• Pain Management – 219 patients, longest wait 22-weeks; *(SBA over performing)* • Endo-Diabetes – 125 patients, longest wait 37-weeks; *(SBA over performing)* • Respiratory – 167 patients, longest wait 25-weeks; *(SBA underperforming)* • Rheumatology - 447 patients, longest wait 38-weeks; *(SBA over performing)* • Paediatric – 4 patients, longest wait 17-weeks; *(SBA over performing)* • Gynaecology – 568 patients, longest wait 27-weeks; *(SBA over performing)* • Gastroenterology (including General Medicine) – 148 patients, longest wait 27-weeks. *(SBA underperforming)* • Breast Family History – 1 patient, longest wait 26-weeks (due to cancellation of clinics due to Consultant bereavement leave) *(SBA over performing)* • Haematology – 7 patients, longest wait 17-weeks *(SBA over performing)* In respect of patients waiting in excess of 9-weeks at end of February there are a total of 16,053 patients (14,941 consultant-led and 1,112 ICATS). 9,534 (8,254 consultant-led and 1,100 ICATS) of these relate to specialty areas that require to achieve 9-weeks. The decision taken in July by HSC to temporarily "pause" sending any additional patients to the Independent Sector for assessment or treatment, revised levels of in-house additional capacity in Q1/2 and no allocation for additional outpatient capacity in Q3/4 has resulted in increased gaps between demand and capacity which will continue to grow and contribute to deteriorating access standards. The Trust is monitoring the performance against SBA to ensure that this is optimised and does not account for growth in access times. Discussions are on-going with the Commissioner in respect of the future management of Ophthalmology. In the meantime SHSCT will	

still report on the two visiting specialties of Ophthalmology and Paediatric Cardiology for completeness.

Two external (visiting specialties) in excess of 15 weeks were Ophthalmology – 2,404 patients, longest wait 49-weeks; and Paediatric Cardiology – 109 patients, longest wait 52-weeks.

A summary of projected access times for month-end January and year-end March is attached in Appendix 2.

Action to Address:

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance.
- Head of Service level performance meetings are held with Paediatrics fortnightly to review both Acute and Community performance. Agreed SBAs are reviewed at these meetings, with remaining SBAs under review.
- Discussions have commenced to develop a project plan to review chronological management practices within the Acute Services Division. This project will review current chronological management practices and will also identify underlying issues ie. consultant practice; administrative errors; short notice booking etc. An action plan will then be developed to implement necessary changes to improve the chronological management, where required.

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
<9-weeks	72% (13633)	67.7% (14316)	69.1% (15232)	62% (14738)	55.1% (13461)	57.5% (14090)	56.8% (14521)	52.8% (13625)	47.7% (12692)	45.5% (12504)	46.9% (13327)		**R**	↓
>15-weeks	4.53% (859)	8.34% (1763)	8.76% (1930)	14.5% (3453)	17.3% (4236)	18.7% (4578)	21.4% (5473)	24.7% (6378)	28% (7477)	32% (8731)	34% (9527)		**R**	↓

OUT-PATIENT REVIEWs Patient waiting beyond their clinically indicated timescales: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

Comments:

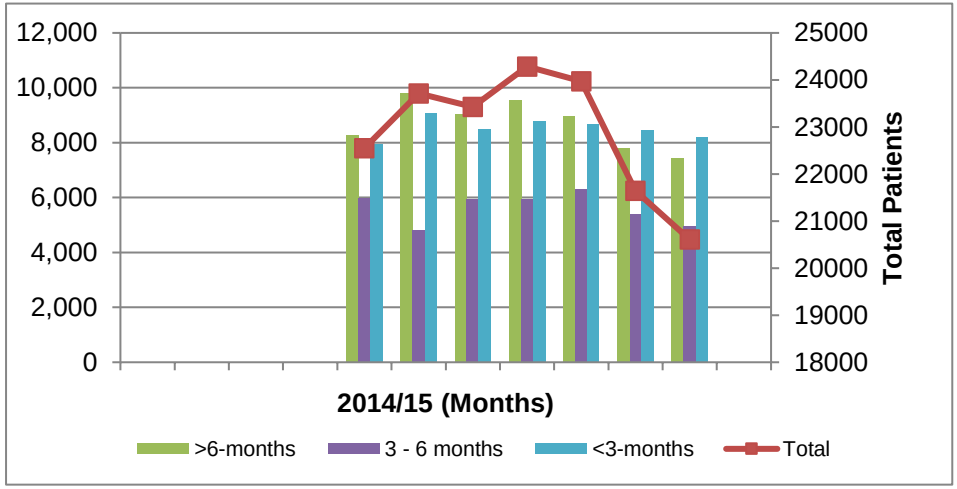
Of the 20,608 patients waiting for review appointments beyond their clinically indicated date :

- 36% (7455) of these are waiting in excess of 6-months;
- 24% (4958) of these are waiting between 3 – 6 months; and
- 40% (8195) waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal funding initiatives, has seen the cohort of patients waiting over 6 months decrease by over 1500 from December to February as per the red line on the chart.

Action to Address:

- Arrangements in place to minimise risk and ensure reviews with high clinical priority take place in accordance with the clinically indicated timescale;
- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- Trust has sought engagement with Primary Care via the SLCG to consider potential solutions in the absence of additional funding options to address backlog;
- Trust has commenced a validation programme to review patients waiting beyond their clinically indicated date. This plan includes both data and patient validation. This has been funded by Trust until March 2015; and
- Funding has in additional been provided by the Trust to provide addition capacity for patients waiting beyond their clinically indicated date. This temporary additional capacity will be directed towards



the longest waiting review patients over the next three months.	

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Total					22552	23715	23431	24286	23970	21645	20608		R	↑
>6-months					8284	9811	9028	9563	8970	7798	7455			
3 – 6 months					5970	4823	5919	5944	6325	5384	4958			
<3-months					7931	9081	8484	8779	8675	8463	8195			
No timescale listed					367	259	272	238	240	231	258			

CP 11: ELECTIVE CARE DIAGNOSTICS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

From April 2014, no patient waits longer than 9-weeks for a diagnostic test and all urgent diagnostic tests are reported on within two-days of the test being undertaken.

Baseline: Diagnostic Testing – 740> 9 weeks (@ 31 March 2014 – 665 Imaging and 75 Non-Imaging)
Endoscopy – 103> 9 weeks (@ 31 March 2014)
Imaging DRTT – 87% < 2 days (2013/2014)
Non-Imaging DRTT – 94% < 2 days (2013/2014)

TDP Assessment: Likely to be achieved with some delay / partially achieved

Standard: Diagnostic Testing 9-weeks
Endoscopy 9-weeks
DRTT 2 days

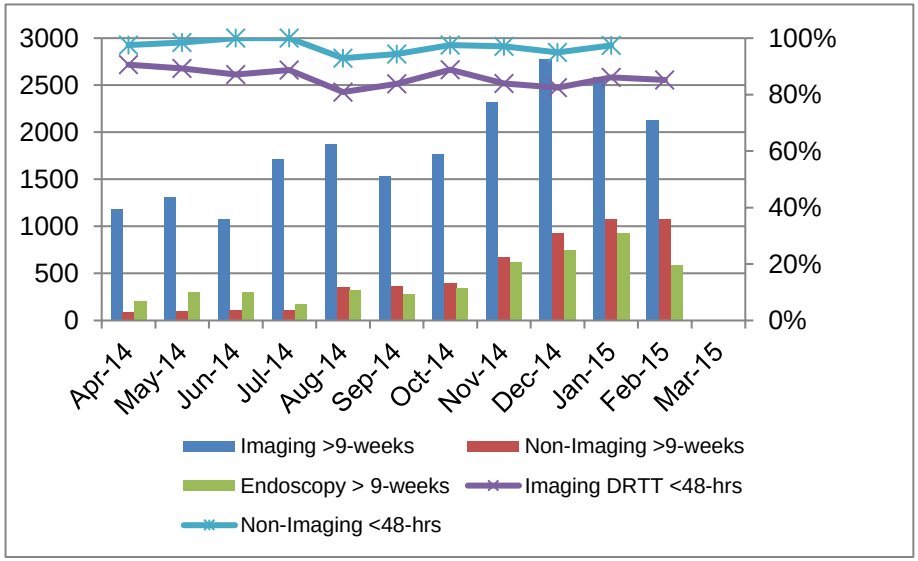
Comments:

- **Imaging** – Demand continues to increase with greater capacity gaps presenting. Whilst diagnostic imaging continues to perform well, against the SBA, capacity is not sufficient to provide for all routine examinations and focus is therefore on in-patients, red flag and urgent patients. HSCB has confirmed additional non-recurrent funding for additional capacity for MRI, CT, non-obstetric ultrasound and plain film reporting in Q3/4.

  Additional capacity will not be sufficient to see the achievement of 9 weeks by March. The estimated best position, subject to no increase is demand is
  - CT: General 13-weeks; CTC 33-weeks
  - MRI: 13-15-weeks
  - Non-Obstetric Ultrasound: 15-17-weeks

  Action to Address:
  - Trust has secured the continuation of the leased MRI mobile facility to accommodate the additional volumes funded non-recurrently by HSCB for Q3/4 and until at least the end of April 2015. It is estimated that the new MRI scanner will be commissioned and in place by June 2015 which should increase capacity for 15/16;
  - Trust has confirmed the allocation of funding and additional activity it can undertake in Q3/4 to HSCB and additional work has commenced; and
  - The Trust has secured capacity within the Independent Sector to increase the volume of CT that can be undertaken; and
    The Trust is developing an investment proposal for additional CT capacity and is in liaison with HSCB re options for an interim mobile solution in 15/16 funded non-recurrently

- **Non-Imaging** – Of the 1084 patients in excess of 9-weeks at the end of February



there are 105 within Urodynamics (Urology) and 979 Cardiac Investigations.

Within Cardiac Investigations it is Echocardiogram examinations, both general (TTE) and Stress (DSE) that are in excess of the 9-week access standard. Whilst the volumes in excess of 9-weeks are increasing, associated with a general demand for cardiology input, it should be noted that at the end of January the SBA was over-performing.

The longest waiter at the end of February was 50-weeks in Urodynamics and it is anticipated that the access time will be 52-weeks at end March 2015.

Actions to Address

- Trust has committed additional funding in year to increase capacity for a range of cardiac investigations which should see an improvement in this position.
- Trust has highlighted increase demand related to cardiac investigations to the commissioner; the commissioner has agreed a capacity gap exists in this service. The Trust awaits confirmation of next steps.

January performance across the Region demonstrates a total of 22,299 waiting in excess of 9-weeks for Imaging and Non-Imaging, ranging from 735 (WHSCT) to 8,911 (BHSCT). The SHSCT has 3,661 which equates to 16.4% of the total waiting in excess of 9-weeks.

- **Endoscopy** – HSCB confirmed a level of additional capacity for endoscopy in Q3/4 which will decrease the routine wait but will not see achievement of 9 weeks. The Trust has committed further funding for additional capacity which will see the access time reduce to an estimated 18-weeks by March 2015. Demand continues to present challenges in maintaining waits for urgent patients and those waiting for repeat procedures.

  Action to Address:

  - Whilst the Trust had previously submitted an IPT for a Nurse Endoscopist, following discussion with HSCB / SLCG and in light of an agreed revised capacity gap the Trust has submitted, at the end of September, a high level proposal paper to meet the gap with 2 Nurse Endoscopists and additional medical-led sessions. Outcome of potential in-year investment is awaited; and
  - Trust has secured capacity both in-house and in the Independent Sector to provide additional capacity in-year funded by HSCB and internally.

A summary of <u>projected</u> access times for month-end February and year-end March is attached in Appendix 2.

- **Diagnostic Reporting** – **Imaging** – **see table below**
- **Diagnostic Reporting – Non-Imaging** – Update not available

January performance across the Region varies from 87% (SHSCT) to 97% (NHSCT and SEHSCT), with an average of 92%.

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Imaging >9-wks	1190	1307	1075	1720	1876	1535	1769	2326	2772	2583	2130		**R**	↓
Non-Imaging >9-wks	91	104	112	115	359	366	396	672	925	1079	1084		**R**	↓
Endos. >9-wks	210	300	304	170	321	285	348	623	752	933	594		**R**	↓
Imaging DRTT Urgents <48-hrs	90.6% (2468 out of 2724)	89.3% (2548 out of 2853)	87.1% (2572 out of 2953)	88.7% (2843 out of 3205)	80.9% (2249 out of 2779)	83.9% (2608 out of 3108)	88.8% (2701 out of 3042)	84% (2417 out of 2877	82.5% (2412 out of 2924	86.1% (2792 out of 3242)	85.2% (2546 out of 2988)		**R**	↓
Non-Imaging DRTT Urgent <48-hrs	97.6% (160 out of 164)	98.5% (130 out of 132)	100% (156 out of 156)	100% (136 out of 136)	92.9% (130 out of 140)	94.4% (151 out of 160)	97.6% (202 out of 207)	97.1% (136 out of 140)	94.9% (168 out of 177)	97.4% (189 out of 194)	N/A		**Y**	⇔

Note: Amendment to January data

CP 12: ELECTIVE CARE IN-PATIENTS AND DAY CASES: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

From April 2014, at least 80% of in-patients and day-cases are treated with 13-weeks and no patient waits longer than 26-weeks.

Baseline: 69% <13-weeks (@ 31 March 2014)
252 >26-weeks (@ 31 March 2014)

TDP Assessment: Achievable, dependent upon additional funding being available

Target: 80% <13-weeks
0 >26-weeks

Comments:

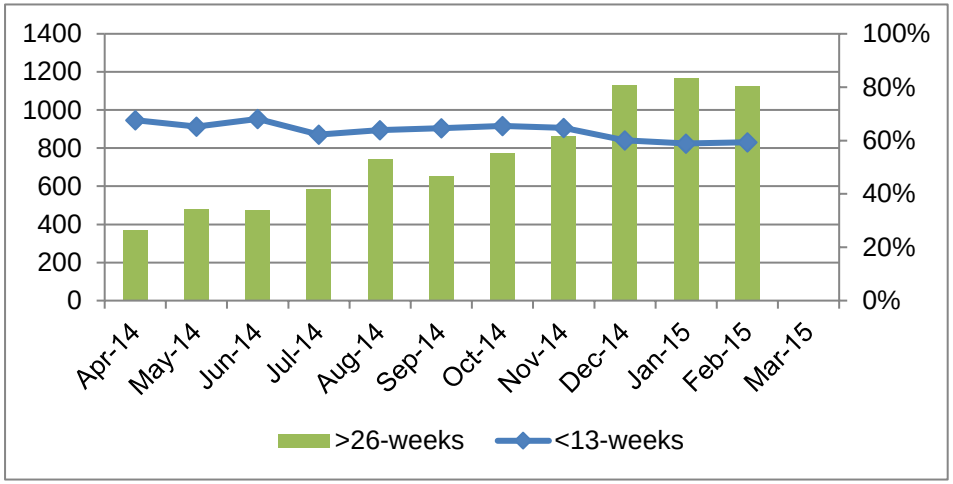
In respect of patients waiting in excess of 13-weeks there is a total of 2,973 patients at end February. 358 of these relate to specialty areas that require to achieve 13-weeks by March 2015, whilst the remaining 2,615 relate to specialty areas where the backstop target has been agreed as a maximum of 26-weeks.

Regionally, January average performance was 54% with performance varying from 42% (BHSCT) to 77% (NHSCT) of patients waiting less than 13-weeks. January performance across the Region demonstrates a total of 11,090 patients waiting in excess of 26-weeks with SHSCT accounting for 10.6% (1,173) of those waiting.

At the end of February the following specialties were in excess of the maximum 26-week backstop:

- General Surgery – 302 patients – longest wait 45-weeks; *(SBA underperforming)*
- Breast Surgery – 3 patients – longest wait 36-weeks; *(SBA over performing)*
- Gynaecology – 29 patients – longest wait 40-weeks; *(SBA underperforming)*
- Pain – 170 patients – longest wait 40-weeks; *(SBA over performing)*
- Urology – 269 patients – longest wait 82-weeks; *(SBA underperforming)*
- Orthopaedics – 355 patients – longest wait 59-weeks. *(SBA underperforming)*
- Gastroenterology – 5 patients – longest wait 29-weeks

One external (visiting specialty) in excess of 26 weeks was Opthalmology – 1 patient, longest wait 29-weeks.



The decision taken in July by HSC to temporarily "pause" sending any additional patients to the Independent Sector for assessment or treatment, revised levels of in-house additional capacity in Q1/2 and no allocation for additional outpatient capacity in Q3/4 has resulted in increased gaps between demand and capacity which will continue to grow and contribute to deteriorating access standards. The Trust is monitoring the performance against SBA to ensure that this is optimised and does not account for growth in access times. HSCB has made arrangements for patients waiting for treatment in the Independent Sector, previously paused, to continue their treatment.

A summary of projected access times for month-end February and year-end March is attached in Appendix 2.

Actions to Address:

- Focus remains on the delivery of core SBA activity with the bi-weekly Director level performance meetings undertaken with the Acute Services Directorate. These meetings review and challenge the SBA performance and access delivery and are utilised to agree remedial action required to improve the areas of underperformance; and
- Discussions have commenced to develop a project plan to review chronological management practices within the Acute Services Division. This project will review current chronological management practices and will also identify underlying issues ie. Consultant practice; administrative errors; short notice booking etc. An action plan will then be developed to implement necessary changes to improve the chronological management, where required.

	Monthly Position (Excluding Scopes):												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
<13-weeks	67.6% (4336)	65.2% (4161)	68.1% (4239)	66.2% (4061)	63.9% (3858)	64.6% (3977)	65.5% (4155)	64.7% (4132)	60.1% (3904)	58.9% (3829)	59.4% (3872)		R	↓
>26-weeks	5.75% (369)	7.6% (482)	7.6% (473)	9.5% (585)	12.3% (742)	10.6% (653)	12.2% (776)	9% (864)	17.4% (1130)	17.9% (1167)	17.3% (1128)		R	↓

CP 13: HEALTHCARE ACQUIRED INFECTIONS: Lead Director Mr John Simpson, Medical Director

By March 2015, secure a further reduction of x% in MRSA and Clostridium Difficile infections compared to 2013/2014.

Baseline: MRSA – 5
C Diff – 31

TDP Assessment: To be confirmed

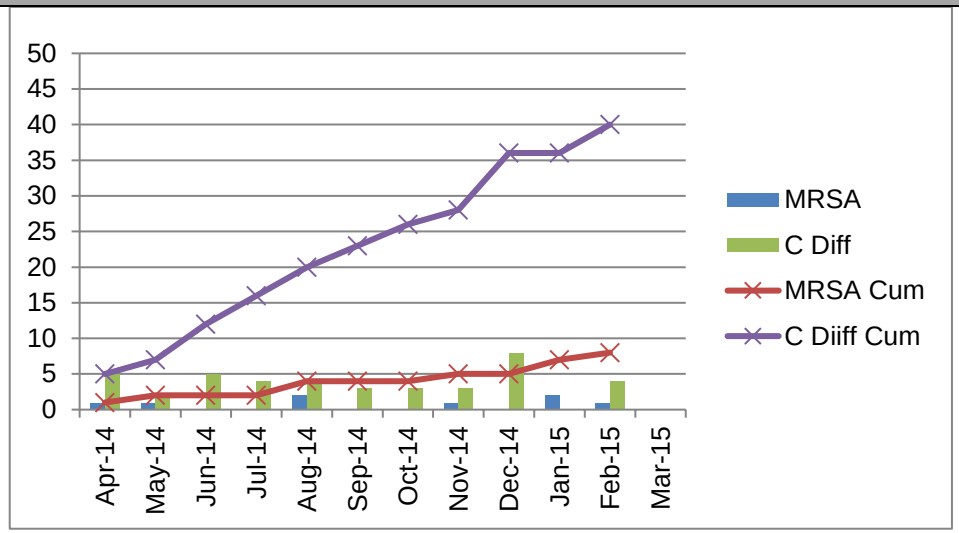
Target: MRSA - 3
C Diff - 32

Comments:

MRSA:
Cumulative Regional performance, April to January, demonstrates +11 (+26%) actual cases against target (42) with 53 cases in total recorded Regionally. 4 out of 5 Trusts are demonstrating levels beyond their profiled target.

