lesion of penis	0	-	0	0		1042	*	10	
BADS: Excision of lesion of testis	1	-	1	0		213	*	*	
BADS: Frenuloplasty of penis	0	-	0	0		1079	*	12	
BADS: Operations on foreskin - circumcision, division of adhesions (Adult)	61	-	61	5	1120%	13149	71	141	
BADS: Operations on foreskin - circumcision, division of adhesions (Paediatric)	4	-	4	0		5842	19	57	
BADS: Orchidectomy	19	-	19	14	36%	2997	14	34	
BADS: Orchidopexy	0	-	0	1	-100%	3683	9	41	
BADS: Orchidopexy-bilateral	0	-	0	0		618	*	9	
BADS: Removal of prosthesis from ureter	46	-	46	46		8235	15	89	
BADS: Renal biopsy	26	-	26	11	136%	8592	10	112	
BADS: Resection of prostate by laser	0	-	0	0		3601	8	80	
BADS: Ureteroscopic extraction of calculus of ureter	102	-	102	123	-17.1%	10649	57	116	
BADS: Urology	1528	-	1528	1662	-8.1%	202642	830	2203	

Length of Stay – CHKS – 1/4/2021 – 31/3/2022

Length of Stay » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
M136 - Percutaneous insertion of nephrostomy tube	72	12	6	2.33	157%	7.1	3.8	9.1	
M162 - Maintenance of drainage tube of kidney	238	66	3.6	2.23	62%	1.65	1.02	2.89	
M165 - Removal of nephrostomy tube	11	8	1.38	1	38%	1.19	0.0303	2	
M193 - Revision of urinary diversion	4	1	4	-		14.1	1.86	10	
M271 - Ureteroscopic laser fragmentation of calculus of ureter	324	161	2.01	1.58	27.4%	0.95	0.61	1.14	
M272 - Ureteroscopic fragmentation of calculus of ureter NEC	4	2	2	8.2	-76%	0.94	0.125	1.33	
M273 - Ureteroscopic extraction of calculus of ureter	25	11	2.27	1.38	64%	0.98	0.47	1.42	
M274 - Ureteroscopic insertion of ureteric stent	71	25	2.84	2	42%	1.70	1	1.97	
M275 - Ureteroscopic removal of ureteric stent	7	14	0.50	0.250	100%	0.50	0.089	0.80	
M292 - Endoscopic insertion of tubal prosthesis into ureter NEC	366	114	3.2	3.6	-9.9%	2.43	1.85	2.72	
M293 - Endoscopic removal of tubal prosthesis from ureter	17	35	0.49	0.42	14.5%	0.37	0.140	1	
M295 - Endoscopic renewal of tubal prosthesis into ureter	189	52	3.6	1.56	134%	0.78	0.44	0.95	
M301 - Endoscopic retrograde pyelography	4	4	1	5	-80%	0.86	0	1	
M308 - Other specified diagnostic endoscopic examination of ureter	15	1	15	0		0.75	0	1	
M309 - Unspecified diagnostic endoscopic examination of ureter	7	10	0.70	0.50	40%	0.48	0	1	

Length of Stay » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
M334 - Percutaneous replacement of plastic stent into ureter	23	4	5.8	1.50	283%	0.96	0	2.50	
M373 - Repair of rupture of bladder	9	1	9	-		9.6	3	15.5	
M381 - Perineal urethrostomy and drainage of bladder	0	1	0	-		2.48	0.50	4	
M382 - Cystostomy and insertion of suprapubic tube into bladder	49	8	6.1	2.50	145%	2.03	0.88	2.61	
M421 - Endoscopic resection of lesion of bladder	197	101	1.95	2.94	-34%	1.56	1.28	1.79	
M422 - Endoscopic cauterisation of lesion of bladder	119	52	2.29	2.34	-2.32%	0.72	0.48	1.10	
M423 - Endoscopic destruction of lesion of bladder NEC	7	4	1.75	2.50	-30%	0.286	0	1	
M441 - Endoscopic lithopaxy	37	18	2.06	1.57	30.8%	1.24	0.93	1.42	
M442 - Endoscopic extraction of calculus of bladder NEC	5	2	2.50	5.5	-55%	1.05	0.33	1.29	
M443 - Endoscopic removal of foreign body from bladder	0	1	0	-		1.15	0	1.50	
M444 - Endoscopic removal of blood clot from bladder	6	1	6	4	50%	7.4	4	10	
M451 - Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder NEC	19	31	0.61	0.229	168%	0.41	0.196	0.49	
M453 - Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder using rigid cystoscope	19	8	2.38	0.67	256%	0.36	0.187	0.44	