C Diff:
Cumulative Regional performance, April to January, demonstrates +83 (+34%) actual cases against target (242) with 325 cases in total reported Regionally. All Trusts are demonstrating levels beyond their profiled target.

Further information on the HCAI rates is provided within the Medical Director's Trust Board Report.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MRSA Actual	1	1	0	0	2	0	0	1	0	2	1		R	↓
MRSA Cum	1	2	2	2	4	4	4	5	5	7	8			
C Diff Actual	5	2	5	4	4	3	2	3	8	0	4		R	↓
C Diff Cum	5	7	12	16	20	23	25	28	36	36	40			

CP 15: SPECIALIST DRUGS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

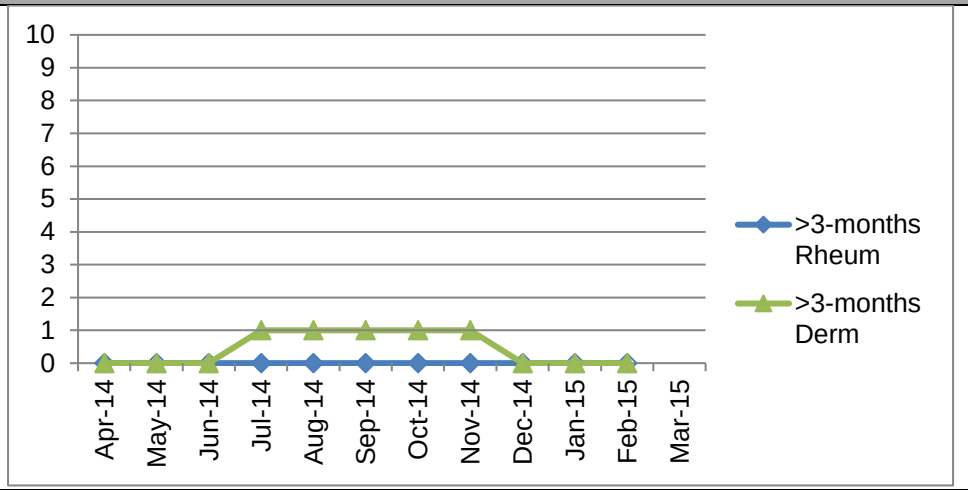
Baseline: Rheumatology – 0 >3-months (@ 31 March 2014)
Dermatology – 0 >3-months (@ 31 March 2014)

TDP Assessment: Achievable, dependent upon additional funding

Comments:

Rheumatology & Dermatology – A revised offer against the joint IPT for Biologic Therapies and the recurrent elective Rheumatology gap has been received and a plan for implementation is currently being developed.

Inflammatory Bowel Disease (IBD) – Whilst not contained within the Commissioning Plan Targets and Standards there is another specific are of funding for Anti-TNF treatments that the Trust participates in. This is for IBD ie. Crohn's disease and Ulcerative Colitis. At present there are 47 patients on Anti-TNF treatment for Crohn's disease and 20 patients on Anti-TNF treatment for Ulcerative Colitis.



	Apr											Mar		Trend
>3-months Rheum	0	0	0	0	0	0	0	0	0	0	0		**G**	↔
>3-months Derm	0	0	0	1	1	1	1	1	0	0	0		**Y**	↔

CP 16: STROKE PATIENTS: Lead Director Mrs Deborah Burns, interim Director of Acute Services

From April 2014, ensure that at least 12% of patients with confirmed Ischaemic stroke receive thrombolysis.

Baseline: 10.5% (April to December 2013)
TDP Assessment: Achievable

Target: 12%

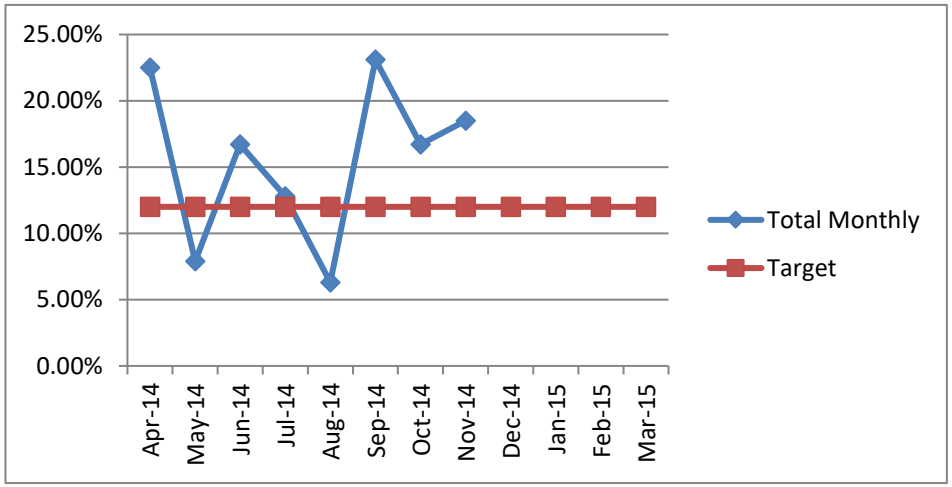
Comments: Reporting three months in arrears.
Up to the end of November 15.3% of patients with confirmed ischaemic stroke received thrombolysis which is above the target of 12% at this point of the year.

Monthly performance against this target is impacted by the variable presentation of strokes, which is affected both seasonally and geographically. It should be noted that as strokes vary in type they will vary in time presentation and whilst no patient has been missed, clinical decisions will determine whether the drug is to be delivered considering the risks and benefits. Reviewing the performance data on an annual basis will demonstrate the performance taking into consideration the seasonal differences and atypical presentations.

Regionally, cumulative performance (April to October) varies from 14% (SEHSCT and NHSCT) to 29% (WHSCT) with a Regional average of 17%.

Actions to Address:

- A 24/7 Consultant-led service is in place;
- Review of time from scanning to reporting with a view to reducing this ongoing;
- Close monitoring of door to need time out of hours; and
- Seeking improvement in communication with and feedback to NIAS.



Site	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		

Trust	22.5%	7.9%	16.7%	12.8%	6.3%	23.1%	16.7%	18.5%					**G**	⇔
Trust Admissions	A 40 T 9	A 38 T 3	A 30 T 5	A 39 T 5	A 32 T 2	A 26 T 6	A 30 T 5	A 27 T 5						
Trust Cumulative	-	-	-	-	-	-	-	15.3%						
CAH	13.3%	3.6%	12.5%	4.3%	11.8%	10.5%	9.5%	15.8%					**Y**	⇔
CAH Admissions	A 30 T 4	A 28 T 1	A 24 T 3	A 23 T 1	A 17 T 2	A 19 T 2	A 21 T 2	A 19 T 3						
CAH Cumulative	-	-	-	-	-	-	-	9.9%						
DHH	50%	20%	33.3%	25%	0%	57.1%	33.3%	25%					**G**	⇔
DHH Admissions	A 10 T 5	A 10 T 2	A 6 T 2	A 16 T 4	A 15 T 0	A 7 T 4	A 9 T 3	A 8 T 2						
DHH Cumulative	-	-	-	-	-	-	-	27.2%						

Note: September / October data updated, based on updated clinical coding levels

Note: Stroke: A = Stroke Admissions / T = Patients Who Had Thrombolysis Administration

CP 17: PRESSURE ULCERS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

By March 2015, secure a 10% reduction in pressure ulcers in all adult in-patient wards.

Baseline: 63
TDP Assessment: Achievable

Target: 10% reduction (57)

Comments: Reporting quarterly – (Quarter 3 data not available until 26/2/15 in line with HSCB reporting schedule)

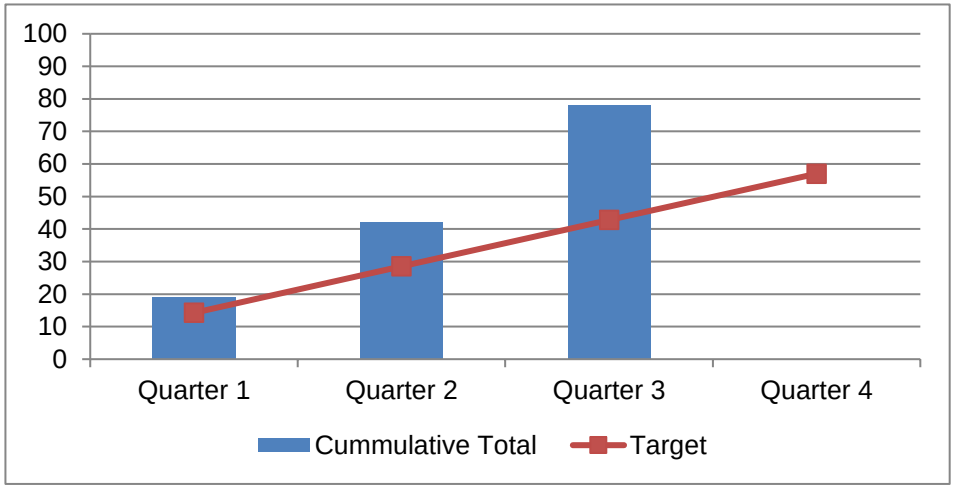
The Trust has 35 reported cases of pressure ulcers above the profiled target of 43 at the end of December 2014.

Regional cumulative performance at the end of Quarter 3 reflected 139 cases beyond the profile, equating to + 28%. 3 out of 5 Trusts reflected a position above the profiled target reduction.

It is recognised regionally that an expected increase in pressures ulcers reported is anticipated associated with increased awareness.

Actions to Address:

- The 'Patient Safety Cross' tool along with appropriate nursing documentation, relating to pressure ulcers, is in use in all Acute and Non-Acute wards since October 2014.
- Nursing education/training has been implemented to support the use of the patient safety cross tool and documentation via a series of workshops focused on recognition, grading and management of pressure ulcers.
- The Trust is considering spread of the project into key adult mental health wards in 2015/16 which is beyond the regional requirements.



	Quarterly Position:				Cum Assess	Trend
	Quarter 1	Quarter 2	Quarter 3	Quarter 4		
Trust Quarterly	19	23	36		R	↑
Trust Cumulative	19	42	78			

CP 18: MEDICINES FORMULARY: Lead Director Mrs Deborah Burns, Interim Director of Acute Services	
From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Target:** 70%

Comments:

Resources and systems are not available to permit a full audit of compliance, however, the Trust is complying with the Regional Formulary and PCE Guidance and by way of assurance has undertaken in-patient prescribing audits on six key areas between April – October 2013 and provided a report on the position to HSCB.

The Trust has, in agreement with HSCB, undertaken to submit audit data on a Chapter of the Formulary once per quarter, for in-patients only with Quarter 1 and 2 2014/15 data now submitted. In addition some small targeted audits of outpatient prescribing/recommendations are taking place. To date all the audits submitted have achieved above the HSCB target of 70% compliance.

Monthly Position:												Cum Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Not Available													

MINISTERIAL PRIORITY: TO IMPROVE THE MANAGEMENT OF LONG-TERM CONIDIONS IN THE COMMUNITY, WITH A VIEW TO IMPROVING THE QUALITY OF CARE PROVIDED AND REDUCING THE INCIDENCE OF ACUTE HOSPITAL ADMISSIONS FOR PATIENTS WITH ONE OR MORE LONG-TERM CONDITIONS

CP 19: ALLIED HEALTH PROFESSIONALS: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2014, no patient waits longer than 9-weeks for referral to commencement of AHP treatment.

Baseline: 234 (@ 31 March 2014)
TDP Assessment: Unlikely to be achieved / affordable

Standard: 0

Comments:

In line with new regional guidance reporting was re-instated for AHPs focusing on Physiotherapy, Occupational Therapy (OT) and Dietetics in July. In October full AHP reporting was re-instated for all professions. New reporting arrangements are being embedded in line with revised regional definitions to ensure robust reporting.

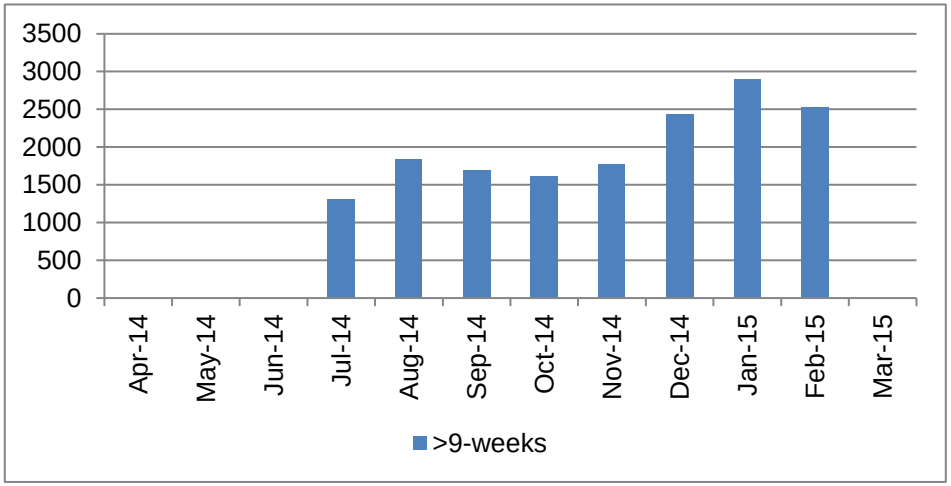
January performance across the Region varies with a total of 18,006 patients in excess of 9-weeks, ranging from 664 (SEHSCT) to 5,625 (BHSCT). SHSCT account for 16% (2,879) of the Regional total of patients waiting in excess of 9 weeks.

At the end of February the following professions were in excess of the 9-week access standard:

- Dietetics – 40-weeks (249 (10%) patients waiting >9 weeks)
- Occupational Therapy (OT) – 31-weeks (370 (15%) patients waiting >9 weeks)
- Physiotherapy – 21-weeks (327 (13%) patients waiting >9 weeks)
- Podiatry – 22-weeks (828 (33%) patients waiting >9 weeks)
- Speech and Language Therapy (SLT) – 28-weeks (748 patients (30%) >9 weeks)
- Multidisciplinary Team AHPs – 11-weeks (5 patients > 9 weeks)

Areas of particular note include:

- Paediatric specialist areas, including OT, dietetics and SLT where manpower issues coupled with demand/demography is particularly



Note: Data represented in graph is for all AHP professions

affecting access times;
- Podiatry services are also challenge by demand beyond capacity; and
- Reviews and treatments beyond their clinically indicated timescale has become an increasing challenge throughout a range of AHP areas and arrangements have been established for reporting of these patients monthly to ensure visibility.

Actions to Address:
- Monthly AHP performance meetings in place with representative from Operational Directorates;
- Additional capacity has been funded by Trust to target review and treatments beyond the clinically indicated timescales and additional temporary staff are in place in Paediatric SLT, OT, Dietetics and podiatry
- Plans focused on reducing longest waits in paediatric and learning disability OT are in place and options to secure additional capacity to reduce longest waits in other areas continue to be explored.
- Internal review of AHP on-going with fortnightly Director-led meetings. Actions plan in place focusing on corporacy, benchmarking staffing and highlighting areas of un-commissioned activity; and
- Trust has sought an update from HSCB/PHA on work to establish capacity, in the form of new SBA, and capacity/demand analysis which has been completed, in order to identify and agree capacity gaps and consider next steps.

Monthly Position:													Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
>9-weeks* (3 Professions)	Reporting suspended			606	700	627	Reporting all Professions from October onwards							
>9-weeks# (All Professions)	Reporting suspended			1304	1837	1696	1611	1773	2437	2890	2527		R	↓

* Note: Reported volumes for July, August and September includes only 3 professions ie. Physiotherapy; Occupational Therapy and Dietetics.
# Note: Reported volumes from October onwards includes all Professions and MDTs

CP 20: TELEHEALTH: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

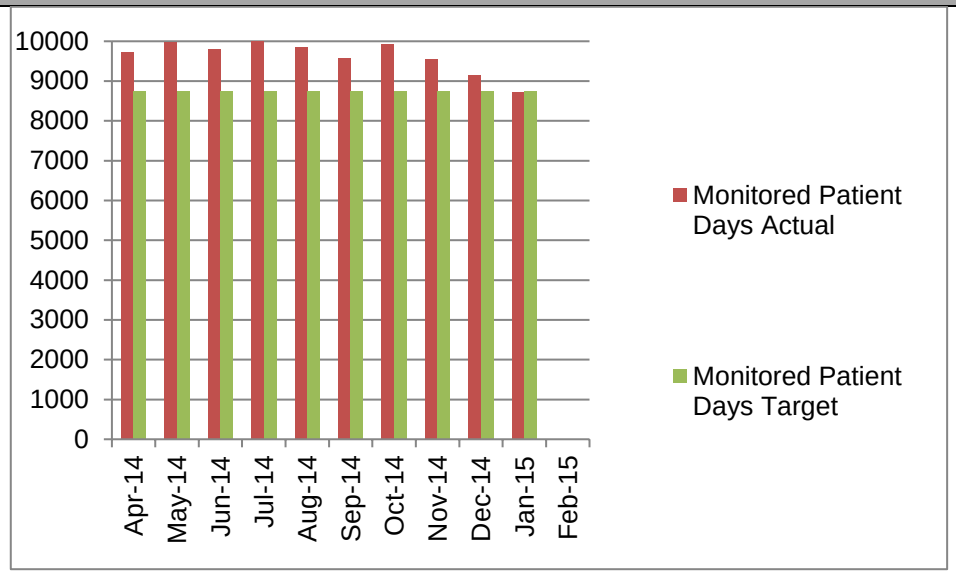
By March 2015, deliver 500,000 Monitored Patient Days Regionally (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.

Baseline: 94,797
TDP Assessment: To be confirmed

Target: To be confirmed

Comments: Reporting one month in arrears.

For the first time this year, the target for monitored patients' days was not delivered.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Actual Monitored Patient Days	9718	9978	9805	10056	9842	9586	9922	9541	9143	8715			G	↔
Target Monitored Patient Days	8750	8750	8750	8750	8750	8750	8750	8750	8750	8750				

CP 21: UNPLANNED ADMISSIONS: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions (using 2012/2013 data as the baseline).

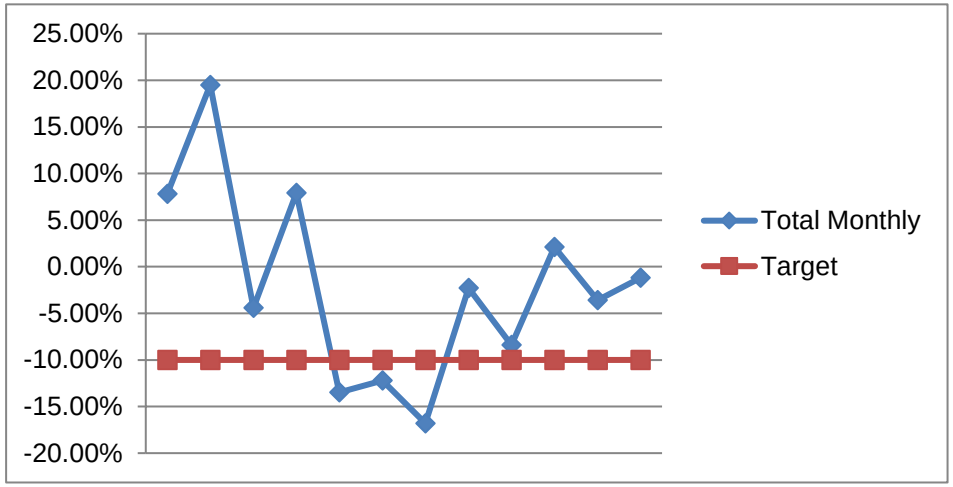
Baseline: 1931 admissions
TDP Assessment: Achievable

Target: 5% reduction
1834 admissions

Comments: Reporting three months in arrears.
As of 1 April 2014 the total conditions specified within this target include COPD, diabetes, heart failure, asthma; and stroke.

The projected level of admissions, based on the cumulative admission to date is 1737. This level appears to be on track to achieve the target of 1834 when profiled on a straight line, however this position is likely to be affected by seasonal variation. Admission for the specific conditions are likely to up to 10% greater between Dec – March than over the rest of the year.

Individually COPD, Asthma and Stroke are on track to meet the -5% reduction at this stage.



	Monthly Position: *(Note: Long-term conditions admissions figures: T = Target / A = Actual In-Year)*												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Total Actual Admissions	141	137	119	129	141	146	159	161						
Target Admissions (to achieve -5% below baseline)	155	148	136	125	146	136	157	155						
Cumulative & % variance against the Target Volume	-	-	-	-	-	-	T 1003 A 972	T 1158 A 1133					**R**	

MINISTERIAL PRIORITY: TO PROMOTE SOCIAL INCLUSION, CHOICE, CONTROL, SUPPORT AND INDEPENDENCE FOR PEOPLE LIVING IN THE COMMUNITY, ESPECIALLY OLDER PEOPLE AND THOSE INDIVIDUALS AND THEIR FAMILIES LIVING WITH DISABILITIES

CP 22: CARERS' ASSESSMENT: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

By March 2015, secure a 10% increase in the number of carers' assessments offered.

Baseline: 704 offered (@ March 2014)
TDP Assessment: Achievable

Target: Increase by 10% (774 offered)

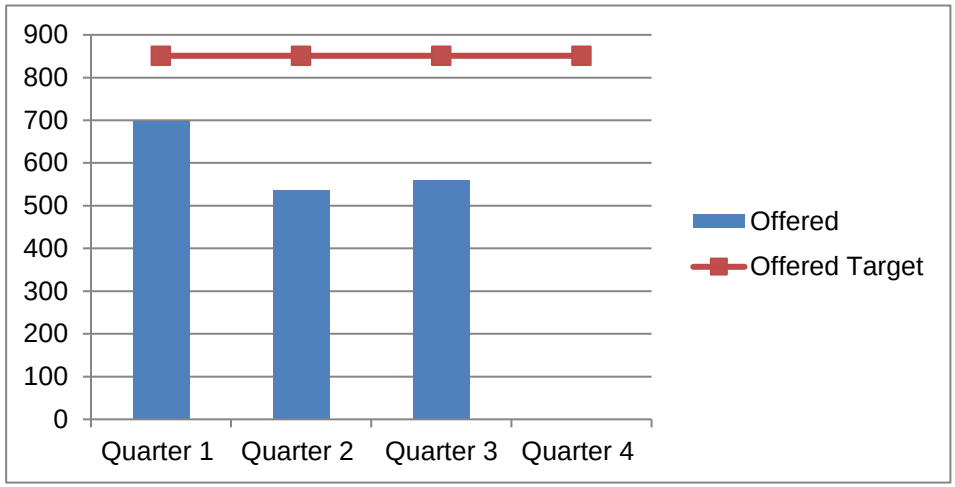
Comments: Reporting quarterly.

It is of note that the target is particularly challenging for the Trust. The target was set on the QE March baseline of 704 offers, however, this was the highest quarterly position achieved in the previous two years (at least 119 higher than any other period) and is unlikely to be representative. The achievability of this target is questionable and all areas are struggling to achieve. The only area on track to achieve the target is children's services where the baseline was initially lower.

Regional performance at Quarter 3 demonstrates a 14.3% decrease (2513) in the number of carers assessment offered in comparison to Quarter 4 2013/2014 (2933).

Actions to Address:

- The Trust has established a 'Carers Reference Group' at which each Directorate is represented by a 'Champion'.
- The CYPS Directorate has further established a 'Young Carers Group'.
- On-going awareness raising with relevant staff about requirements regarding Carers Assessments.



						Trend
				Quarter 4 (January to		
Offered	697	537	560	No update		↓

CP 23: DIRECT PAYMENTS: Lead Director Mr Miceal Crilly, Interim Director of Mental Health and Disability

By March 2015, secure a 5% increase in the number of direct payments across all programmes of care.

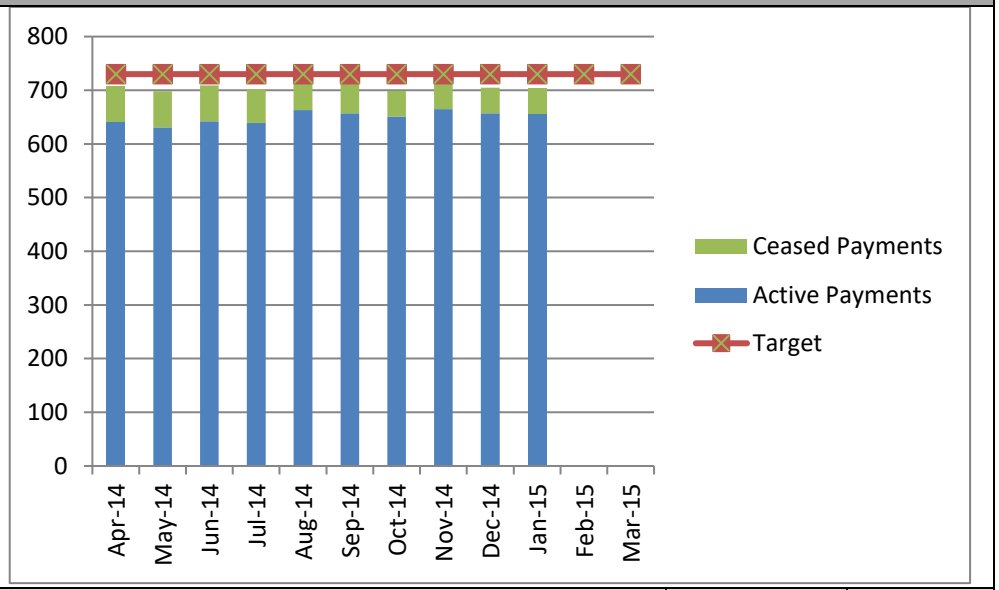
Baseline:631 active + 64 ceased payment = 695 (March 2014 CC8)
TDP Assessment: Achievable

Target: Increase by 5% (730)

Comments: February update not available
This target is made up of active payments and payments which were previously made and ceased within the quarter.

Information is available monthly on the active payments, however is only available at the quarterly point for ceased payments. Therefore the performance can accurately be measured at each quarter end.

Regionally there were 2,895 direct payments against the target at the end of Quarter 3, with the SHSCT accounting for 24% of this volume. Only 1 (WHSCT) out of 5 Trusts are on track at this stage to achieve the profiled target.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust total	708	698	709	702	726	720	699	713	707	703	No update		Y	↔
Trust Ceased (Quarterly only)	67			63			48			Using Q3 as proxy for Q4 (48)				
Trust Active (Monthly)	641	631	642	639	663	657	651	665	657	655	No update			

Breakdown by Programme of Acute Payments														
Primary Health & Adult Community	0	0	0	0	0	0	0	0	0	0				
Physical & Sensory Disability	176	167	176	173	176	174	173	177	174	173				
Mental Health	50	49	50	51	51	52	50	52	54	53				
Learning Disability	251	250	251	255	264	267	264	269	265	270				
Elderly	164	165	165	160	172	164	164	167	164	169				

CP 24: TELECARE: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.

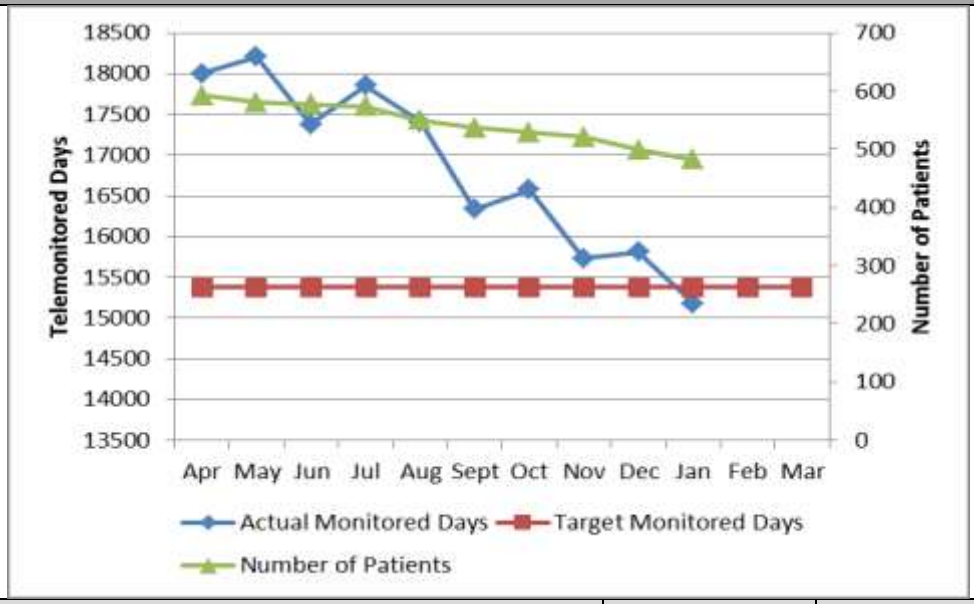
Baseline: To be confirmed
TDP Assessment: To be confirmed

Target: 184,506 monitored patient days (507 patients)

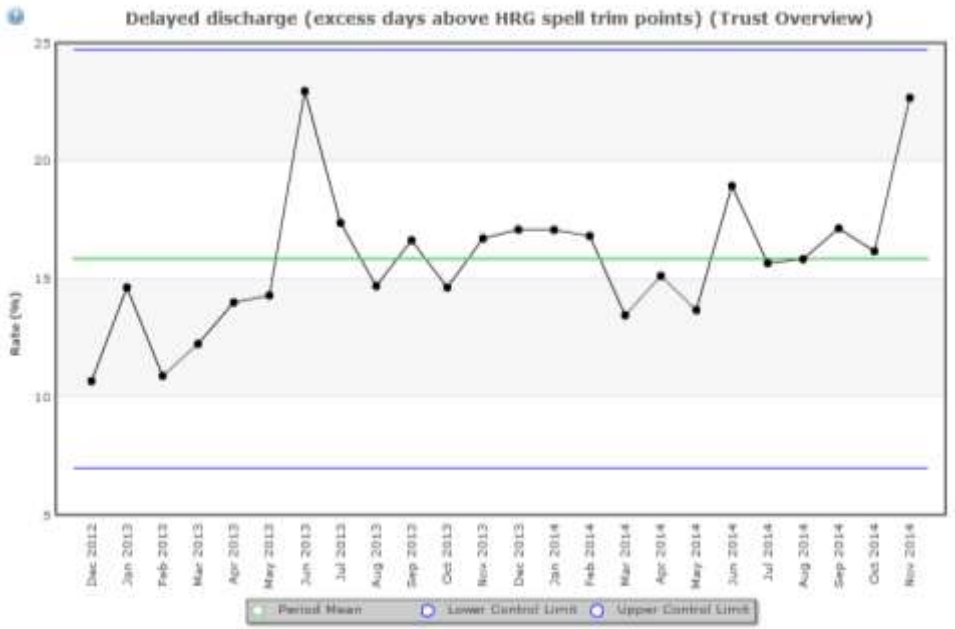
Comments: Reporting one month in arrears.
Information provided by Older Persons and Primary Care Directorate as outlined below.

Information to monitor this target is sourced from Fold, the contracted provider. Work is ongoing to try and improve the timeliness of information flows from this third party.

The Southern Trust share of Regional Target equates to 184,506 monitored patient days which is equivalent to 507 patients.



Monthly Position:													Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Actual Monitored Days	18000	18206	17375	17852	17408	16336	16576	15729	15809	15180			G	↓
Target Monitored Days	15376	15376	15376	15376	15376	15376	15376	15376	15376	15376				
Number of Patients	593	581	578	574	550	537	529	521	499	482				

CP 29: UNNECESSARY HOSPITAL STAYS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services	
By March 2015, reduce the number of excess beddays for the Acute Programme of Care by 10% (using 2012/2013 data as the baseline).	
Baseline: To be confirmed **TDP Assessment:** To be confirmed	**Target:** Reduce by 10%
Comments: Reporting three months in arrears. HSCB information against this target demonstrates April to October performance with a Regional average of -1% with performance varying across the Trusts from +45% (SHSCT) to -22% (SEHSCT). CHKS, the comparative benchmarking system, measures excess beddays against the Top Hospital peers. Whilst this definition and the comparators are different from that used by HSCB as it is based on expected length of stay at condition level calculated for the payment by results (PbR) methodology adopted in England, it is a useful guide to peer performance. CHKS utilises information on 'spells' which will include the aggregated length or stay (beddays) in a patients total journey in the hospital system, including acute and non-acute hospital episodes and transfers across hospital sites. Information available using CHKS data, April to November 2014, demonstrates the Trust with excess beddays of 16.5% against the HES Peer Average of 15.1%. Peer benchmarks against the 25th Percentile and 75th Percentile are 17.1% and 12%. The chart opposite demonstrates a timeline analysis of excess beddays at Trust level over the last two years.	

Monthly Position:													Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		

HSCB Data	+45% (3,274 excess beddays)						R	

CP 30: CANCELLED CLINICS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services	
By March 2015, reduce the number of hospital cancelled consultant-led out-patient appointments by 17%.	
Baseline: 15235 (2012/2013) **TDP Assessment:** Likely to be achieved with some delay / partially achieved	**Target:** Reduce by 17% (12645)

Comments:

Regional performance, April to January demonstrates a significant increase in the number of cancelled appointments, with a total of 144,016 cancellations, which equates to +20% above the profiled reduction target. In January the SHSCT volume of cancellations equated to 9.95% of the Regional total.

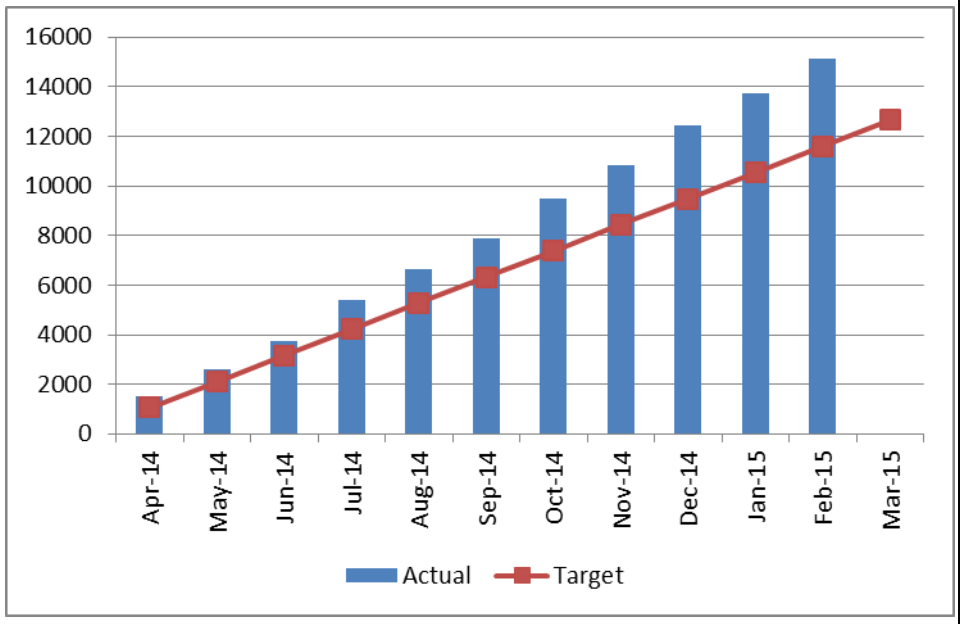
As an outcome of a Short Life Working Group, at the request of the Health Committee, work has been undertaken to ascertain the level of cancellations that had a direct impact on patients.

April to January demonstrated that 65,208 out of 144,016 cancellations had a direct impact on patients. This equates to 45.3% of the total cancellations. The SHSCT volume of cancellations equated to 10% (6,786) of the total 65,208 cancellations.

The SHSCT volume of cancellations that had a direct impact on patients (6,786) equated to 47.4% of the total SHSCT cancellations (14,330).

Action to Address:

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



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust Monthly Cancellations	1531	1086 (Cum 2617)	1101 (Cum 3718)	1662 (Cum 5380)	1245 (Cum 6625)	1251 (Cum 7876)	1618 (Cum 9494)	1350 (Cum 10884)	1593 (Cum 12437)	1268 (Cum 13705)	1404 (Cum 15109)		R	↔
Total Attendance	18085	18174	19762	18231	16780	21794	20888	18982	18061	20202	19141			
% Cancellation in Month	7.8%	5.6%	5.3%	8.4%	6.9%	5.4%	7.2%	6.6%	8.1%	5.9%	6.8%			

Note: Amendments to June, August, September, October, November and December data

CP 31: PATIENT DISCHARGE: Lead Director Mr Miceal Crilly, Interim Director of Mental Health & Disability

From April 2014, ensure that 99% of all learning disability and mental health discharges take place within 7-days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

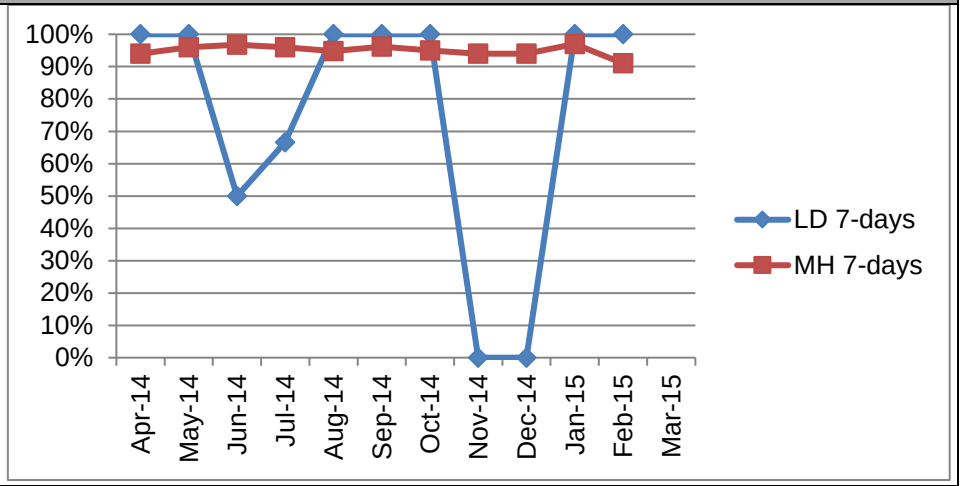
Baseline: LD – 72% (2013/2014)
MH – 95% (2013/2014)
TDP Assessment: To be confirmed

Standard: 99% 7-days
0 > 28-days

Comments:

Learning Disability – Regional performance in December demonstrates an average performance of 56% with performance varying across the Trusts from 0% (SHSCT) to 75% (NHSCT).

Mental Health – Regional performance in December demonstrates an average performance of 97% with performance varying across the Trusts from 94% (SHSCT) to 100% (NHSCT and SEHSCT).



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD 7-days	100% (2 out of 2)	100% (3 out of 3)	50% (1 out of 2)	66% (2 out of 3)	100% (2 out of 2)	100% (1 out of 1)	100% (0 out of 0)	0% (0 out of 2)	0% (0 out of 1)	100% (3 out of 3)	100% (1 out of 1)		**G**	↔
LD >28-days	0	0	1	0	0	0	0	1	1	0	0		**A**	↔
MH 7-days	94% (75 out of 80)	96% (104 out of 108)	97% (122 out of 126)	96% (118 out of 123)	94.8% (111 out of 117)	96.2% (126 out of 131)	95% (95 out of 100)	94% (120 out of 127)	94% (94 out of 100)	97% (108 out of 111)	91% (80 out of 88)		**Y**	↔
MH >28-days	4	1	2	2	1	2	1	1	3	2	3		**A**	↔

CP 31: PATIENT DISCHARGE: Lead Directors Mrs Deborah Burns, Interim Director of Acute Services and Mrs Angela McVeigh, Director of Older People & Primary Care

From April 2014, ensure that 90% of complex discharges from an Acute Hospital take place within 48-hours, with no complex discharge taking more than 7-days; and all non-complex discharges from an Acute Hospital take place within 6-hours.