Length of Stay » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
M459 - Unspecified diagnostic endoscopic examination of bladder	85	950	0.089	0.078	15.3%	0.138	0.158	1.37	
M471 - Urethral irrigation of bladder	208	32	6.5	7.2	-9.5%	3.9	3.2	4.9	
M472 - Change of urethral catheter into bladder	14	8	1.75	1.50	16.7%	1.09	1	3.4	
M473 - Removal of urethral catheter from bladder	36	10	3.6	2.33	54%	0.257	0.147	2	
M475 - Maintenance of urethral catheter in bladder	1	1	1	-		0.55	0	1.25	
M479 - Unspecified urethral catheterisation of bladder	163	38	4.3	4.6	-7.1%	2.50	2.08	3.6	
M481 - Suprapubic aspiration of bladder	17	3	5.7	0		3.9	0	3	
M492 - Change of suprapubic tube into bladder	8	5	1.60	1	60%	0.49	0.198	1.50	
M653 - Endoscopic resection of prostate NEC	74	18	4.1	3.10	33%	2.04	1.71	2.37	
M792 - Dilation of urethra NEC	27	14	1.93	0		0.34	0.107	0.43	
M814 - Dilation of meatus of urethra	12	4	3	0		0.274	0	0.33	
N032 - Drainage of scrotum	84	12	7	2	250%	3.14	2	3.9	
N034 - Exploration of scrotum	5	5	1	1.20	-16.7%	0.74	0.38	1	
N063 - Orchidectomy NEC	12	6	2	1.23	62%	1.28	0.50	1.57	
N064 - Excision of testicular appendage	2	2	1	-		0.57	0.167	1	
N066 - Inguinal orchidectomy NEC	9	16	0.56	0.250	125%	0.32	0.083	0.38	
N071 - Excision of lesion of testis	8	8	1	0.111	800%	0.49	0.33	0.57	

Length of Stay » Scorecard

Disp

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
N131 - Drainage of testis	11	1	11	-		3.5	1	3	
N242 - Operations on skin of male perineum NEC	48	1	48	-		8	1	6.7	
N291 - Implantation of prosthesis into penis	6	1	6	-		1.75	1	2	
N303 - Circumcision	2	57	0.035	0.71	-95%	0.091	0.040	0.129	
N304 - Dorsal slit of prepuce	4	4	1	-		0.84	0	1	
N306 - Manual reduction of prepuce	2	1	2	-		0.41	0	0.50	
N321 - Biopsy of lesion of penis	8	5	1.60	4	-60%	0.188	0	0.125	
N322 - Drainage of penis	10	1	10	-		2.22	0.50	2.60	
T877 - Excision or biopsy of inguinal lymph node	7	1	7	0		0.99	0	0.79	
U051 - Computed tomography of head	102	6	17	11.2	51%	14.1	7.5	18	
U055 - Magnetic resonance imaging of spine	5	1	5	6	-16.7%	6.8	1	11	
U071 - Computed tomography of chest	2	1	2	9	-78%	6.2	2	8	
U081 - Computed tomography of abdomen NEC	4	1	4	-		3.3	2	5.5	
U085 - Magnetic resonance imaging of abdomen	10	1	10	13	-23.1%	4.6	1	7	
U093 - Magnetic resonance imaging of pelvis	13	1	13	3	333%	5.7	3	8	
U123 - Ultrasound of kidneys	0	8	0	0		0.128	0	0	
U162 - Magnetic resonance	18	2	9	-		6.7	3	9	

Length of Stay » Scorecard

Description	Local Numerator	Local Denominator	Apr 21 - Mar 22	Apr 20 - Mar 21	Change	Peer Value	25th Percentile	75th Percentile	Performance
U162 - Magnetic resonance cholangiopancreatography	18	2	9	-		6.7	3	9	
U201 - Transthoracic echocardiography	10	2	5	17	-71%	12.3	6	13.9	
U211 - Magnetic resonance imaging NEC	57	9	6.3	18	-65%	4.4	1.89	7	
U212 - Computed tomography NEC	554	103	5.4	6.6	-18.2%	2.89	2.39	4.1	
U354 - Computed tomography of pulmonary arteries	23	2	11.5	-		7.5	3.8	9.7	
U372 - Computed tomography of kidneys	44	5	8.8	8.5	3.5%	2.18	1	4	

Average Length of Spell –

Healthcare Resource Groups (HRG) are a method of grouping inpatient and daycase episodes. Data items recorded on the Patient Administration System are used to allocate episodes to a particular HRG. The data items include:

- Primary and secondary procedures
- Primary, subsidiary and secondary diagnoses
- Age
- Sex
- Method of discharge (to indicate whether the patient was dead on discharge)
- Length of stay (duration of Finished Consultant Episode)

HRGs are used to produce casemix information which can be used for costing and comparative purposes. Chapter L relates to urinary tract and the male reproductive system.

The table below compares the Southern HSC Trust's average length of spell with the Northern Ireland peer group for the period 1st January 2009 – 31st December 2009.

Peer Group Comparison for Length of Spell
Peer Group is taken from CHKS Peer for January 2009 - December 2009

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

HRG v3.5	Spells	SHSCT LOS	Peer LOS
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

HRG v3.5	Spells	SHSCT LOS	Peer LOS
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

Note – 'Non OR' indicates a procedure which is so minor that it does not affect the resources used within the episode.

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 table overleaf compares the Trust's performance with the BADS targets for urology. The following notes apply:

- Trust activity for 2009/10 has been used (from Business Objects). At 2nd 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;
- The numbers of day cases and FCEs are given in the column on the right. The numbers of FCEs with a zero length of stay are also noted as these could potentially have been recorded as day cases.

British Association of Day Surgery (BADS) Basket of Procedures for Urology

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
1	Ureteroscopic extraction of calulus of ureter	M27.1, M27.2, M27.3	50	50		0%	53%		0 DCs, 41 FCEs. **8 FCEs had 0 LOS**
2	Endoscopic insertion of prosthesis into ureter	M29.2, M29.5	90	10		0%	38%		0 DCs, 8 FCEs. **1 FCE had 0 LOS**
3	Removal of prosthesis from ureter	M29.3	100			38%			6 DCs, 10 FCEs. **4 FCEs had 0 LOS**
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%		1 DC, 18 FCEs. **10 FCEs had 0 LOS**
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%		11 DCs, 73 FCEs. **16 FCEs had 0 LOS**
6	Cystostomy and insertion of suprapubic tube into bladder	M38.2	90	10		0%	10%		0 DCs, 10 FCEs.
7	Endoscopic resection/ destruction of lesion of bladder	M42	20	50	30	3%	32%	23%	2 DCs, 63 FCEs. **6 FCEs had 0 LOS**
8	Endoscopic extraction of calculus of bladder	M44.1, M44.2	50	50		0%	10%		0 DCs, 10 FCEs. **1 FCE had 0 LOS**
9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%		775 DCs, 114 FCEs. **26 FCEs had 0 LOS**
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%	1 FCE
11	Dilation of outlet of female bladder	M58.2		90	10	100%			1 Daycase
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%		1 DC, 6 FCEs. **1 FCE had 0 LOS**
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%			6 DCs
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%	0 DCs, 111 FCEs.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%		3 FCEs
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10					None recorded
17	Operations on urethral orifice	M81	90	10		33%	50%		2 DCs, 4 FCEs. **2 FCEs had 0 LOS**
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%		4 DCs, 5 FCEs. **2 FCEs had 0 LOS**
19	Excision of lesion of testis	N06.4, N07	90	10					None recorded
20	Orchidopexy - bilateral	N08	60	35	5				None recorded
21	Orchidopexy	N09	75	20	5	60%	40%		3 DCs, 2 FCEs. **1 FCE had 0 LOS**
22	Correction of hydrocoele	N11	90	10		80%	10%		8 DCs, 2 FCEs.
23	Excision of epididymal lesion	N15	90	10		90%	0%		9 DCs, 1 FCE.
24	Operation (s) on varicocoele	N19	90	10		60%	40%		6 DCs, 4 FCEs. **3 FCE had 0 LOS**
25	Excision of lesion of penis	N27	50	50		100%			1 DC
26	Frenuloplasty of penis	N28.4	90	10		100%			5 DCs
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%		36 DCs, 15 FCEs. **6 FCE had 0 LOS**
28	Optical urethrotomy	M76.3	90	10		7%	56%		2 DCs, 25 FCE.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	OPCS Codes	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	DAY CASE %	23 HOUR STAY %	UNDER 72 HOUR %	NOTES
29	Laparoscopic nephrectomy	M02.1,M02.5, M02.8,M02.9 (+Y75.2)	5	75	25	0%	11%	0%	9 FCEs
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10				None recorded
31	Laparoscopic radical prostatectomy	M61.1,M61.2, M61.9 (+Y75.2)		5	90		0%	0%	1 FCE