Baseline: Non-Complex 6-hours – 93.3% (2013/2014)
Complex 48-hours – 98.1% (2013/2014)
All Discharges 7-days – 99.7% (2013/2014)
TDP Assessment: Achievable

Standard: Non-complex 6-hours 100%
Complex 48-hours 90%
All discharges 7-days 100%

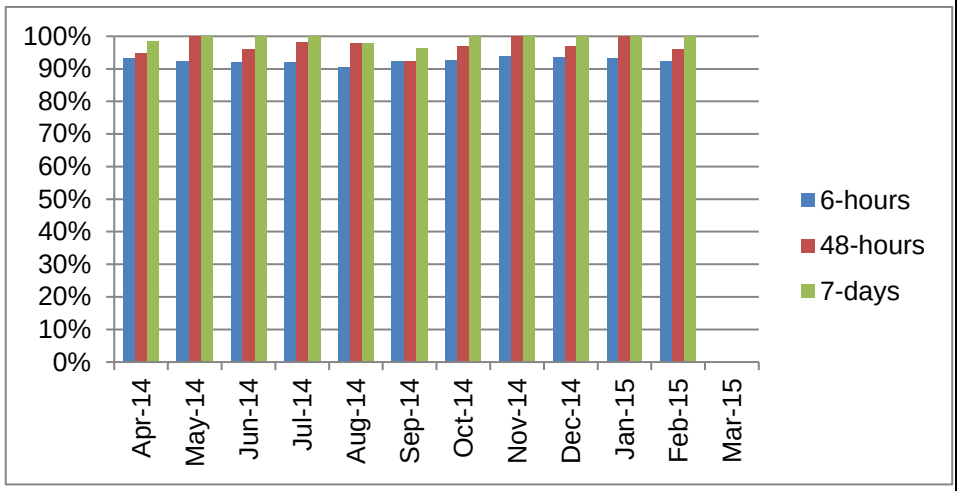
Comments:

Non-Complex Discharges – Performance against the 6-hour standard remains challenging and is affected by a number of challenges:

- Conflicting pressures on staff, causing delays in discharge letters and discharge scripts;
- Delays in discharge transportation;
- Issues with re-starting community packages;
- Issues with delivery of community equipment;
- Families being able to collect relatives or be at home to receive them

Actions to Address:

- An Admission & Discharge Steering Group has been established with a work plan focussing on 3 main areas:
  - Use of the Information Hub, so that Acute and Community staff are aware of existing services to patients;
  - Medication; and
  - Equipment.
- An increased focus on discharges before 1.00pm, which will in-turn assist with improving the 6-hour performance.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
6-hours	93.2% (1999 out of 2146)	92.2% (1950 out of 2114)	92% (1804 out of 1960)	92% (1924 out of 2087)	90.6% (1807 out of 1994)	92.1% (1929 out of 2095)	92.5% (2023 out of 2186)	93.8% (1894 out of 2019)	93.6% (1984 out of 2119)	93.1% (1668 out of 1792)	92.3% (1647 out of 1784)		A	⇔
48-hours	94.9% (56 out of 59)	100% (51 out of 51)	96.1% (49 out of 51)	98.2% (55 out of 56)	97.9% (49 out of 50)	92.9% (52 out of 56)	96.8% (61 out of 63)	100% (56 out of 56)	96.7% (87 out of 89)	100% (84 out of 84)	96% (72 out of 75)		G	⇔
7-days	98.31% (58 out of 59)	100% (51 out of 51)	100% (51 out of 51)	100% (56 out of 56)	97.9% (49 out of 50)	96.4% (54 out of 56)	100% (63 out of 63)	100% (56 out of 56)	100% (90 out of 90)	100% (84 out of 84)	100% 75 out of 75)		Y	⇔

Note: Amendment to July, December and January data

MINISTERIAL PRIORITY: TO ENSURE THE MOST VULNERABLE IN OUR SOCIETY, INCLUDING CHILDREN AND ADULTS AT RISK OF HARM ARE LOOKED AFTER EFFECTIVELY ACROSS ALL OUR SERVICES

CP 32: LEARNING DISABILITY / MENTAL HEALTH: Lead Director Mr Miceal Crilly, Interim Director of Mental Health & Disability

By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.

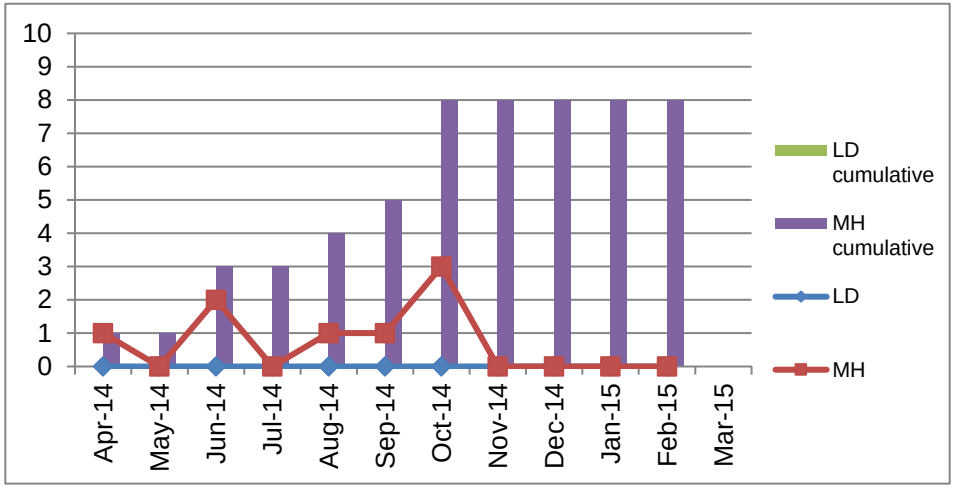
Baseline: Learning Disability – 30 (2013/2014)
Mental Health – 6 (2013/2014)
TDP Assessment: Learning Disability – Achievable
Mental Health – Achievable

Target: Learning Disability - 1
Mental Health – 10 (7 SHSCT & 3 Non-SHSCT)

Comments:

2014/15 targets for resettlement confirmed as 1 for Learning Disability and 10 for Mental Health. The Mental Health target relates to 7 SHSCT patients & 3 SHSCT residents currently residing in SEHSCT facilities.

- **Learning Disability** – One single target patient remains to be resettled, from Muckamore.
- **Mental Health** – The end of March 2015 target has been adjusted and is now reduced to 8 patients to be resettled. All 8 patients have now been resettled and the target for March 2015 is fully achieved.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
LD	0	0	0	0	0	0	0	0	0	0	0			
LD Cumulative	0	0	0	0	0	0	0	0	0	0	0		Y	↔

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
MH St Lukes	1	0	2	0	1	1	0	0	0	0	0			
MH Downshire	0	0	0	0	0	0	3	0	0	0	0			
MH Cumulative	1	1	3	3	4	5	8	8	8	8	8		**G**	⇔

CP 33: MENTAL HEALTH SERVICES: Lead Director Mr Miceal Crilly, Interim Director of Mental Health & Disability

By April 2014, no patient waits longer than 9-weeks to access child and adolescent mental health services; 9-weeks to access dementia services; and 13-weeks to access psychological therapies (any age).

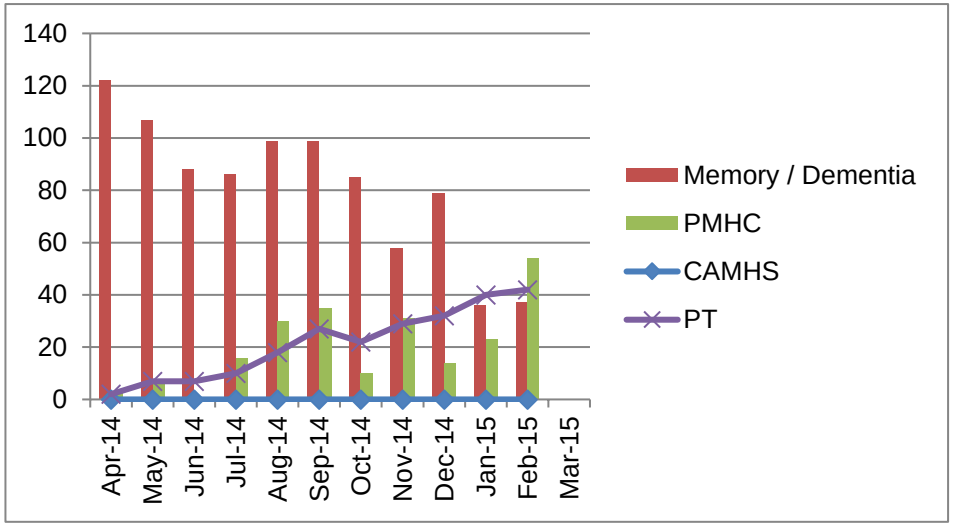
Baseline:	CAMHS – 0 (@ 31 March 2014) PMHC – 0 (@ 31 March 2014) Dementia Services – 74 (@ 31 March 2014) Psychological Therapies – 0 (@ 31 March 2014)	**Target:**	CAMHS 9-weeks PMHC 9-weeks Dementia Services 9-weeks Psychological Therapies 13-weeks
TDP Assessment:	CAMHS – Achievable PMHC – Achievable Dementia Services – To be confirmed Psychological Therapies – Achievable		

Comments:

- **Primary Mental Health Care –** Key issues relate to an increase in referrals equating to 33% over the past 6 months, with a 50% rise in referrals prioritised as "urgent" within this cohort. In addition the service is facing capacity issues associated with sickness absence. The service anticipates an increase in access time with 97 patients in excess of 9 weeks by end of March 2015.

  Action to Address
  - Service have undertaken analysis and prepared an action plan to mitigate as far as possible the anticipate impact on performance which includes
    - Refocus of internal resources with additional capacity established to try and mitigate the increase in referrals.
    - Procurement of additional capacity in the Independent Sector (post March 2015 due to procurement lag time
  - Position escalated to Commissioner.

- **Memory/Dementia Services** –New reporting arrangements have been established in January to bring reporting into line with regional definitions. The longest waits are for those patients triaged as requiring to access to the Consultant element of the multi-disciplinary service. Additional capacity for consultant activity has been put in place temporarily funded internally.



January performance across the Region demonstrates a total of 41 patients in excess of 9-weeks. 88% (36) of these relate to SHSCT patients with 12% (5) relating to WHSCT patients.

Action to Address:

- Whilst reporting has been revised there is ongoing work to look at recording and flows of information throughout the service. Work to establish capacity has been initiated. This will link into regional implementation of the Dementia Strategy which will look at capacity and demand issues.
- Additional temporary capacity has been put in place in the community response service and for consultant activity, funded by Trust..

- **Psychological Therapies** – Recruitment for the vacancies has been successful with 2 members of staff to commence in January and 1 further member of staff to commence in March.

  January performance across the Region demonstrates a total of 831 patients in excess of 13-weeks, ranging from 40 patients (SHSCT) to 477 patients (SEHSCT).

  Action to Address:

  - Head of Service level performance meetings are held with Mental Health Directorate monthly to review performance against the access standards. SBAs are under review for this area and when agreed a monitoring process will require to be implemented.

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
CAMHS	0	0	0	0	0	0	0	0	0	0	0		G	↔
Memory / Dementia	122	107	88	86	99	99	85	58	79	36	37		R	↔
PMHC	3	7	1	16	30	35	10	31	14	23	54		R	↓
PT	2	7	7	10	18	27	22	29	32	40	42		R	↓

OUT-PATIENT REVIEWs Patient waiting beyond their clinically indicated timescales: Lead Director Mr Miceal Crilly, Interim Director of Mental Health & Disability

Comments:

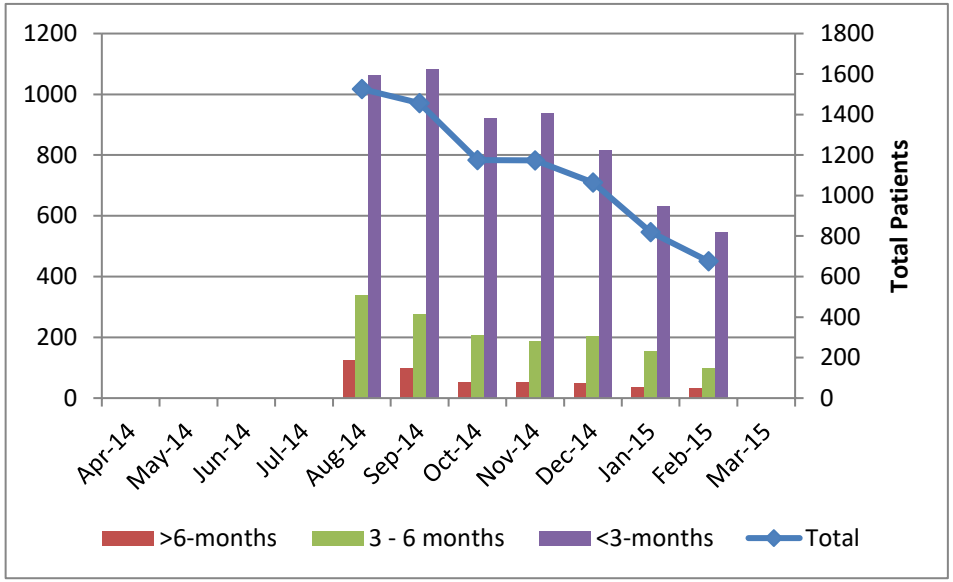
Of the 819 review patients waiting beyond their clinically indicated timescales:

- 4% (36) of these are waiting in excess of 6-months;
- 19% (155) of these are waiting between 3 – 6 months;
- with the remaining 77% (630) are waiting less than 3-months.

Focus on the longest waiters, with validation and additional capacity created via internal funding initiatives, has seen the cohort of patients waiting over 6 months decrease by over 700 from August to February as per the blue line on the chart.

Action to Address:

- Discussion paper submitted to HSCB and SLCG to highlight ongoing issues (July);
- Trust has sought engagement with Primary Care via the SLCG to consider potential solutions in the absence of additional funding options to address backlog; and
- Trust has ring-fenced additional temporary funding for additional capacity to be established in MHD to target patients beyond their clinically indicated timescale. Work is ongoing to consider how this can be put in place.



	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Total					1526	1456	1176	1174	1064	819			R	↑
>6-months					125	97	51	50	48	36				↑
3 – 6 months					339	277	206	188	202	153				↑
<3-months					1062	1082	919	936	814	630				↑

CP 34: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%

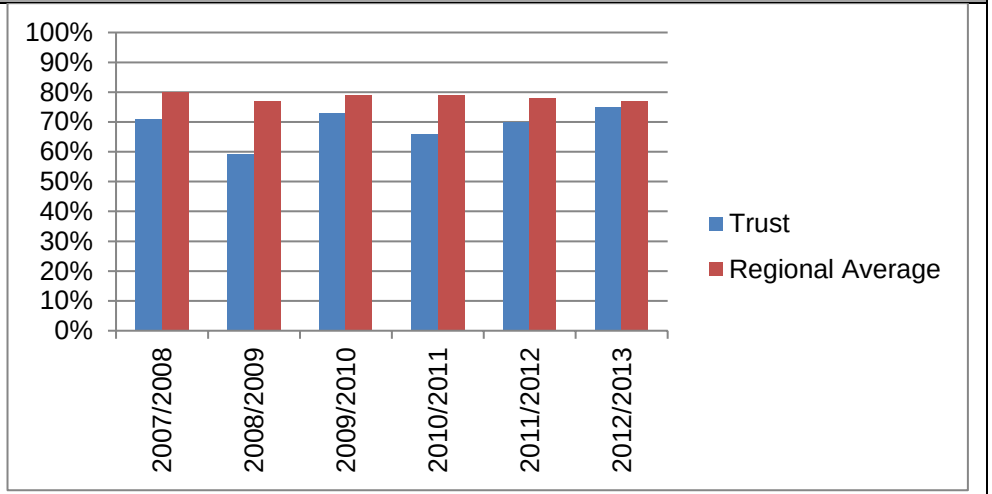
Baseline: To be confirmed
TDP Assessment: Achievable

Standard: Increase to 85%

Comment/Actions:

Information reported annually and therefore, will not be available until Quarter 1 2015/2016.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008 to 2012/2013. Trust performance in 2012/2013 was at its highest, for this 6-year period, at 75%. Trust performance is below the Regional average during all 6-years.



	Yearly Trend Position:						
	2007/2008	**2008/2009**	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**	**Trend**
Trust	71%	59%	73%	66%	70%	75%	⇔
Regional Average	80%	77%	79%	79%	78%	77%	⇔

CP 35: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

By March 2015, ensure a 3-year time frame for 90% of children who are to be adopted from care.

Baseline: To be confirmed
TDP Assessment: Achievable

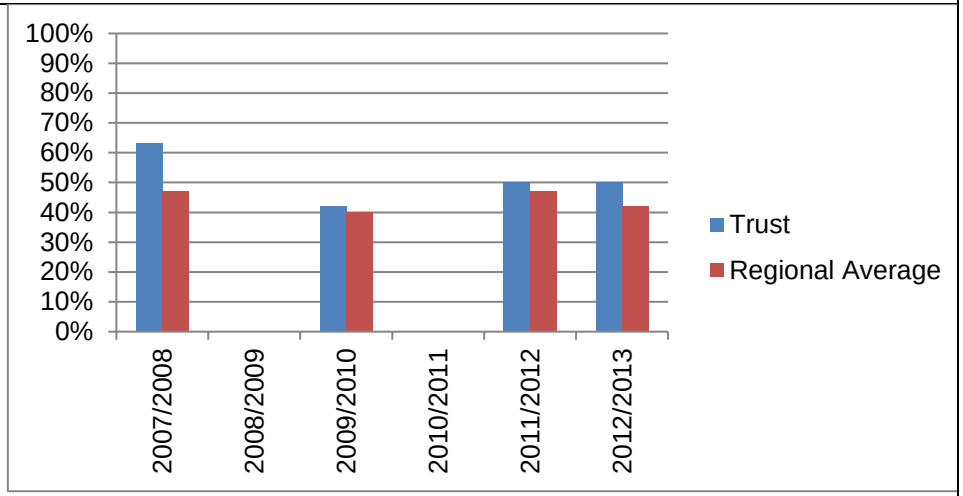
Standard: 3-Year Timeframe for 90%

Comment/Actions: Information reported annually and therefore, will not be available until Quarter 1 2015/2016.

Comment/Actions:

Information reported annually and therefore, will not be available until Quarter 1 2015/2016.

Detailed below is Trust and Regional performance (sourced from HSCB Trust Board Performance Report), against this standard, from 2007/2008; 2009/2010; 2011/2012; and 2012/2013. Trust performance during these 4-years has been in excess of the Regional average.



	Yearly Trend Position:						
	2007/2008	**2008/2009**	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**	**Trend**
Trust	63%	No data	42%	No data	50%	50%	⇔
Regional Average	47%	No data	40%	No data	47%	42%	⇔

CP 36: CHILDREN IN CARE: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services														
From April 2014, ensure that all school-age children who have been in care for 12-months or longer have a Personal Education Plan (PEP).														
Baseline: To be confirmed **TDP Assessment:** Achievable								**Standard:** 100% for 12-Months or Longer						
Comment/Actions: Information reported annually and therefore, will not be available until Quarter 1 2015/2016.														
Monthly Position:													**Cum Assess**	**Trend**
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**			
Not available until Quarter 1 2015/2016														

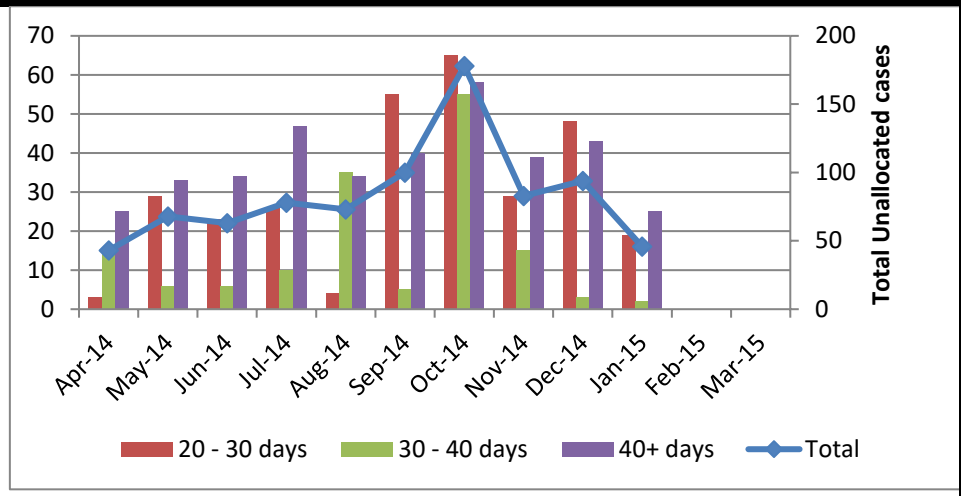
UNALLOCATED CHILD CARE CASES: Lead Director Mr Paul Morgan, Director of Children & Young Peoples Services

Comment/Actions: February Update not available

At 31 January 2015 there are a total of 46 unallocated child care cases in excess of 20-days, represented by the blue line, which is a significant improvement from the peak reported in October of 178.