Southern Health and Social Care Trust

Urology Service

Benchmarking of Current Service (v0.1)

The guidance relating to the implementation plan for the urology review included a requirement to benchmark the current urology service. The following pages provide some benchmarking information.

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

	2006/07	2007/08	2008/09	2009/10
All Trusts	1.96	2.03	1.79	1.68

	2006/07	2007/08	2008/09	2009/10
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
Southern Trust	4.04	3.27	3.28	2.09
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)

Note: The national new to review ratio is 1:2.1. It is accepted that there will be some variation due to case mix/complexity. The plan should explain the actions to deal with those teams who are an outlier from this level, and to achieve a performance in the upper quartile, at 1:1.5

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
	Daycase Rate	**50.1**	**48.5**	**49.8**	**48.5**

		2006/07	2007/08	2008/09	2009/10
Belfast Trust	Daycases	1737	1584	1896	1615
	Elective Admissions	1938	2092	2015	1873
	Total	**3,675**	**3,676**	**3,911**	**3,488**
	DC Rates	47.3	43.1	48.5	46.3
Northern Trust	Daycases	211	209	241	372
	Elective Admissions	465	430	582	448
	Total	**676**	**639**	**823**	**820**
	DC Rates	31.2	32.7	29.3	45.4
South Eastern Trust	Daycases	930	912	940	751
	Elective Admissions	257	325	369	328
	Total	**1,187**	**1,237**	**1,309**	**1,079**
	DC Rates	78.3	73.7	71.8	69.6
Southern Trust	Daycases	579	576	770	433
	Elective Admissions	742	691	807	650
	Total	**1,321**	**1,267**	**1,577**	**1,083**
	DC Rates	43.8	45.5	48.8	40.0
	CHKS Rates	72%	72.2%	74.3%	74.8%
Western Trust	Daycases	336	452	408	321
	Elective Admissions	378	425	520	411
	Total	**714**	**877**	**928**	**732**
	DC Rates	47.1	51.5	44.0	43.9

Urology - Average LOS (Episode based)

April 06 - Feb 10

Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	3.7	3.5	3.4	2.9

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

Non Elective

	2006/07	2007/08	2008/09	2009/10
All Trusts	4.8	4.7	4.6	4.4

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

Average Length of Spell

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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