41% (19) of these are waiting between 20 and 30 days; 4% (2) between 30 and 40 days; with 54% (25) in excess of 40-days.

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



	Monthly Position												
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Trend
Total	43	68	63	78	73	100	178	83	94	46	No update		↑
>20 - <30-days	3	29	23	26	4	55	65	29	48	19			
>30 - <40-days	15	6	6	10	35	5	55	15	3	2			
>40-days	25	33	34	47	34	40	58	39	43	25			

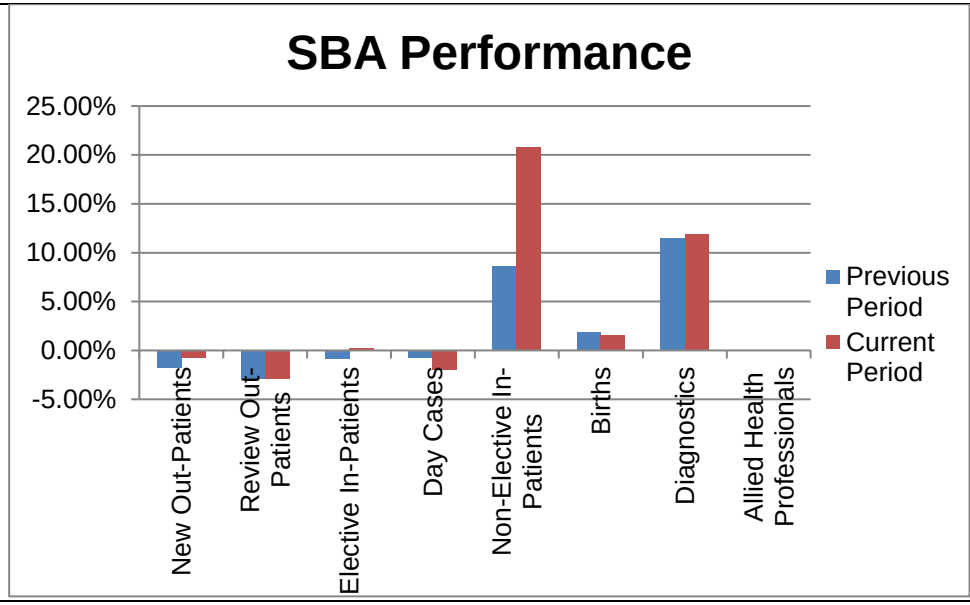
SBA PERFORMANCE SUMMARY FOR TRUST BOARD – MONTH END JANUARY 2015 APPENDIX 1

Total SBA Performance Per Activity Type (inclusive of newly agreed in-year uplifts):
Table 1 below provides a summary of the total performance against elective and non-elective SBA; this excludes visiting services where the Trust is not responsible for the SBA, a number of areas in Mental Health Directorate where SBAs require to be updated/agreed and activity related to daycentres and bedday contracts. AHPs are currently excluded from SBA analysis pending input from HSCB/PHA on new baselines.

This position as at end of January 2015 reflects a fairly static position in all areas with all areas performing above the - 5% tolerance limit. February data not yet available

Table 1

Activity Type*	Performance**	Trend
New Out-Patients	-0.75% (-500)	↓
Review Out-Patients	-2.87% (-3290)	↓
Elective In-Patients	-0.28% (-15)	↑
Day Cases	-1.98% (-524)[1]	↓
Non-Elective In-Patients	+20.80% (+5431)	↑
Births	+1.54% (+75)	↓
Diagnostics	+11.94% (+23785)	↑
Allied Health Professionals	SBA not yet agreed	-



* **Note:** SBA performance includes ASD; CYPS; and OPPC specialties, where robust SBAs are in place. MHD is excluded as robust SBAs are not yet developed.
** **Note:** SBA Performance 1/4/14 – 31/12/14.

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

[1] Note: Cardiology Cath Lab January activity not yet available – therefore, SBA performance will be subject to change

ANTICIPATED ACCESS TIMES
OUTPATIENTS

		Actual Access Time and Volume of Waits (by Time Band) at end of February 2015						
Specialty	**Access Standard or Backstop**	**Actual End of February 2015 position**	**Actual Volume of patients waiting in excess of backstop**	**Timebands (in weeks)**				**Estimated End of March 2015 position**
				15 - 20	**21 - 30**	**31 - 40**	**41 - 50**	**50 +**	
Anti-Coagulant	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Breast Family History	9-weeks	26-weeks	1	-	1	-	-	-	9-weeks
Cardiology	9-weeks	31-weeks	470	310	159	1	0	0	32-weeks
Cardiology ICATS	9-weeks								
Cardiology – Rapid Access Chest Pain	2-weeks	3-weeks	-	-	-	-	-	-	2/3-weeks
Chemical Pathology	9-weeks	9-weeks	-	-	-	-	-	-	13-weeks
Colposcopy	9-weeks	5-weeks	-	-	-	-	-	-	4-weeks
Community Paediatrics	9-weeks	30-weeks	27	9	18	0	0	0	9-weeks
Dermatology	15-weeks	40-weeks	1688	556	760	372	0	0	42-weeks
Dermatology ICATS	15-weeks								
Endocrinology / Diabetes	9-weeks	37-weeks	125	65	56	4	0	0	Diabetes 40-wks Endo 30-wks

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)					Estimated End of March 2015 position
				15 - 20	21 - 30	31 - 40	41 - 50	50 +	
ENT	9-weeks	25-weeks	673	663	9	0	0	0	29-weeks
ENT ICATS	9-weeks								
Gastro-enterology	9-weeks	27-weeks	148	136	12	0	0	0	24-weeks
General Medicine	9-weeks								
Geriatric Medicine	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Geriatric Medicine – OrthoGeriatric	9-weeks	46-weeks	41	13	10	13	5	0	45-weeks
General Surgery	9-weeks	21-weeks	262	236	26	0	0	0	24-weeks
Gynaecology	9-weeks	27-weeks	568	551	17	0	0	0	28-weeks
Haematology	9-weeks	17-weeks	7	7	0	0	0	0	22-weeks
Nephrology	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Neurology	9-weeks	29-weeks	450	213	237	0	0	0	34-weeks
Orthopaedics	13-weeks	36-weeks	770	318	390	62	0	0	38-weeks
Orthopaedics ICATS	9-weeks	42-weeks	445	421	23	0	1	0	24-weeks
Paediatrics	9-weeks	17-weeks	4	4	0	0	0	0	9-weeks
Pain Management	9-weeks	22-weeks	219	190	29	0	0	0	24-weeks

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)					Estimated End of March 2015 position
				15 - 20	21 - 30	31 - 40	41 - 50	50 +	
Rheumatology	15-weeks	38-weeks	447	156	210	81	0	0	42-weeks
Symptomatic Breast Clinic	9-weeks	2-weeks (Red Flag) & 12-weeks (routine)	-	-	-	-	-	-	2-weeks (Red Flag) & 9-weeks (routine)
Thoracic Medicine	9-weeks	25-weeks	167	142	25	0	0	0	30-weeks
Urology	9-weeks	53-weeks	1020	210	387	362	60	1	46-weeks
Urology ICATS	9-weeks								

IN-PATIENTS / DAY CASES

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)				Estimated End of March 2015 position
				26 - 40	41 - 60	61 - 80	80 +	
Breast Surgery	26-weeks	36-weeks	3	3	0	0	0	27-weeks
Cardiology	13-weeks	26-weeks	1	1	0	0	0	18-weeks
Community Dentistry	13-weeks	14-weeks	-	-	-	-	-	13-weeks
Dermatology	13-weeks	17-weeks	-	-	-	-	-	16-weeks
ENT	13-weeks	22-weeks	-	-	-	-	-	28-weeks
Gastro-enterology	13-weeks	29-weeks	5	5	-	-	-	TBC
General Surgery	26-weeks	45-weeks	302	289	13	0	0	50-weeks
Gynaecology	13-weeks	40-weeks IP & 13-weeks DC	29	29	0	0	0	38-weeks IP & 13-weeks DC
Haematology	13-weeks	13-weeks	-	-	-	-	-	13-weeks
Orthopaedics	26-weeks	59-weeks	355	218	137	0	0	62-weeks
Pain Management	26-weeks	40-weeks	170	170	0	0	0	40-weeks
Rheumatology	26-weeks	24-weeks	-	-	-	-	-	16-weeks
Urology	26-weeks	82-weeks	269	113	110	45	1	84-weeks

DIAGNOSTICS

Specialty	Sub Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)				Estimated End of March 2015 position
					9 - 13	13 - 21	22 - 26	26 +	
Endoscopy	-	9-weeks	28-weeks (routine) *(Actual 35-weeks)* 15-weeks (urgent)	594	224	264	83	23	18-weeks
Non Imaging	Audiology	9-weeks	9-weeks	-	-	-	-	-	9-weeks
	Cardiac Investigations		Total 9-weeks	979	550	420	89	0	TBC
	Echo		Echo 16-weeks	867	448	411	8	0	22-weeks
	Neurophysiology		9-weeks	-	-	-	-	-	9-weeks
	Respiratory Physiology		9-weeks	-	-	-	-	-	9-weeks
	Urodynamics (Urology)		50-weeks	105	22	36	11	36	46-weeks
	Urodynamics (Gynae)		9-weeks	-	-	-	-	-	<9-weeks
	Sleep Studies		9-weeks	-	-	-	-	-	9-weeks

Specialty	Sub Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)				Estimated End of March 2015 position
					9 - 13	13 - 21	22 - 26	26 +	
Imaging	Plain Film	9-weeks	< 9-weeks	-	-	-	-	-	< 9-weeks
	CT		CT (excl CTC) 23-weeks	801	294	368	125	14	CT:13-weeks CTC:34-weeks
	CTC		CTC 35-weeks						
	USS		13-weeks	788	761	27	0	0	15-weeks
	Dexa		15-weeks	325	229	96	0	0	16-weeks
	MRI		22-weeks	178	81	95	2	0	13-weeks
	Fluoroscopy			24	23	1	0	0	15-weeks
	Barium Enema			1	1	-	-	-	9-weeks
	Gut Transit Studies			-	-	-	-	-	9-weeks
	Obstetrics Ultrasound			-	-	-	-	-	9-weeks
	Radio Nuclide			-	-	-	-	-	9-weeks

MENTAL HEALTH AND DISABILITY

Specialty	Sub Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)					Estimated End of March 2015 position
					9 - 13	13 - 18	18 - 26	26 - 39	39 +	
Adult Mental Health Services	Primary Mental Health Care	9-weeks	13-weeks	54	53	1	0	0	0	12-weeks
	Memory / Dementia Services		29-weeks	37	16	8	6	7	0	39-weeks
CAMHS	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Learning Disability	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Psychiatry of Old Age	-	9-weeks	9-weeks	-	-	-	-	-	-	9-weeks
Autism	-	13-weeks	13-weeks	-	-	-	-	-	-	13-weeks
Psychological Therapies	-	13-weeks	27-weeks	42	28	12	2	0	0	28-weeks

ALLIED HEALTH PROFESSIONALS

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)			Estimated End of March 2015 position
				9 - 13	13 - 26	26 +	
Dietetics – Acute	9-weeks	9-weeks	-	-	-	-	9-weeks
Dietetics – Elderly and Primary Health Care	9-weeks	11-weeks	1	1	0	0	12-weeks
Dietetics – Paediatrics	9-weeks	39-weeks	282	36	145	101	42-weeks
Occupational Therapy – Acute	9-weeks	23-weeks	9	7	2	0	9-weeks
Occupational Therapy – Elderly and Primary Health Care	9-weeks	27-weeks	172	66	105	1	29-weeks
Occupational Therapy – Paediatric	9-weeks	34-weeks	136	39	77	20	35-weeks
Occupational Therapy – Physical Disability	9-weeks	18-weeks	56	24	32	0	28-weeks

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)			Estimated End of March 2015 position
				9 - 13	13 - 26	26 +	
Occupational Therapy – Learning Disability	9-weeks	14-weeks	9	8	1	0	9-weeks
Orthoptics	9-weeks	9-weeks	-	-	-	-	9-weeks
Physiotherapy – Adult	9-weeks	17-weeks	321	306	13	2	21-weeks
Physiotherapy – Paediatrics	9-weeks	18-weeks	20	15	4	1	15-weeks
Podiatry – Adult	9-weeks	25-weeks	710	255	455	0	21-weeks
Podiatry – Paediatrics	9-weeks	20-weeks	118	45	73	0	21-weeks
Speech & Language Therapy Elderly & Primary Health	9-weeks	21-weeks	2	1	1	0	9-weeks
Speech & Language Therapy Paediatrics	9-weeks	29-weeks	751	137	589	25	30-weeks

Specialty	Access Standard or Backstop	Actual End of February 2015 position	Actual Volume of patients waiting in excess of backstop	Timebands (in weeks)			Estimated End of March 2015 position
				9 - 13	13 - 26	26 +	
Speech & Language Therapy Physical Disability	9-weeks	9-weeks	-	-	-	-	9-weeks
Speech & Language Therapy Learning Disability	9-weeks	16-weeks	1	0	1	0	9-weeks

Southern Health and Social Care Trust

Quality Care - for you, with you

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2014/2015

INDICATORS OF PERFORMANCE

March 2015 for February 2015 Performance

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A10. Number of A & E presentations due to deliberate self-harm (self-harm/suicide attempt/ideation)	191	215	232	215	166	226	186	227	226	204	217	
A23. Uptake of seasonal flu vaccine by front-line health and social care workers.	Vaccination programme not yet commenced – commencing 1 October 2014						1205	66	42	34	No update	
A24. Note – Performance reported 1-month in arrears Admissions for Venous Thromboembolism.	Information report being developed by the Acute Information Team (March report)											
A25. Level of activity in maternity and child health programme of care including average length of stay.	Report to be developed – Head of Performance to discuss with Acute Information Team											
A26. Percentage of babies born by caesarean section and number of babies born in midwife-led units, either freestanding or alongside.	C-S 31.62% MLU 17.2%	C-S 26.43% MLU 13.2%	C-S 31.63% MLU 14.6%	C-S 34.96% MLU 14.1%	C-S 29.07% MLU 14.5%	C-S 31.17% MLU 14.6%	C-S 33.14% MLU 14.9%	C-S 30.27% MLU 14.7%	C-S 30.26% MLU 14.5%	C-S 37.71% MLU 13.8%	C-S 31.16% MLU 13.7%	C-S MLU
A28. Rate of each core contact with the pre-school child health promotion programme offered by health visitors												

QE June 2014	Number of Children reviewed	Number of children contact undertaken	Percentage rate of contact
4 year record review by Health Visitor	7029	1785	25.4%

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
A29. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.	April 2013 to April 2014 (CHKS): • Elective C-Section (only): Trust 16.34% Peer 10.79% • Emergency C-Section (only): Trust 17.57% Peer 14.99%											
B1. Number of red flag cancer referrals	742	816	935	862	821	956	967	926	890	882	931	
B2. Percentage of patients triaged at levels 1-5 of the Manchester Triage Scale at Type 1 or 2 emergency departments												
(a) Level 1	0.5%	0.4%	0.4%	0.5%	0.5%	0.4%	0.6%	0.5%	0.6%	0.6%	0.6%	
(b) Level 2	16%	15.5%	14.6%	14.3%	14.7%	16.2%	16.4%	18.6%	20.1%	18.6%	18.9%	
(c) Level 3	42%	43.5%	42.2%	42.5%	42.3%	42.5%	43.2%	45.6%	47.3%	48.4%	45.8%	
(d) Level 4	34%	34.8%	36.4%	37%	37.3%	35.3%	34.3%	32.4%	31%	31.7%	33.8%	
(e) Level 5	4.4%	4.4%	4.6%	4.5%	4%	4.6%	4.7%	1.9%	0.3%	0.4%	0.2%	
B3. Percentage of new and unplanned review attendances at emergency care departments waiting within timebands below before being treated or discharged and admitted												
(a) < 30 minutes	13.4%	15%	13.9%	15.9%	16%	14.3%	14.1%	13.7%	11.6%	11.6%	No update	
(b) 30 minutes – 1 hour	13.2%	14.2%	15.3%	15.1%	15.8%	15%	15.4%	14.8%	14.0%	14.4%		
(c) 1 – 2 hours	18.2%	20.1%	20.2%	20.6%	20.9%	20.1%	20.1%	23%	21.2%	20.1%		
(d) 2 – 3 hours	16.9%	19.3%	17.3%	19.3%	18.5%	19.3%	19%	20.8%	20.2%	19.4%		
(e) 3 – 4 hours	16%	15.6%	14.8%	15.8%	15.5%	17.4%	17.9%	16.8%	18.7%	17.8%		

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
(f) 4 – 6 hours	13.8%	11.8%	12.7%	9.5%	9.6%	9.6%	8.9%	7.6%	9.9%	10.8%		
(g) 6 – 8 hours	5.2%	3.1%	3.9%	2.7%	2.7%	2.9%	2.9%	2.2%	3.0%	3.5%		
(h) 8 – 10 hours	2%	0.7%	1.2%	0.7%	0.6%	1.1%	1.0%	0.7%	0.8%	1.2%		
(i) 10 – 12 hours	1.3%	0.1%	0.6%	0.3%	0.3%	0.4%	0.6%	0.4%	0.4%	1.0%		
(j) 12 hours or more	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
B7. Percentage of unplanned re-attendances at emergency departments within seven days of original attendance	5.9%	6%	6.5%	6.5%	6.9%	6.2%	6.4%	5.6%	5.4%	6.0%	6.5%	
B8. Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the A&E department, for admitted and non-admitted patients.	Information report being developed by the Acute Information Team – estimated timescale for availability 28 February 2015 (March report) – Information not available											
B9. Percentage of people who leave the emergency department before their treatment is complete.	4.6%	2.9%	3.7%	3.2%	2.6%	2.5%	2%	2%	2.8%	2.6%		
B10. Time from (i) arrival to initial assessment and (ii) initial assessment to treatment in emergency departments.	Information report being developed by the Acute Information Team – revised timescale for availability 31 March 2015 (April report)											
B12. Number of GP	7388	7822	7892	7588	6580	7803	8107	6975	6552	7479	7368	

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
referrals to consultant-led outpatient services.												
B13a. Number of out-patient appointments with procedures within pain management	52	54	60	75	46	86	125	73	92	83	19	
B13b. Number of out-patient appointments with procedures within gynaecology	796	713	932	879	798	1055	975	1006	981	320	667	
B13 c. Number of out-patient appointments with procedures within general surgery	198	153	217	180	176	240	216	217	228	173	185	
B13 d. Number of out-patient appointments with procedures within dermatology	0	0	0	0	0	0	0	0	0	0	0	
B14. Number of radiology tests (for discrete list of tests). **Note: Tests undertaken in core SBA sessions* *BE – Barium Enema* *CT* *MRI* *US – Non-obstetric* *Plain – Plain Film*	BE 38 CT 1613 MRI 517 US 3101 Plain 16275	BE 42 CT 1352 MRI 618 US 3118 Plain 16591	BE 56 CT 1805 MRI 645 US 3189 Plain 16736	BE 30 CT 1756 MRI 649 US 3010 Plain 16267	BE 28 CT 1386 MRI 582 US 2735 Plain 14380	BE 41 CT 1612 MRI 656 US 3436 Plain 16757	BE 43 CT 1936 MRI 609 US 3354 Plain 16547	BE 43 CT 1748 MRI 589 US 3203 Plain 15047	BE 43 CT 1710 MRI 556 US 2865 Plain 14545	BE 39 CT 1872 MRI 596 US 3084 Plain 15999	BE 25 CT 1889 MRI 590 US 2723 Plain 15429	BE CT MRI US Plain

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
B15. Total number of patients admitted for inpatient treatment in the independent sector	17	6	17	11	12	10	2	3	3	6	7	
B16a. Total number of attendances at consultant-led **new** outpatient services in the independent sector	56	23	152	158	162	8	0	1	0	0	0	
B16b. Total number of attendances at consultant-led **review** outpatient services in the independent sector	139	110	175	119	129	79	78	79	36	39	16	
B17. Note – Performance reported 3-months in arrears Number of patients admitted with stroke	40	38	30	39	32	26	30	27				
B18. Variation in death rate for emergency admissions (all diagnoses) comparing patients admitted at the weekend and patients admitted during the week	Information report to be developed by the Acute Information Team – timescale for availability (February report) – not yet available											
B19. Variation in death rate for emergency admissions comparing patients admitted at the weekend and patients admitted during the week for (i) heart attacks; (ii) heart	Information report to be developed by the Acute Information Team – timescale for availability (February report) – not yet available											