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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
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L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
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3	Removal of prosthesis from ureter	M29.3	100			38%			6 DCs, 10 FCEs. **4 FCEs had 0 LOS**
4	Endoscopic retrograde pyelography	M30.1	90	10		5%	84%		1 DC, 18 FCEs. **10 FCEs had 0 LOS**
5	Other endoscopic procedures on ureter	M27, M28, M29.1,M29.4, M29.8, M29.9	90	10		13%	46%		11 DCs, 73 FCEs. **16 FCEs had 0 LOS**
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9	Diagnostic endoscopic examination of bladder (inc any biopsy)	M45	90	10		87%	8%		775 DCs, 114 FCEs. **26 FCEs had 0 LOS**
10	Operations to manage female incontinence	M53.3, M53.6, M53.8	80	10	10	0%	0%	100%	1 FCE
11	Dilation of outlet of female bladder	M58.2		90	10	100%			1 Daycase
12	Endoscopic incision of outlet of male bladder	M66.2	50	50		14%	71%		1 DC, 6 FCEs. **1 FCE had 0 LOS**
13	Endoscopic examination of urethra +/- biopsy	M77		100		100%			6 DCs
14	Endoscopic resection of prostate (TUR)	M65.1,M65.2, M65.3, M65.8	15	45	40	0%	0%	20%	0 DCs, 111 FCEs.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
15	Resection of prostate by laser	M65.4, M65.3+Y08.3, M65.3+Y08.4	90	10		0%	33%		3 FCEs
16	Prostate destruction by other means	M67.1,M67.2, M67.5, M67.6	90	10					None recorded
17	Operations on urethral orifice	M81	90	10		33%	50%		2 DCs, 4 FCEs. **2 FCEs had 0 LOS**
18	Orchidectomy	N05, N06.1, N06.2, N06.3, N06.8, N06.9	90	10		44%	56%		4 DCs, 5 FCEs. **2 FCEs had 0 LOS**
19	Excision of lesion of testis	N06.4, N07	90	10					None recorded
20	Orchidopexy - bilateral	N08	60	35	5				None recorded
21	Orchidopexy	N09	75	20	5	60%	40%		3 DCs, 2 FCEs. **1 FCE had 0 LOS**
22	Correction of hydrocoele	N11	90	10		80%	10%		8 DCs, 2 FCEs.
23	Excision of epididymal lesion	N15	90	10		90%	0%		9 DCs, 1 FCE.
24	Operation (s) on varicocoele	N19	90	10		60%	40%		6 DCs, 4 FCEs. **3 FCE had 0 LOS**
25	Excision of lesion of penis	N27	50	50		100%			1 DC
26	Frenuloplasty of penis	N28.4	90	10		100%			5 DCs
27	Operations on foreskin - circumcision, division of adhesions	N30	90	10		71%	14%		36 DCs, 15 FCEs. **6 FCE had 0 LOS**
28	Optical urethrotomy	M76.3	90	10		7%	56%		2 DCs, 25 FCE.

			BADS RECOMMENDATION			SHSCT PERFORMANCE			
	DESCRIPTION	**OPCS Codes**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**DAY CASE %**	**23 HOUR STAY %**	**UNDER 72 HOUR %**	**NOTES**
29	Laparoscopic nephrectomy	M02.1,M02.5, M02.8,M02.9 (+Y75.2)	5	75	25	0%	11%	0%	9 FCEs
30	Laparoscopic pyeloplasty	M05.1+Y75.2	10	80	10				None recorded
31	Laparoscopic radical prostatectomy	M61.1,M61.2, M61.9 (+Y75.2)		5	90		0%	0%	1 FCE

Urology PIG Meeting

9 December 2020 at 2pm

Agenda

1. Welcome
2. Stones pathway update – Michael Young
3. Bladder outflow procedures pathway update – Ajay Pahuja
4. Daycase TURP protocol and outcomes – Alex MacLeod
5. Update on TURBT – Mark Haynes
6. Day Procedure - Anaesthetics update – Rachel Deyermond
7. Utilisation of IS for urology – David McCormick
8. Pyeloplasty provision – David McCormick
9. Regional penile cancer and andrology implant service – Alex MacLeod
10. Rezum treatment for BPH - David McCormick
11. Recruitment update – all Trusts to advise
12. AOB
13. Date of Next Meeting

Appendix 1

This is the provisional process map template that will be used for the data mapping exercise being completed. The Urology Team reviewed and ensured this accurately reflected the current process. We are awaiting update on the process.

Urology Pathway Proces Map_QI Team

NEW REFERRAL PATHWAY UROLOGY SERVICES

NOTE

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

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

Referral Appears in NIECR automatically registers on PAS

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

NOTE NOTE

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

Accept Referral (NOTE)

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

- OUTPATIENT
- DIAGNOSTIC PATHWAY

NOTE

- RED FLAG TEAM
Should be seen first apt in pathway 14 days
- NEW Urgent
- NEW Routine

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(most of the time) - electronic triage has helped this

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- New Urgent WL
General List
+ Each Doctor has WL
(6 weeks)
HOS/OSL will give this information
- New Routine WL
General WL
+ Each Doctor has WL
(9 Weeks)
HOS/OSL will give this information
- Urgent Review WL
Each Doctor has WL
- Routine Review WL
Each Doctor has WL
- Out Patient
Stone Clinic/Treatment WL
Mr Young

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

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NOTE

CONSULTANT NEW PATIENT APPOINTMENT TAKES PLACE

- Consultant Review
- Diagnostic
- Decision to Admit made for Inpatients
- Decision to Admit for Day Case
- Nurse Review
- Discharge

Nurse Review →
- Urgent Review Nurse led clinic
- Routine Review nurse led clinic
- Nurse Led Diagnostic Procedure

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

REDFLAG PATH REFERRAL PATHWAY UROLOGY SERVICES

REFERRAL SOURCE

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Other Consultant

Other Hospital

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

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

MDM

OUTPATIENTS

NOTE

F2F / Virtual /OP Apats
Red Flag Urology

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

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New/Urgent Review
i.e. not red flag

THESE APTS ARE BOOKED BY BOOKING CENTRE TEAM

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Takes Place Weekly
Thursday Afternoon

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(REQUEST FOR DIAGNOSTICS OR MDM OR DISCHARGED)
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This apt is booked by Medical Secretary

DECISION TO TREAT PATHWAY

NOTE

Priority status changed?

Yes

No

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CHEMOTHERAPY
Consultant will do referral - dictate letter medical secretary type and send referral

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NOTE

DIAGNOSTIC
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Referrals received from Urology Clinic apts - Consultant, Nurse Specialists, Junior Doctors any medical within Urology, urology wards (Inpatients would be q quicker turn around), ED

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e.g. Flexible Cystoscopy
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ECR

Sectra Order Management

Triaged by
Radiologist/Radiographer
Daily

NOTE
NOTE

Downgraded to New urgent/New Routine/Planned Booking Centre Staff will process these

No

If referral not accepted letter or email to referer dictated by consultant/typed by medical secretary

Accepted

Yes

MRI

CT

ULTRASOUND

NUCLEAR MEDICINE

PLAIN FILM
i.e. xray

ECR

INTERVENTIONAL PROCEDURES
i.e. stent, flourscopy

CHALLENGES NOTED

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Appendix 2- These are the 7 elements included in clinical governance. Individually and collectively they allow an organisation to establish how well they are performing, identify areas for quality improvement, to safeguard and maintain standards and provide assurance that a service is functioning and delivering high quality safe care.

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Sectra Order Management

Triaged by Radiologist/Radiographer

NOTE
NOTE

Non Approved

Approved although Down Graded to Urgent, Routine or

Approved as Red Flag

During Justification process, if examiantion is not justified, an approval note outlying the reasoning why it has been rejected is added onto the system. This is then copied into the body of the report text associated with the examination.
The referrer is also directly contacted to make them aware that the examination has been cancelled.

During justification process a request maybe downgraded to urgent/ Routine or planned. An assocaited downgrade flag is added at the time of justification which allow this to populate into another dynamic worklist. These are then actioned by radiology admin staff advising the referrer of this downgrade by letter.

The examination reamins on the system and is appointed according to the new prioirty level.

Independent sector - in line with agreed contracts suitable patients are selected for transfer on behalf of the SHSCT.

The PACS Team manage the transfer of these paitents on the RIS system. Each of the current IS providers are an assoicated site within the RIS whereby these patients are transferred electronically directly to the required IS provider, for appointing by the IS site.
An associated note is added to the request to identify that these have been sent to the IS for ref for the Admin team in dealing with patient / referrer queries. - Cancer trackers can view this for tracking patients through the system.