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
failure; (iii) stroke and (iv) aortic aneurysm												
B21. Percentage of all adult inpatient wards in which the Fall Safe bundle has been implemented.	Timescale for implementation of bundles on wards as follows: • 9 wards in July 2014; • 18 wards in September 2014; and • All 26 wards by November 2014 9 wards have commenced and are beginning to audit											
B22. Number of hearing aids fitted within 13 weeks as a percentage of completed waits.	100%	100%	98% (194 out of 197)	100%	100%	100%	100%	100%	100%	100%	100%	
B23. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).	7%	11%	6%	7%	4%	16%	22%	24%	24%	23%	4%	
B24. Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the OT assessment and options appraisal.	100%	100%	95% (18 out Of 19)	100%	96% (25 out Of 26)	100%	95% (20 out Of 21	100%	88% (21 out Of 24)	78% (7 out Of 9)	73% (11 out Of 15)	
B25. Level of prescribing compliance with the NI Formulary	The Trust has, in agreement with HSCB, undertaken to submit audit data on 2 Chapters of the Formulary once per quarter, for in-patients only. Agreement has been reached Regionally on a programme of chapters and when they are to be undertaken.											
B34. Percentage increase in access to cardiac catheterisation.	Information report to be developed by the Acute Information Team – timescale for availability not defined as Regional interpretation issues – as an interim the number of procedures undertaken is to be used											
Angio (A) PCI (P) Permanent Pacing (PP) Other (O)	Cum. A 51 P 66 PP 8 O 9	Cum. A 125 P 102 PP 16 O 16	Cum. A 233 P 146 PP 24 O 24	Cum. A 325 P 190 PP 33 O 34	Cum. A 404 P 237 PP 44 O 70	Cum. A 503 P 285 PP 52 O 104	Cum. A 609 P 330 PP 60 O 134	Cum. A 684 P 379 PP 57 O 182	Cum. A 789 P 434 PP 60 O 171	Cum. A 904 P 478 PP 66 O 193	Cum. A 1029 P 523 PP 72 O 215	

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
B35. Percentage of patients, where clinically appropriate, waiting less than 7 days for in-patient fracture treatment.	100%	100%	95.3% (61 out Of 64)	100%	98.5% (66 out Of 67)	98.2% (54 out Of 55)	97.8% (87 out Of 89)	98.5% (67 out Of 68)	91% (61 out Of 67)	94.6% (53 out Of 56)	96.6% (56 out Of 58)	
B36. Number of Emergency admissions for acute conditions which should not usually require hospital admissions.	Information report to be developed by the Acute Information Team (February report) – not yet available											
B37. Number and proportion of emergency admissions and readmissions for people aged 0 – 64 and 65+, (i) with and (ii) without a recorded long-term condition, in which medicines were considered to have been the primary or contributory factor.	Information report to be developed by the Acute Information Team – revised timescale (April report)											
C3. Note – Performance reported 1-month in arrears. Number of patients benefiting from remote telemonitoring	21	17	16	11	23	14	21	9	12	18		

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
D1.	Number of adults in receipt of day opportunities, by programme of care	Information reported annually and therefore, will not be available until Quarter 1 2015/2016 – Information Team to explore quarterly submission with information available for November report – Information not available											
D2.	Number of people eligible for social care services who are accessing self-directed support through a personal budget	Information reported annually and therefore, will not be available until Quarter 1 2015/2016 – Information Team to explore quarterly submission											
D3.	Number of older persons living in supported living facilities	Information was to be reported annually, however, monthly information is now available from July 2014.											
					11	11	12	12	9	9	9	No update	
D4.	**(i)** Number of people with continuing care needs waiting longer than five weeks for an assessment of need to be completed and (ii) Number of people with continuing care needs waiting longer than eight weeks, from their assessment of need, for the main components of their care needs to be met	(i) < 5-weeks – 100% (ii) <8-weeks – 100%			(i) < 5-weeks – 100% (ii) <8-weeks – 100%			(i) < 5-weeks – 100% (ii) <8-weeks – 100%					
D5.	Number of patients benefiting from the provision of telecare services.	593	581	578	574	550	537	529	521	499	482		

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
F1.	**Note – Performance reported 3-months in arrears.** Elective average pre-operative stay. **Note: Beddays used by elective admissions not on day of surgery – Reported 3-months in arrears*	60	59	71	36	23	56	73	58				
F2.	Average length of stay in acute programme of care.	Elect 2.82 Non-Elect 5.63	Elect 2.7 Non-Elect 5.05	Elect 3.09 Non-Elect 6.83	Elect 2.44 Non-Elect 6.63	Elect 2.39 Non-Elect 4.81	Elect 2.79 Non-Elect 5.07	Elect 2.91 Non-Elect 4.69	Elect 2.6 Non-Elect 5.06	Elect 2.4 Non-Elect 4.86	Elect 2.52 Non-Elect 5.29	Elect 2.52 Non-Elect 6.41	
F3.	**Note – Performance reported 3-months in arrears.** Average length of stay for stroke patients within the acute programme of care. **Note: Reported 3-months in arrears*	10.3%	10.6%	3.9%	10.4%	10.4%	11.2%	13.3%	12.6%	8.0%			
F4.	**Note – Performance reported 3-months in arrears.** Day surgery rate for each of a basket of 24 elective procedures. **Note: Reported 3-months in arrears*	65%	69%	62%	64%	67%	70%	70%					

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
F5.	Percentage of operations cancelled for non-clinical reasons.	1.1%	1.2%	1.2%	1.2%	1.1%	1.3%	1.4%	1.2%	1.4%	2.1%	1.8%	
F6.	**Note – Performance reported 3-months in arrears.** Percentage of patients admitted electively who have their surgery on the same day as admission. **Note: Reported 3-months in arrears*	92.78%	93.63%	92.97%	93.63%	93.85%	93.88%	93.74%	93.42%				
F7.	Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.	Imag. 94% Non-Imag. 98.5%	Imag. 95.2% Non-Imag. 99.9%	Imag. 93.4% Non-Imag. 98.7%	Imag. 86% Non-Imag. 97.3%	Imag. 89.7% Non-Imag. 98.6%	Imag. 93.9% Non-Imag. 98.8%	Imag. 96.3% Non-Imag. 99.5%	Imag. 97.5% Non-Imag. 99.9%	Imag. 95.8% Non-Imag. 99.8%	Imag. 95.9% Non-Imag. 99.9%	Imag. 96% Non-Imag. No update	Imag. Non-Imag.
F8.	Percentage of routine diagnostic tests reported within 4 weeks of the test being undertaken.	Imag. 99.5% Non-Imag. 99.8%	Imag. 99.6% Non-Imag. 99.9%	Imag. 99.4% Non-Imag. 99.1%	Imag. 96.5% Non-Imag. 97.9%	Imag. 96.7% Non-Imag. 99.9%	Imag. 98.6% Non-Imag. 99.0%	Imag. 98.9% Non-Imag. 99.5%	Imag. 99.4% Non-Imag. 99.9%	Imag. 99.5% Non-Imag. 99.8%	Imag. 99.0% Non-Imag. 100%	Imag. 99.4% Non-Imag. No update	Imag. Non-Imag.

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
F9. Ratio of new to review outpatient appointments attended **Note: N:R based on actual activity – not scheduled*	1: 1.9	1: 2	1: 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	1 : 2	
F10. Rate of New and Review outpatient appointments where the patient did not attend. **Note: Cons-Led OP Only*	N 6.2% R 6.9%	N 6.8% R 7.1%	N 6.0% R 7.0%	N 6.7% R 7.7%	N 6.0% R 7%	N 6.3% R 6.5%	N 5.9% R 6.6%	N 6.3% R 6.9%	N 7.2% R 6.7%	N 6.3% R 7.0%	N 6.2% R 6.3%	
F11. Rate of New and Review outpatient appointments cancelled by the hospital.	N 6.2% R 8.6%	N 4% R 6.5%	N 4.0% R 6.0%	N 6.9% R 9.2%	N 5.4% R 7.7%	N 3.5% R 6.6%	N 4.9% R 8.5%	N 4.9% R 7.6%	N 5.3% R 9.6%	N 3.7% R 7.1%	N 5.0% R 7.7%	
F12. Ratio of new to review outpatient appointments cancelled by the hospital	1 : 2.7	1 : 3.1	1 : 2.4	1 : 2.4	1 : 2.5	1 : 3.1	1 : 3.0	1 : 2.6	1 : 3.4	1 : 3.7	1 : 3.1	
F13. Number of 30 day emergency readmissions by days after discharge	Information report to be developed by the Acute Information Team (March report)											
F14. Percentage of emergency admissions returning within 7 days and within 8 - 30 days	0-7 days 2.9%			Update not yet available								
	8-30 days 5.1%			Update not yet available								
F15. Clinical causes of emergency readmissions (as a percentage of all readmissions) for (i)	Information report to be developed by the Acute Information Team (March report)											

IoP		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
	infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF)												
F16.	GP Out of Hours Attendance by timeband (i) 12 am to 8.30 am; (ii) 8.30 am to 6pm; and (iii) 6pm to 12 am	Information report to be developed by the OPPC Directorate – timescale for availability not yet defined											
G1.	Percentage of all foster care placements that are kinship care placements. **Note: Data reflects kinship foster carers panel and field work approved*	34.7%	34.9%	35.9%	37.2%	37.4%	36.4%	37.2%	37.2%	38.1%	38.1%	No update	
G2.	Number of residential care leavers in education, training and employment. **Note: Data relates to over 19 years care leavers*	35	33	35	33	35	32	40	35	34	37	No update	
G3.	Percentage of care leavers at age 18, 19 and 20 years in education, training and employment.	95%	92%	90%	91%	87%	87%	87%	86%	82%	85%	No update	

IoP	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
G4. Percentage of children with an adoption best-interests decision notified to the Regional Adoption Information system (RAIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. – *Reported 3 months in arrears*	4			0			7					
G6. Length of time for Best Interest Decision to be reached in the adoption process.	Information reported annually and therefore, will not be available until Quarter 1 2015/2016											
G7. Number of children and number of times absconding from residential or foster care has been notified to police	Information reported 6 monthly – April – September 2014 Number of children: 3 Number of events: 5											
G9. Number of referrals for ASD (under 18)	23	35	22	19	15	16	28	16	17	No update		
G10. Number diagnosed with ASD (under 18)	4	3	5	5	2	11	15	8	4	No update		
G11. Number of Adult Protection Referrals received by HSC Trusts	471			170	121	117	113	131	90	102	178	

Note: Only those IoPs applicable to the Trust have been included in this report.

Stinson, Emma M

From: Stinson, Emma M <[redacted]>
Sent: 03 June 2013 16:43
To: Leyden, Francesca; Donaldson, Ruth
Cc: Wilson, Valerie
Subject: Acute Patient Experience Meetings
Attachments: image001.jpg

Dear Francesca and Ruth

One of the actions out of last month's Acute Directorate Governance meeting was to amend the agenda and add the Professional Governance Reports to our Patient Experience agenda instead. I have listed below the dates for these meetings and the Governance dates can be removed from your diary.

Tuesday 11th June 2013
Tuesday 9th July 2013
Tuesday 13th August 2013
Tuesday 10th September 2013
Tuesday 8th October 2013
Tuesday 12th November 2013
Tuesday 10th December 2013
Tuesday 14th January 2014
Tuesday 11th February 2014
Tuesday 11th March 2014

All meetings are at 2.00 pm and are in the Meeting Room on the Admin Floor.

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]
P Please consider the environment before printing this email

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Stinson, Emma M

From: Stinson, Emma M <[redacted]>
Sent: 03 June 2013 14:27
To: Harney, Carmel
Cc: governance, ahp
Subject: Acute Patient Experience Meetings
Attachments: image001.jpg

Dear Carmel

One of the actions out of last month's Acute Directorate Governance meeting was to amend the agenda and add the Professional Governance Reports to our Patient Experience agenda instead. I have listed below the dates for these meetings and the Governance dates can be removed from your diary.

Tuesday 11th June 2013
Tuesday 9th July 2013
Tuesday 13th August 2013
Tuesday 10th September 2013
Tuesday 8th October 2013
Tuesday 12th November 2013
Tuesday 10th December 2013
Tuesday 14th January 2014
Tuesday 11th February 2014
Tuesday 11th March 2014

All meetings are at 2.00 pm and are in the Meeting Room on the Admin Floor.

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

Email: [redacted]
P Please consider the environment before printing this email

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Stinson, Emma M

From: Burns, Deborah <[redacted]>
Sent: 30 May 2014 19:30
To: Stinson, Emma M
Subject: FW: RESPONSE DUE BY FRIDAY 20 JUNE 2014: Consultation Paper on the Directorate Structures within Southern HSC Trust
Attachments: Consultation Paper on the Directorate Structures within the SHSCT.FINAL.docx

Please discuss with me Monday am

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Mallagh-Cassells, Heather
Sent: 30 May 2014 15:56
To: Burns, Deborah; Clarke, Paula; Crilly, Miceal; McAlinden, Mairead; McNally, Stephen; McVeigh, Angela; Morgan, Paul; Rice, Francis; Simpson, John
Cc: Toal, Vivienne; Alexander, Ruth; Feely, Roisin; Gilmore, Sandra; Griffin, Tracy; Radcliffe, Sharon; Stinson, Emma M; Taylor, Karen; Wright, Elaine; Burns, Sinead; Johnston, Jenny; McElrath, Lindsay; Mallon, Maura; Walker, Helen; Anderson, Karen; Campbell, Catriona; Gordon, Lynda; Hynds, Siobhan; King, Ray; Parks, Zoe; Patterson, Karyn
Subject: RESPONSE DUE BY FRIDAY 20 JUNE 2014: Consultation Paper on the Directorate Structures within Southern HSC Trust

30 May 2014

Dear Colleague,

Please find attached the Consultation Paper on the above, I should be grateful if you would arrange to share this throughout your Directorate.

You will note that I have made provision for individuals or groups to contact my office to arrange to meet with the appropriate Director/s on the issues to be addressed in the paper. However, if you feel that there are specific individuals or groups within your Directorate, please let me know. In addition, I would be grateful for your co-operation in making yourself available during this consultation period, if necessary.

The consultation will run from today until Friday 20 June 2014.

Any queries - please let me know.

Kieran

Heather Mallagh-Cassells

Personal Assistant to Kieran Donaghy
Director of Human Resources & Organisational Development Southern Health & Social Care Trust
8 Personal Information redacted by the USI
((028) Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Consultation Paper on the Directorate Structures within the Southern HSC Trust

Consultation begins:	Friday 30th May 2014
Consultation ends:	Friday 20th June 2014
Response to:	Office of Director of Human Resources & Organisational Development Trust HQ, Craigavon Area Hospital site
Informal Queries to:	Kieran Donaghy Director of Human Resources & Organisational Development Telephone: [redacted] E-Mail: [redacted]

Executive Summary

The Southern Trust was formed in 2007, and management structures have remained largely unchanged since then. With the approval of the Trust Board, the Senior Management Team met in February 2014 to consider the challenges facing the organisation, the business changes over the past seven years and the known future challenges to our core business, and to consider any key organisational changes needed to ensure the Southern Trust remained and developed as a 'fit for purpose' organisation.

Subsequent to this initial review by SMT, a number of follow up meetings were held by SMT and within individual Directorates resulting in an interim paper being circulated within Directorates at the beginning of April 2014. Feedback from these discussions indicated that the following changes were required within the Directorate structure to meet the original aims of the review.

- Creation of an Executive Director of Nursing, Allied Health Professions with an operation management role for Dementia Services

- Further re-balancing of Directorate responsibilities to achieve a more even distribution of workload and create management capacity for service areas subject to significant strategic change and development

    - Creation of a Children & Woman's Directorate for an interim period of 2 years
    - GP Out of Hours to the Directorate of Mental Health & Disability
    - Contract Monitoring to the Directorate of Finance & Procurement
    - Estate Services to the Director of Human Resources & Organisational Development

- To increase the capacity within clinical and social care governance by the appointment of a full time Assistant Director for Clinical & Social Care Governance, and to stabilise the C&SCG management arrangement in the Acute Directorate.

- Development of an Integrated Quality Framework, led by the Director of Performance and Reform, to better co-ordinate and focus the systems with the Trust to drive and achieve quality improvement

This paper outlines the rationale behind these proposals.

Introduction

The Trust's management structure has evolved through the historical existence of four legacy Southern Area Trusts and the Review of Public Administration (RPA). As an organisation we are continually being challenged to become more efficient, this is against the increasing demand on front line services while continuing to deliver high quality and safe health and social care for the population we serve.

The Chief Executive and Senior Management Team agreed Terms of Reference for a review of the Trust's management structures in order to ensure that they are fit for purpose now and in the future given significant changes in the Trust's business, that the organisation is placing a 'doable ask' on the management teams, and to ensure efficiency in line with the NI benchmark for HPSS management costs.

As part of this review, there was a need to ensure that the current Directorate structure within the Trust is fit for purpose taking into account current and future work pressures and demands. Towards this end, a Senior Management Team workshop was held on the 24th and 25th February 2014. The aims of this workshop were:

- Identify and agree weaknesses/issues within the current structures.
- Review functions/services within current Directorates with a view to ensuring that those functions/services cannot be better delivered either through another Directorate or a provider outside the Trust.
- Take into account the changing emphasis on service delivery taking place over the next 3/5 years.
- Agree solutions that are specific to those issues identified and that can be implemented within an agreed time frame.

In considering the above aims, the SMT developed a number of principles including:

- Services must be integrated around the client groups.
- Clear line of sight from the Chief Executive through the Director to the delivery of front line service in terms of accountability and responsibility.
- Decision making should be taken as close to the point of service delivery as possible.

- The Operational Manager has primary responsibility and accountability for the performance of all staff who are involved in service delivery within their service area.

- Operational Management are responsible for the safety and quality of services within their Directorate, supported by advice and expertise and input from professional governance structures.

- The "professional executive" and their professional governance staff to provide the organisation with professional guidance, advice and expertise in relation to the Trust's achievement against agreed standards for quality and care and the competence of the professional workforce.

- Any change in services must be in line with the agreed direction as outlined within Transforming Your Care (TYC).

The outputs of the Review process are summarised in the following proposals for change:

1. **Creation of an Executive Director of Nursing, Allied Health Professions and Dementia Services**

Rational for Change

- The nursing workforce is the largest group of staff within the Trust and the capability and capacity of this workforce has a fundamental impact on the quality of care provided in acute and community settings. A number of other Trust have recognised the need to create capacity for strong professional leadership of the nursing workforce by the creation of Director of Nursing (DoN) roles without the level of operational responsibility to district or deflect from this focus.

- The DoN role lends itself well to organisational leadership of the user experience and public and patient involvement, currently part of Director of OPPC role. The OPPC Directorate is a large and diverse Directorate with significant span of financial and service responsibilities, and this realignment would balance that workload.

- In considering the need for a dedicated DoN role, SMT also considered that a limited and focused operational role in an area of service change and

development would be appropriate and would support equilibrium on workload across the Directorates. Senior Management Team considered that the complex challenges inherent within the Dementia Strategy require a strategic focus and that Dementia Services should be planned and delivered within a single Directorate.

- Subsequently it was agreed that integration of Dementia Services, which are currently split across OPPC and MHD Directorates, would have significant benefit operationally and would further benefit from alignment with the DoN role given the nursing workforce, programme of change and escalation demand issues within this area of service.

Way Forward

SMT propose the creation of an Executive Director of Nursing, Allied Health Professionals and Dementia Services.

The post holder would be responsible for the professional governance for the Nursing workforce, nursing workforce planning, patient/client experience, Personal and Public Involvement (PPI).

The Director of Nursing, in addition to their executive professional role, would have responsibility for developing and implementing the Dementia Strategy and managing Dementia Services within the Trust

2. Creation of a Children & Woman's Directorate

Rational for Change

- It is recognised that the pace and volume of strategic change impacting on maternity, obstetrics, acute paediatrics and community midwifery services is considerable over the next number of years. These include:

    - Delivery of the Trust's 'Changing for Children' Strategy which has now secured commissioner approval and financing for both capital development and service change.