Current contracts allow for CT,MRI and US outpatient only to be outsourced . PACS Team monitor the current WL and allocate according to the contract specifications eg longest waiters or other specific criteria.

Referral booked by the Relevant Appointment team for modality request is for.

MRI

CT

ULTRASOUND

NUCLEAR MEDICINE

PLAIN FILM i.e. xray

DXA ?

INTERVENTIONAL PROCEDURES i.e. stent, flourscopy

Examination performed added to reporting pool.

Examiantion not performed. Patient DNA'S or examaintion Returned to trust from IS sector.

NOTE

Once Examaintions is performed they populate into the Reporitng Worklists present in SECTRA PACS.

Reporting worklists are based upon modality type, within each of these we can identify Red Flag, Urgent, Routine and Planned.

Radiologists work of these worklists on a daily basis.

On occasions depending on the exam type a radiologist may be assigned as the reading physician at the time of the examiantion, or allocated by admin staff.
Once assigned these examaintions then fall into the reporters dedicited worklist.

Examinations may be sent to the Independent Sector for reporting if in house capacity is not available.

Reports can be flagged for communication of urgent, incidental and significant findings. Radiology have an internal policy in which staff must follow for this to occur.

PACS Team monitor the reporting worklists daily and send weekly figures to senior management team relating to exams awaiting reports.

On certain occasions the patient does not attend for their appointed examiantions.

Inhouse Examinations

SHSCT Radiology have a DNA policy which correspnds to the IEAP process.

Option 1 : Patient DNA with confirmation - Examaintion cancelled of system with an associacted report.

Option 2 : Patient DNA without confirmation - Exmiantion cancelled of the system with an associated report for the referrer. The patient also recieves a letter informing them of the cancellation and the chance to have the request if still required brought back into the system.

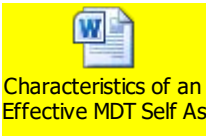
IS Examinations

PACS Team monitor worklists bulit on examaintions that havebenn flagged byt the IS proivders as RTT.

DNA's are processed as above for these examinations.

Patients may wish to be RTT to have the examaintions performed in house in this instance, then the clock is reset for this xamaintion and falls back ino the general pool for the appointment team to action.

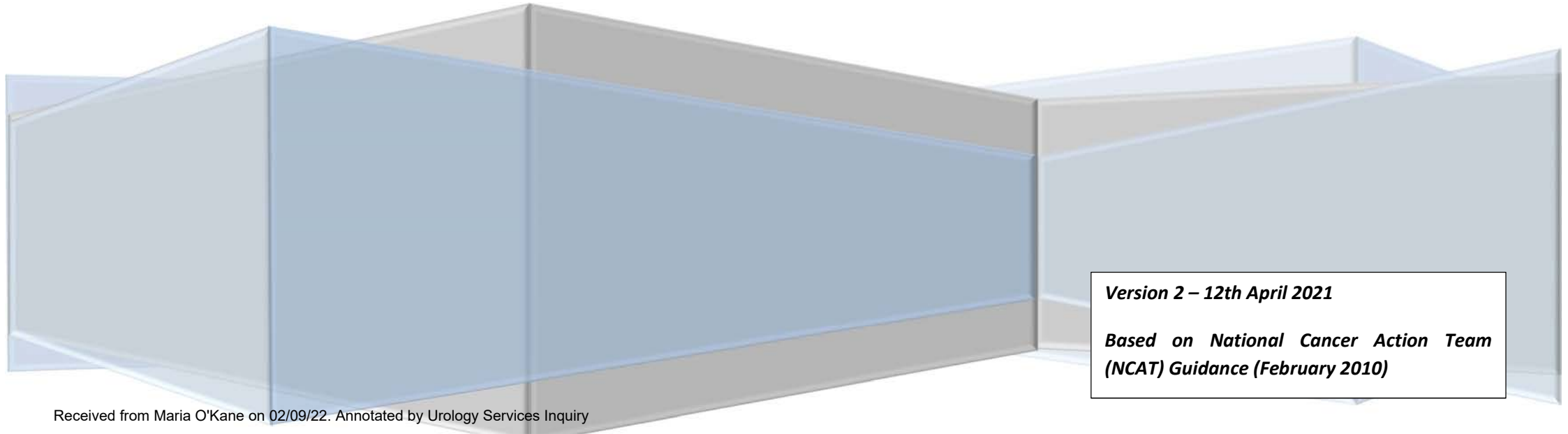
Appendix 3- This is the regional tool used for assessing the structure/ performance of and MDT