    - The Trust's rate of Caesarean Sections is an outlier by NI and UK comparators and will require significant management focus to deliver the Trust's plans for improvement.

- Strategy for Maternity Care In Northern Ireland 2012-2018
- Strategy for the delivery of paediatric services in Northern Ireland
- Workforce strategy for Paediatrics
- Ongoing review of specialist Neonatal services

- The SMT considered that the synergies between paediatrics, maternity and obstetric services, currently split across Acute and CYP Directorates, and considered there would be benefits of integration. This, aligned with the significant change agenda above, would justify a dedicated, integrated management focus for a time limited period to drive forward the necessary change and improvement.

- In the original Terms of Reference (see Appendix 1), the first principle that SMT agreed was that *"Organisational structures should as far as practicable ensure a balanced and equitable distribution of workload across Directorates and Divisions taking into account grading/ banding and levels of accountability/responsibility"*. This proposed change would reduce the complexity and span of financial and managerial control of the Acute Services Directorate, which is the largest in the Trust.

Way Forward

In order to provide a focus and create sufficient management capacity to deliver the changes outlined above, the SMT proposed to create an Interim Directorate of Children and Women's Health. The budget for such a Directorate would be £29m with 565wte staff.

It is further proposed to offer a secondment opportunity, initially internal to the Trust to support succession planning, for a period of 2 years. After this period, assuming sufficient progress with the change agenda, consideration would be given to integrating this service unit into an existing Directorate.

3. Development of an Integrated Quality Framework to provide clarity on what process we have/will have in place to drive and achieve quality improvement

Rational

- SMT proposed the need for an integrated Quality Framework to better co-ordinate and focus the systems with the Trust to drive and achieve quality improvement

This includes consideration of the following:

- Scoping the breadth of Quality Improvement (QI) systems and initiatives underway across whole Trust, and driving improved integration.

- Defining how we will continually prioritise QI activity to focus organisational energies on an agreed (smaller) number of QI actions that will make a big impact on the issues of safety and quality arising from internal and external intelligence, AI, complaints and litigation systems.

- Defining how we will better organisationally support/enable a culture of QI within front line staff.

- Developing our thinking on how our QI work/priorities (top down and bottom up) are driven by the voice of the customer and put MDT working front and centre.

- Clarifying what “toolbox” for supporting QI we will provide organisationally to deliver against top down/bottom up ideas and plans (tapping into skills across the organisation including Lean training; e-learning; support from virtual continuous improvement/QI “team”).

- Reminding us about getting the basics right.

Way Forward

SMT propose that the Lead Director for the Trust’s Quality Systems development/Quality Framework would be Paula Clarke, supported by Professional Directors

4. Further Re-balancing of Directorate Workload

Rational for Change

As indicated earlier in this paper, the first principle that SMT agreed was that *"Organisational structures should as far as practicable ensure a balanced and equitable distribution of workload across Directorates and Divisions taking into account grading/ banding and levels of accountability/responsibility"*.

The changes already indicated will mean that in order to look towards a balanced and equitable distribution of workload across Directorates, the following changes are proposed:

- GP Out of Hours to the Directorate of Mental Health & Disability, to balance the adjustment of hospital dementia services moving to DoN role.

- Contract Monitoring to the Directorate of Finance & Procurement to integrate this function under the procurement role of the Director of Finance.

- Estate Services to move to the Director of Human Resources & Organisational Development, recognising the capacity needed by the Director of Performance and Reform to undertake a lead role for quality systems development.

5. To increase the capacity within governance by the appointment of a full time Assistant Director for Clinical & Social Care Governance

Rationale

At the SMT Workshop, Directors reflected on the following issues within the current clinical and social care governance structure:

- Interface issues around corporate, professional and operational governance not enough joint working
- Need for role clarity of professional governance staff
- Need to ensure governance staff are empowered to effectively discharge challenge function particularly Governance Co-Ordinators
- Need for more effective alignment and integration of Governance resources.

As a result of the above, SMT re-asserted the following requirements:

- "Challenge function" is central to assurance. In order to achieve this aim, the key role of Directorate Governance Co-Ordinators needs to reflect this challenge function.

- Need for Assistant Director for Clinical & Social Care Governance to undertake a co-ordinating and lead role with the Directorate Governance Co-Ordinators particularly in relation to supporting and providing challenge at a corporate level.

- Need to scope out all those involved in Governance to assess/ensure:

    - Role Clarity.
    - Accountability.
    - Fit within the organisation.
    - Maximising utilisation of all resources to corporate priorities.

Way Forward

- Need to stabilise current structure by increasing capacity of Assistant Director for Clinical & Social Care Governance – move to full time role as soon as possible.

At Appendix 1, you will find a Consultation Questionnaire which has been developed to help you provide a response to the Trust on this document. **The timeline for response is 3-weeks commencing on Friday 30 May 2014 ending on Friday 20 June 2014**.

All enquiries regarding this document should be directed to:

Mr Kieran Donaghy
Director of Human Resources & Organisational Development
Telephone: Personal Information redacted by the USI
E-Mail: Personal Information redacted by the USI

In addition, throughout the consultant process members of the Senior Management Team will be available to meet with individuals or groups. If you are interested in a meeting, please contact the Director of Human Resources & Organisational Development's office as indicated above in order that the necessary arrangements can be made to meet.

Appendix 1

Consultation Questionnaire - Directorate Structures within the Southern HSC Trust

The Trust wishes to consult internally on the above proposal. Please use this questionnaire to detail your comments and return to:

Mr Kieran Donaghy
Director of Human Resources & Organisational Development
Trust HQ, Craigavon Area Hospital site
E-Mail: Personal Information redacted by the USI

by **Friday 20 June 2014.**

1. Do you agree with the creation of an Executive Director of Nursing, Allied Health Professions and Dementia Services?

   If you do not agree, please give your reason/s below:

2. Do you agree with the creation of a Children & Woman's Directorate?

   If you do not agree, please give your reason/s below:

3. Do you agree with the development of an Integrated Quality Framework?

   If you do not agree, please give your reason/s below:

4. Do you agree with the re-balancing of Directorate workload?

   If you do not agree, please give your reason/s below:

5. Do you agree with the need to increase the capacity within governance by the appointment of a full time Assistant Director for Clinical & Social Care Governance?

   If you do not agree, please give your reason/s below:

Please include any other comments you wish to make on the proposals outlined within this document.

Stinson, Emma M

From: Walker, Helen [redacted]
Sent: 30 May 2014 10:57
To: Stinson, Emma M
Subject: FW: ASD Management Review process

EMMA AS DISCUSSED TO RUN BY DEBBIE BEFORE I SEND TO ADs.
Will have draft paper with her by COP today.

Dear all
Following our discussion on Tuesday pm I sought Kieran's advice on above. His view is that we have a 2 week internal Directorate consultation period and then present our recommended proposal for final approval to SMT based on the outcome of this consultation process.
I would therefore propose the following timetable/process:- Tuesday 3rd June – Brief managers re key messages ie. I have booked the Boardroom CAH all afternoon. You need to arrange for your Heads of Service, Lead Nurses and managers you identify as being directly affected in your Division to meet there at 2pm for half an hour. Debbie will give a high level picture of what we are proposing. ie, release management capacity to progress service improvement initiatives, even out workload, strengthen nursing focus and governance focus, etc. Key message is that we are commencing a 2 week period of consultation within the Directorate commencing Wednesday 4th until Wednesday 18th June. I will brief the relevant TU reps in confidence in advance of this meeting.
0n the basis that there is no change proposed for existing IM&WH, Anne has agreed to proceed with her own Divisional follow up meeting with these managers to answer any queries they may have. Tracey is on leave but on the basis that there will be no direct change in Pharmacy I see her area as the same as Anne's and I can arrange to give John, Lynn and Jayne a quick briefing on Tuesday.
From 2.30 – 5pm we will have a series of meetings with managers from each of the other Divisions which I will attend as follows:-
2.30 – 3pm- Medicine and Unscheduled Care 3pm – 3.30 – Surgery and Elective Care
3.30 – 4.00 – Cancer and Clinical Services
4.00- 5pm – FSS
Wednesday 4th June – Wednesday 18th June – 2 week consultation period - Would suggest any feedback comes directly to me Friday 13th – To be discussed as JOF agenda item (NB. Debbie is on leave on this date and so will not be in attendance for this discussion. Also I have rearranged the JOF meeting to be held in Committee Room 1, DHH that day as there is a meeting from 9.30- 10.30 that morning with DHH stroke staff as this is the start of the 3 month Stroke centralisation consultation period).
Tuesday 17th June – Acute HR/Finance SMT meeting to discuss feedback to date Wednesday 18th June – Friday 20th June - We finalise recommended proposal for SMT meeting on 25th June Wednesday 25th June – Recommended proposal is presented to Acute SMT for final approval.

Stinson, Emma M

From: Carroll, Ronan <[redacted]>
Sent: 30 May 2014 14:52
To: Stinson, Emma M; Carroll, Anita; McVey, Anne; Boyce, Tracey; Conway, Barry; Walker, Helen; Gibson, Simon; Trouton, Heather
Subject: Acute Services Directorate Management Review - 2014
Attachments: Acute Services Directorate Management Review - 2014.docx

amended

Acute Services Directorate – Management review Consultation

Aim

The purpose of this paper is to set out the proposals for the revised Acute Services Directorate Management Structure for the purposes of consulting internally with the Directorate managers and key stakeholders.

Proposed structure

The organisation structure chart in Appendix 1 shows how it is proposed that the work of the Acute Services Directorate will be divided between Directorate and Divisional/operational duties and how these various activities will be managed.

The Acute Senior Management Team will comprise the Director of Acute Services and 5 Divisional (operational) ADs and 3 Directorate (strategic) ADs with limited operational portfolios. The team will be supported by an aligned ADHR and an aligned Finance manager.

The 3 Directorate ADs will be as follows:-

- The **AD of Nursing and Patient Experience** will provide professional guidance, advice, expertise and assurance in relation to the Directorate's achievement against agreed standards for quality and care and the competence of the nursing workforce. The role will be separate and distinct from the 2 Trust wide professional ADs of Nursing in that the Directorate AD of Nursing and Patient Experience will be essentially strategic with regard to service developments within the Acute Services Directorate. The AD of Nursing and Patient Experience will facilitate action to devise and implement the appropriate change strategies necessary to increase quality, access, and value in a patient-centred environment. This will include the creation and adoption of innovative patient-centred care models. The role will have the operational responsibility for AHPs, Patient Flow and Patient Support services which includes Chaplains. The AD of Nursing and Patient Experience will also have overall responsibility all the aspects of change management associated with the roll out and embedding of E-Rostering across the Directorate. Ultimately it is envisaged that the role will also assume operational responsibility for Domestic and Catering services, however these will remain under the operational management of the AD with responsibility for Functional Support Services (FSS) until such time as the existing FSS management structure has been reviewed and strengthened. It has been agreed that the existing AD for Surgery and Elective Care will move into this role thereby leaving a vacant operational AD post.
  The proposed management structure to support this role is attached as Appendix 2

- The **AD of Governance** will undertake a co-ordinating and lead role in relation to supporting and providing challenge at a corporate level. It is agreed that the current Director of Pharmacy will assume this role and that this will be supported by the existing Governance team and 3 band 7 Risk Nurse/Midwife posts who will report directly to the operational ADs who will retain the operational responsibility for the delivery of the Governance agenda within their own Division. In order to reflect the

full responsibilities the title of the post will **be Director of Pharmacy, Medicines Management and Governance Assurance.**
The proposed management structure is attached as Appendix 3

- The **AD of Strategic Transformation and Service Improvement** will take the lead in supporting the Acute Services Director to deliver the Directorate's overall strategic transformation and service improvement agenda. It is agreed that the current AD for Functional Support Services (FSS) will assume this strategic role and the existing FSS management structure will be reviewed and strengthened to release the capacity of the AD and to prepare for the eventual transfer of operational responsibility for domestic and catering services to the AD of Nursing and Patient Experience. The post will retain operational management responsibility for all other areas of Functional Support, ie CSSD, Laundry, Portering, Switchboard and Security and Admin and Clerical and Services. The transformational and service improvement aspects of the role will be further supported by a band 8a Service Improvement post.
The proposed management structure is attached as Appendix 4

Key features of Corporate and Divisional roles:-

- The Corporate AD roles and the Divisional AD roles are equivalent in status. While the Corporate roles will be strategic in focus, they will have operational responsibility for appropriate Directorate functions. Conversely, while the Divisional AD roles will be operational in focus, they will also undertake strategic work specific to their own Division.
- There will be strong joint working between the Corporate ADs and the Divisional ADs and both will work collaboratively to reach agreement on any issues to be addressed within each Division.
- The Corporate ADs will be empowered to effectively discharge their challenge function and any involvement in Divisional activities will have the full support and backing of the operational AD.

The Directorate will be divided into 5 service Divisions each headed by an AD who will have the responsibility and accountability for the performance of all staff who are involved in service delivery within their service areas.

Key features of Divisions:-

- Each Division will be divided into a number of Service areas managed by a Head of Service.
- Each Service area will be designed around a patient group or patient service.
- There will be 3 dedicated Risk Managers to support the direct patient care Divisions:-
  1 X Medicine
  1 X Surgery and Cancer and Clinical Services
  1 X Integrated Maternity and Women's Health
- Ward Sisters will be supernumerary and there will be a direct reporting line from the Ward Sisters to the relevant Head of Service.

The 5 service Divisions will be as follows:-

1. **Emergency Care and Specialty Medicine**
2. **Elderly Care and Specialty Medicine**

It is proposed that the existing Medicine and Unscheduled Care Division is broadly divided into 2 service areas, one focussing on Emergency Medicine and the other focussing on Care of the Elderly. In order to have the most equitable balance of workload and budgetary responsibility, both Divisions will have the various Medical specialties divided between them.

Emergency Care and Specialty Medicine

Head of Service 1 – Emergency Medicine and Acute Medicine

Head of Service 2 – Gastroenterology, Rheumatology, Nephrology

Head of Service 3 – Social Work.

There will be a direct reporting line from the Ward Sisters to the relevant Head of Service.

In addition to support the Governance agenda there will be a Band 7 Risk Manager post reporting to one of the Heads of Service which will be shared between both Medicine Divisions.

The proposed management structure is attached as Appendix 5.

Appendix 5a further supplements this by detailing the wards and departments under each Head of Service.

Elderly Care and Specialty Medicine

Head of Service 1 – Stroke, Geriatric Medicine and Ortho-Geriatrics

Head of Service 2 – Dermatology, Neurology, Cardiology

Head of Service 3 – Respiratory, Diabetes, Endocrinology

There will be a direct reporting line from the Ward Sisters to the relevant Head of Service.

In addition to support the Governance agenda there will be a Band 7 Risk Manager post reporting to one of the Heads of Service which will be shared between both Medicine Divisions.

The proposed management structure is attached as Appendix 6.

Appendix 5a further supplements this by detailing the wards and departments under each Head of Service.

Integrated Maternity and Women's Health

It is proposed that the management structure at Head of Service and Lead Midwife level will remain unchanged.ie.

Head of Service x 1

Lead Midwife 1 – Inpatients and outpatients, Maternity and Gynae

Lead Midwife 2 – Intrapartum Care, Delivery Suites and MLUs

Lead Midwife 3 – Community

The Lead Midwife posts will remain in maternity due to the fact that the organisational management structure for midwifery is different from nursing in that midwives are band 6 and therefore the band 7 role in midwifery functions essentially as a clinical band 6 within nursing. The Lead Midwife role therefore has to undertake some of the functions and responsibilities that a band 7 ward/department sister would be required to undertake within nursing.

This Division also currently has a full time band 7 Risk Midwife which it is proposed will remain in place on the basis of the high risks associated with this Division.

In order to equalise out the workload between Divisions it has been agreed that Laboratory services will transfer from Cancer and Clinical Services Division to Integrated Maternity and Women's Health.

The proposed management structure is attached as Appendix 7.

Surgery and Elective Care

It is proposed that the management structure at Head of Service level will remain largely unchanged with the exception that Audiology which will transfer from Cancer and Clinical Services to be managed with the ENT specialty and Breast Surgery and Pre-op Assessment will transfer from Surgery and Elective Care Division to Cancer and Clinical Services Division.

The Surgery and Elective Care Head of Services structure will be as follows:-

Head of Service 1 – General Surgery

Head of Service 2 – ENT, Audiology and Urology.

Head of Service 3 – Trauma and Orthopaedics

There will be a direct reporting line from the Ward Sisters to the relevant Head of Service.

In addition to support the Governance agenda there will be a Band 7 Risk Manager post reporting to one of the Heads of Service which will be shared between Surgery and Elective Care Division and Cancer and Clinical Services Division.

The proposed management structure is attached as Appendix 8.

Cancer & Clinical Services and ATICs

This Division is currently the largest in terms of budget and staffing numbers and it is proposed that there are some transfers of services in and out of this Division to equalise the workload. These are suggested as follows:-

Services transferred into Cancer and Clinical Services:-

- Pre-op Assessment
- Breast Surgery

Services transferred out will be:-

- AHPs – transferring to Nursing and Patient Experience
- Audiology – transferring to Surgery and Elective Care
- Neurophysiology – transferring to Neurology under Elderly Care and Specialty Medicine
- Laboratories – transferring to Integrated Maternity and Women's Health

The revised Head of Service structure will therefore be as follows:-

Head of Service 1 – Diagnostics

Head of Service 2 – Cancer Services

Head of Service 3 – ATICS

It is proposed that the ATICS Head of Service will be supported by an 8A Senior Manager due to:-

- The high numbers of medical staff within ATICS (30+ Consultants, 9 SAS grades and 20+ trainees)
- The responsibilities associated with the management of the medical equipment
- The need to maximize the Theatre Utilization
- The on-going demand for service expansion.

In addition to support the Governance agenda there will be a Band 7 Risk Manager post reporting to one of the Heads of Service which will be shared between Surgery and Elective Care Division and Cancer and Clinical Services Division.

The proposed management structure is attached as Appendix 9

Consultation period and Feedback

This consultation period will be from Wednesday 4th June 2014 to Wednesday 18th June 2014. During this period all comments and feedback are welcome through the relevant AD, the relevant AMD, Helen Walker, ADHR, or alternatively any of the Directorate's local Trade Union representatives.

On receipt and review of feedback from this consultation a final recommended proposal with be presented to the Trust's Corporate SMT for formal approval prior to implementation.

Stinson, Emma M

From: Burns, Deborah <[redacted]>
Sent: 29 April 2014 09:30
To: Trouton, Heather; Corrigan, Martina; Glenny, Sharon
Subject: RE: Funding to address Review Backlog in Urology

Follow Up Flag: Follow up
Flag Status: Flagged

Hi great news indeed – can you come back to me with how we are going to do this – consultant led please and use innovatively ie to get maximum benefit - ie telephone / chart face to face and monitor discharge rate??? – could I see plan

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 28 April 2014 18:11
To: Burns, Deborah
Subject: FW: Funding to address Review Backlog in Urology

Good news below. Working up a plan to make the most use of these 700.
Your views welcome.

Heather

From: Corrigan, Martina
Sent: 28 April 2014 09:26
To: David McCormick
Cc: Trouton, Heather
Subject: RE: Funding to address Review Backlog in Urology

Thanks David

This actually came through this morning after I had sent your email. Now that I know definitely that I have funding for 700 reviews I will work through and firm up the plan and forward to you.

Many thanks for the confirmation.

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: David McCormick [mailto: Personal Information redacted by the USI]
Sent: 28 April 2014 09:24
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: RE: Funding to address Review Backlog in Urology

"This email is covered by the disclaimer found at the end of the message."

Martina

The Trust has been given approval for 700 urology review patients (see attached)

Can you share your plan as it would make sense that the funding allocated for the 700 should be used flexibly. For example if you are doing more telephone reviews / chart reviews one would assume that a greater level of activity could be delivered than via the traditional face to face method but we would need to ensure that the activity is recognised and indeed has a clear impact on your backlog (and the reviews associated with the additional new patients)

Regards
David

From: Corrigan, Martina [mailto: Personal Information redacted by the USI]
Sent: 28 April 2014 07:03
To: David McCormick
Cc: Trouton, Heather
Subject: Funding to address Review Backlog in Urology

David,

Mr Young advises me that he had spoken with you after the meeting on 3 April and you advised him that there was some funding that could be used to address the Review Backlog in Urology?