Characteristics of an Effective MDT Self As

Southern Health and Social Care Trust

Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire



Version 2 – 12th April 2021

Based on National Cancer Action Team (NCAT) Guidance (February 2010)

Southern Health and Social Care Trust

1. The Multidisciplinary Team

Membership

No.	Effective MDT Characteristic	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.			
1.1.2	The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.			
1.1.3	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible.			
1.1.4	Members have the level of expertise and specialization required by the MDT in question – where there are no relevant peer review measures or accreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.			

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Attendance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.2.1.	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.			
1.2.2	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.			
1.2.3	Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.			
1.2.4	The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent			

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	non-attendance is addressed during appraisal processes & job plan reviews.			
1.2.5	A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.			
1.2.6	Extended members and non-members attend for the cases that are relevant to them.			
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.			

Leadership

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.3.1	There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person			
1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.			
1.3.3.	The chair has skills in the following areas: • meeting management; • listening & communication; • interpersonal relations; • managing disruptive			

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	personalities & conflict; • negotiations; • facilitating effective consensual clinical decision making; • time-management.			
1.3.4.	The chair: • prepares and/or agrees the agenda with the MDT coordinator; • ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered recommendations and ensures that eligibility for relevant clinical trial recruitment is considered; • ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts; • ensures relevant demographic and clinical data items are recorded; • ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and			

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	clinical team within a locally agreed timeframe; • ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted.			
1.3.5.	The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for: • issues of governance e.g. setting clear objectives/purpose for the team/what is expected of members etc; • ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care; • negotiating locally for funding/resources needed for the MDT to be effective; • escalating issues of concern that may impact on safety of MDT Recommendations etc.			

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Team working & culture

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.4.1.	Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.			
1.4.2.	The team has agreed what is acceptable team behavior/etiquette including: • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear.			
1.4.3.	MDT members play a role in sharing learning and best practice with peers.			

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Personal development & training

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.5.1.	Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as appropriate and members take up relevant CPD opportunities.			
1.5.2.	There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.			
1.5.3.	There is access to training opportunities as required to support an individual's role in the MDT in areas such as: • leadership skills; • chairing skills; • advanced communication skills including listening, presenting and, where relevant, writing; • time management;			

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	• confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas).			
1.5.4.	There is a teaching & training role for MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).			

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.			
2.1.2.	The room is environmentally appropriate in size and layout ie. All team members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.			

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Technology & equipment (availability & use)

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.2.1.	Rooms where MDT meetings take place have: • access to equipment for projecting and viewing radiology images including retrospective images; • facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports; • connection to relevant IT systems; • access to a database or proforma to enable documentation of recommendations in real-time; • projection facilities so members can view and validate the recommendations being recorded; • facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with them.			

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2.2.2.	There is commitment/buy-in from all sites to provide technology and equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as: • standards of data transfer; • image quality; • bandwidth - speed for loading images, time delay for discussions; • inter-hospital compatibility / cross-site co-ordination etc. This specification is kept under review and updated in light of technological advances.			
2.2.3	There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.			

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3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.1.1.	MDT meetings take place regularly (as set out in Manual of Cancer Services).			
3.1.2.	MDT meetings are held during core hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.			

Preparation prior to MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.2.1.	Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with			

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	metastatic disease/recurrence should take place.			
3.2.2.	There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency..			
3.2.3.	Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.			
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.			
3.2.5.	A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-			

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	morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.			
3.2.6.	Members know what information from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.			

Organisation/administration during MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.			
3.3.2.	A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and			

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	radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings in all cases.			
3.3.3.	There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.			
3.3.4.	Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a			