We have come up with a plan that involves chart review/telephone clinics and actual clinics but this can only take place outside of core hours, e.g. evenings and Saturday's. as you are aware there is no funding for quarters 1/2 for Urology so I have not been able to give the go ahead to do this work, and when I mentioned this to Michael he advised me of your conversation.

Can you confirm and if so how much is the funding available?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients

Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

in relation to virus scanning. All emails held by HSCNI may be subject to public disclosure under the Freedom of Information Act 2000."

Stinson, Emma M

From: Burns, Deborah <[redacted]>
Sent: 09 May 2014 19:47
To: Glenny, Sharon; Richardson, Phyllis; McAreavey, Lisa; Clayton, Wendy; Forde, Helen; Robinson, Katherine; Boyce, Tracey; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Stinson, Emma M; Trouton, Heather; Walker, Helen; Burke, Mary; Carroll, Kay; Corrigan, Martina; Devlin, Louise; Donaldson, Ruth; Magee, Brian; McGeough, Mary; McGoldrick, Kathleen; McIlroy, Cathie; McLoughlin, Sandra; McStay, Patricia; Murray, Eileen; Nelson, Amie; Reddick, Fiona; Reid, Trudy; Robinson, Jeanette
Cc: Stinson, Emma M
Subject: IMPORTANT FOR ACTION+++

Importance: High

Dear all
I had my Director to director hscb meeting today. As suspected the message was uncompromising and very clear:
Performance at end of June must be no worse than that at end of March.

My expectation is that all specialties with the exception of Dermatology and Urology will achieve under -5% on contracted volumes and that the longest wait at end of June will be no longer than that at end of March.

Please focus all energies from AD, HOS and OSL to profile and achieve this and be able to confirm this at our next Wednesday perf meeting. While I absolutely appreciate the excellent performance last year , and having been an operational manager realise only too well that April / May is always difficult (dare I say the dreaded 4 bank holidays and annual leave) there is no rational argument why specialties would do 20-30% less work in this period than the last quarter. It also means that if this happens we have to work twice as hard the rest of the year to make this up

So I am asking for less than -5% and waiting time no longer than March. Please advise by next Wednesday any risk to this – and please focus on this to make it achievable

Thanks
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

Interview with Debbie Burns
currently, Director of Care and Quality Governance, NI Hospice.

5Th June 2019 @ 08.30 in Northern Ireland Hospice, Somerton Road, Belfast.

PRESENT: Dr JR Johnston (JRJ)

Trudy Reid scheduled to be present but unavoidably unable to attend at short notice.

Debbie held post of Director of Acute Services, CAH from April 2013 – August 2015.

I indicated this interview was confined to the issue of triaging GP referrals to the Urology Service, CAH. I would not and did not wish to venture into any other issues relating to personnel in the Urology Service, CAH.

Q. *JRJ - Importance of triaging cancer referrals from GPs – especially from patient's perspective?*
A. "Vital". Patients are often anxious and depend on the system to work, dealing with diagnosis and treatment in a timely fashion.

Q. *Where does triaging rank in importance (for patients) when comparing it to other medical staff issues i.e. probity, health, performance, patient experience?*
A. "Very significant". Very high up the list in terms of importance.

Q. *What system did you inherit? Who did not triage?*
A. When Debbie was responsible for this area, Urology was ~~very much~~ an outlier~~, a "Maverick Team"~~.
Urology had poor cancer performance data. Their cancer targets were a main issue and triaging was part of this.

However, there were mitigations; they were short of staff; on call was an issue.

AO'B was the most consistent offender. He did the work in HIS own time.
MY 'covered' for him and the delays or non-performance of triaging.
EM & MY couldn't really tackle AO'B.

Q. *Why was there a problem for so long?*
A. EM & MY unable to really deal with AO'B and this problem; they did not have good working relationship.
DB then tackled issue.
DB felt AO'B was difficult to manage, with fellow clinicians finding it particularly difficult.
However, she met with AO'B – colourful language. Following discussions, DB indicated that AO'B had to stop triaging. This was at the time NICAN guidelines were issued which AO'B had done a lot of work for, chairing for Urology. Used this as a covering excuse which AO'B thanked her for – saving face.

Following this, DB found AO'B did comply with her requests and that he became more manageable.

DB unaware that AO'B had returned to triaging before she left this post in August 2015.
However, she indicated that Cancer performance figures improved when he was not triaging.

Q. *Questioned about Informal Default Process (IDP) for dealing with non-triaging.*
A. DB not aware of IDP – even though it started during her time i.e. May '14.

Q. *DB's opinion of IDP?*
A. "Completely ridiculous" because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11/12.

Q. *Discuss AO'B inability to triage. Why could/did he not do it?*
A. "Eccentric" "Disorganised"
Very good with patients when he was aware and dealing with them but left those who he wasn't aware of on the waiting list and unattended.
"He would NOT allow himself to be organised by others."

Q. *What is the evidence that problem was referred to higher authority?*
A. John Simpson MD at that time; Mairead McAlinden CEO and Roberta Brownlee Chairperson of Board.
JS not good relationship with Acute Sector Consultants.
DB cannot remember if she made JS aware of problem.
DB considered issue dealt with when AO'B taken off triaging i.e. no need to refer 'upwards'.
There were also other issues concerning AO'B which were being dealt with.

Q. *Handover of triaging issue with Ester K.*
A. DB considered issue was dealt with, so no need to handover.

Q. *Any other information*
A. In 2007, DB (while in previous post in CAH - Assistant Director of Performance and Reform) found a waiting list – 10 years long.
Worked on this with AO'B and cleaned it up; found no serious issues.

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 29 March 2015 14:21
To: Burns, Deborah
Cc: Trouton, Heather
Subject: RE: CB GP Forum issues

Hi Debbie

I will look into this as Aidan hasn't been triaging and I had been advised that he was up-to-date.

It may be a GP letter that he has been sent direct and I will check with his secretary tomorrow and let you know.

Martina

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

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

From: Burns, Deborah
Sent: 27 March 2015 18:56
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: FW: CB GP Forum issues

Can you update me if issue resolved please

Debbie Burns
Acting Director of Acute Services
SHSCT
[redacted]
Tel: [redacted]

From: Clarke, Paula
Sent: 26 March 2015 18:12
To: Burns, Deborah
Subject: CB GP Forum issues

Deb reference by GP today re referral to urology in Dec that GP chased up this week to be advised this was "still waiting for grading by Dr O'Brien". Left with secretary to come back to him but clearly this is not in line with our triage process/timelines so can you follow up please

Thanks

Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform

Personal Information redacted by the USI

You can follow us on Facebook and Twitter

Stinson, Emma M

From: Robinson, Katherine <[redacted]>
Sent: 13 February 2014 15:17
To: Burns, Deborah; Carroll, Anita; Reid, Trudy; Glenny, Sharon
Subject: Opthalmology Triage
Attachments: Opthalmology - 13.02.14.xlsx

As requested please find attached report on referrals not triaged for Opthalmology. The ones which have 'Sorted' beside them have just been returned today so will not show on Business Objects until tomorrow.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: [redacted]
e: [redacted]

Ophthalmology

Hosp	CHI Number	Casenote	Forenames	Surname	Age	Telephone	Telephone Work	Spec Code	Cons Code	Priority	Referral Date Only	Days From Ref Date	Non Clinical Comments	WL Code	WL Cnc Code
STH	[redacted]							OPHT	SUT	ROUTINE	18/11/2013	87	RE SENT TO PHYLISS 13/02/2014		
STH								OPHT	SUT	ROUTINE	20/11/2013	85	RE SENT TO PHYLISS 13/02/2014		
ACH								OPHT	DIP	ROUTINE	21/10/2013	115	SORTED		
ACH								OPHT	DIP	URGENT	21/10/2013	115	SORTED		
ACH								OPHT	DIP	ROUTINE	24/10/2013	112	SORTED		
ACH								OPHT	DIP	ROUTINE	29/10/2013	107	SORTED		
ACH								OPHT	DIP	URGENT	04/11/2013	101	SORTED		
ACH								OPHT	DIP	ROUTINE	13/11/2013	92	SORTED		
ACH								OPHT	DIP	URGENT	14/11/2013	91	SORTED		
ACH								OPHT	DIP	ROUTINE	14/11/2013	91	SORTED		
ACH								OPHT	DIP	ROUTINE	19/11/2013	86	SORTED		
ACH								OPHT	DIP	ROUTINE	20/11/2013	85	SORTED		
ACH								OPHT	DIP	ROUTINE	20/11/2013	85	SORTED		
ACH								OPHT	DIP	ROUTINE	20/11/2013	85	SORTED		
ACH								OPHT	DIP	ROUTINE	20/11/2013	85	SORTED		
ACH								OPHT	DIP	URGENT	20/11/2013	85	SORTED		
ACH								OPHT	DIP	ROUTINE	19/12/2013	56	SORTED		
ACH								OPHT	DIP	ROUTINE	20/12/2013	55	SORTED		
ACH								OPHT	DIP	ROUTINE	09/01/2014	35	SORTED		
ACH								OPHT	DIP	ROUTINE	20/01/2014	24	SORTED		
CAH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	24/10/2013	112	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	URGENT	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	14/11/2013	91	SORTED		
DHH								OPHT	ABP	ROUTINE	21/11/2013	84	SORTED		
DHH								OPHT	ABP	ROUTINE	21/11/2013	84	SORTED		
DHH								OPHT	ABP	URGENT	29/11/2013	76	SORTED		
DHH								OPHT	ABP	ROUTINE	03/12/2013	72	SORTED		
DHH								OPHT	ABP	ROUTINE	05/12/2013	70	SORTED		
DHH								OPHT	ABP	ROUTINE	05/12/2013	70	SORTED		
DHH								OPHT	ABP	ROUTINE	05/12/2013	70	SORTED		
DHH								OPHT	ABP	ROUTINE	05/12/2013	70	SORTED		
DHH								OPHT	ABP	ROUTINE	19/12/2013	56	SORTED		
DHH								OPHT	MCI	ROUTINE	18/10/2013	118	SORTED		
DHH								OPHT	MCI	ROUTINE	19/10/2013	117	SORTED		
DHH								OPHT	MCI	ROUTINE	21/10/2013	115	SORTED		
DHH								OPHT	MCI	URGENT	21/10/2013	115	SORTED		
DHH								OPHT	MCI	ROUTINE	25/10/2013	111	SORTED		
DHH								OPHT	MCI	ROUTINE	25/10/2013	111	SORTED		
DHH								OPHT	MCI	ROUTINE	16/11/2013	89	SORTED		
DHH								OPHT	MCI	ROUTINE	13/12/2013	62	SORTED		
DHH								OPHT	MCI	ROUTINE	13/12/2013	62	SORTED		
DHH								OPHT	MCI	ROUTINE	13/12/2013	62	SORTED		
DHH								OPHT	MCI	ROUTINE	16/12/2013	59	SORTED		
DHH								OPHT	MCI	ROUTINE	17/12/2013	58	SORTED		
DHH								OPHT	MCI	ROUTINE	17/12/2013	58	SORTED		
DHH								OPHT	MCI	ROUTINE	17/12/2013	58	SORTED		
DHH								OPHT	MCI	URGENT	17/12/2013	58	SORTED		
DHH								OPHT	MCI	ROUTINE	17/12/2013	58	SORTED		
DHH								OPHT	MCI	ROUTINE	17/12/2013	58	SORTED		
DHH								OPHT	MCI	ROUTINE	27/12/2013	48	SORTED		
DHH								OPHT	MCI	ROUTINE	03/01/2014	41	SORTED		
DHH								OPHT	MCI	URGENT	03/01/2014	41	SORTED		
DHH								OPHT	SUT	ROUTINE	14/01/2014	30	SORTED		

Personal information redacted by the USI

	Personal Information redacted by the USI									
DHH	[redacted]	OPHT	SUT	ROUTINE	15/01/2014	29	SORTED		
DHH	[redacted]	OPHT	SUT	ROUTINE	15/01/2014	29	SORTED		
DHH	[redacted]	OPHT	SUT	ROUTINE	15/01/2014	29	SORTED		
STH	[redacted]	OPHT	DIP	ROUTINE	18/10/2013	118	SORTED		
STH	[redacted]	OPHT	DIP	URGENT	21/10/2013	115	SORTED		
STH	[redacted]	OPHT	DIP	URGENT	21/10/2013	115	SORTED		
STH	[redacted]	OPHT	DIP	ROUTINE	20/11/2013	85	SORTED		
STH	[redacted]	OPHT	DIP	ROUTINE	22/11/2013	83	SORTED		
STH	[redacted]	OPHT	DIP	URGENT	30/12/2013	45	SORTED		
STH	[redacted]	OPHT	DIP	ROUTINE	14/01/2014	30	SORTED		
STH	[redacted]	OPHT	SUT	ROUTINE	21/11/2013	84	SORTED		
STH	[redacted]	OPHT	SUT	ROUTINE	21/11/2013	77	SORTED		
STH	[redacted]	OPHT	SUT	ROUTINE	21/11/2013	77	SORTED		
ACH	[redacted]	OPHT	DIP	ROUTINE	20/01/2014	24			
ACH	[redacted]	OPHT	DIP	ROUTINE	21/01/2014	23			
ACH	[redacted]	OPHT	DIP	ROUTINE	21/01/2014	23			
ACH	[redacted]	OPHT	DIP	ROUTINE	21/01/2014	23			
ACH	[redacted]	OPHT	DIP	ROUTINE	21/01/2014	23			
ACH	[redacted]	OPHT	DIP	ROUTINE	23/01/2014	21			
ACH	[redacted]	OPHT	DIP	ROUTINE	28/01/2014	16			
ACH	[redacted]	OPHT	DIP	ROUTINE	28/01/2014	16			
ACH	[redacted]	OPHT	DIP	ROUTINE	28/01/2014	16			
ACH	[redacted]	OPHT	DIP	ROUTINE	29/01/2014	15			
CAH	[redacted]	OPHT	DIP	ROUTINE	24/10/2013	112			
CAH	[redacted]	OPHT	DIP	ROUTINE	24/10/2013	112			
CAH	[redacted]	OPHT	DIP	ROUTINE	24/10/2013	112			
CAH	[redacted]	OPHT	GEYE	ROUTINE	26/09/2013	140			
CAH	[redacted]	OPHT	GEYE	ROUTINE	02/10/2013	134			
CAH	[redacted]	OPHT	GEYE	ROUTINE	15/10/2013	121			
CAH	[redacted]	OPHT	GEYE	URGENT	19/10/2013	117			
CAH	[redacted]	OPHT	GEYE	ROUTINE	22/10/2013	114			
CAH	[redacted]	OPHT	GEYE	ROUTINE	31/10/2013	105			
CAH	[redacted]	OPHT	GEYE	ROUTINE	04/11/2013	101			
CAH	[redacted]	OPHT	GEYE	ROUTINE	04/11/2013	101			
CAH	[redacted]	OPHT	GEYE	ROUTINE	15/11/2013	90			
CAH	[redacted]	OPHT	GEYE	ROUTINE	20/11/2013	85			
CAH	[redacted]	OPHT	GEYE	ROUTINE	22/11/2013	83			
CAH	[redacted]	OPHT	GEYE	ROUTINE	03/12/2013	72			
CAH	[redacted]	OPHT	GEYE	ROUTINE	18/12/2013	57			
CAH	[redacted]	OPHT	GEYE	ROUTINE	21/12/2013	54			
CAH	[redacted]	OPHT	GEYE	ROUTINE	21/12/2013	54			
CAH	[redacted]	OPHT	GEYE	URGENT	21/12/2013	54			
CAH	[redacted]	OPHT	GEYE	ROUTINE	20/01/2014	24			
CAH	[redacted]	OPHT	GEYE	ROUTINE	24/01/2014	20			
CAH	[redacted]	OPHT	GEYE	ROUTINE	24/01/2014	20			
CAH	[redacted]	OPHT	GEYE	ROUTINE	24/01/2014	20			
CAH	[redacted]	OPHT	GEYE	ROUTINE	27/01/2014	17			
CAH	[redacted]	OPHT	MM	ROUTINE	22/01/2014	22			
CAH	[redacted]	OPHT	RMB	URGENT	12/12/2013	63			
CAH	[redacted]	OPHT	RMB	ROUTINE	02/01/2014	42			
CAH	[redacted]	OPHT	RMB	ROUTINE	29/01/2014	15			
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DHH	[redacted]	OPHT	DIP	ROUTINE	21/01/2014	23			
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DHH	[redacted]	OPHT	MCI	ROUTINE	17/01/2014	27			
DHH	[redacted]	OPHT	MCI	ROUTINE	20/01/2014	24			
DHH	[redacted]	OPHT	MCI	URGENT	20/01/2014	24			

Personal Information redacted by the USI

DHH	[redacted]	OPHT	MCI	ROUTINE	20/01/2014	24			
DHH	[redacted]	OPHT	MCI	ROUTINE	20/01/2014	24			
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DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
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DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
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DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
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DHH	[redacted]	OPHT	MCI	URGENT	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	URGENT	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
DHH	[redacted]	OPHT	MCI	ROUTINE	21/01/2014	23			
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DHH	[redacted]	OPHT	MCI	ROUTINE	27/01/2014	17			
DHH	[redacted]	OPHT	MCI	ROUTINE	27/01/2014	17			
DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
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DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	MCI	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	SUT	ROUTINE	28/01/2014	16			
DHH	[redacted]	OPHT	SUT	ROUTINE	29/01/2014	15			
DHH	[redacted]	OPHT	SUT	ROUTINE	29/01/2014	15			
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DHH	[redacted]	OPHT	SUT	ROUTINE	29/01/2014	15			
STH	[redacted]	OPHT	DIP	ROUTINE	22/01/2014	22			
STH	[redacted]	OPHT	DIP	ROUTINE	22/01/2014	22			
STH	[redacted]	OPHT	DIP	ROUTINE	22/01/2014	22			
STH	[redacted]	OPHT	DIP	ROUTINE	23/01/2014	21			
STH	[redacted]	OPHT	DIP	ROUTINE	23/01/2014	21			
STH	[redacted]	OPHT	DIP	ROUTINE	23/01/2014	21			
STH	[redacted]	OPHT	DIP	ROUTINE	23/01/2014	21			
STH	[redacted]	OPHT	DIP	ROUTINE	24/01/2014	20			
STH	[redacted]	OPHT	DIP	ROUTINE	24/01/2014	20			
STH	[redacted]	OPHT	DIP	URGENT	24/01/2014	20			
STH	[redacted]	OPHT	GEYE	ROUTINE	01/11/2013	104			
STH	[redacted]	OPHT	GEYE	ROUTINE	01/11/2013	104			

Stinson, Emma M

From: Robinson, Katherine <[redacted]>
Sent: 13 February 2014 15:48
To: Glenny, Sharon; Burns, Deborah; Carroll, Anita; Reid, Trudy
Subject: RE: Opthalmology Triage

All would have been chased with the secretary, but the report may not have been updated properly on our shared drive. This report is a lot better today than it was yesterday!

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Glenny, Sharon
Sent: 13 February 2014 15:26
To: Burns, Deborah; Carroll, Anita; Reid, Trudy; Robinson, Katherine
Subject: FW: Opthalmology Triage

Hi Katherine

Thanks for that. Could I just check what has happened to date with the patients at the long end of the list – there are 23 patients waiting longer than 42 days for triage.

Sharon

From: Robinson, Katherine
Sent: 13 February 2014 15:17
To: Burns, Deborah; Carroll, Anita; Reid, Trudy; Glenny, Sharon
Subject: Opthalmology Triage

As requested please find attached report on referrals not triaged for Opthalmology. The ones which have 'Sorted' beside them have just been returned today so will not show on Business Objects until tomorrow.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: [redacted]
e: [redacted]

Stinson, Emma M

From: Reid, Trudy [redacted]
Sent: 13 February 2014 17:41
To: Burns, Deborah; Trouton, Heather
Subject: RE: Triage

Debbie I have escalated to Stephen Boyd last night and in more detail today.
Following discussion with Stephen Boyd ophthalmology clinics were reduced over the last few months (they were reported by Consultant to be too busy and the reduction was to make them more manageable and to allow for admin) I have forward each consultants list to their secretaries for Consultants, so they are individually aware of who needs triaged urgently

Regards,

Trudy

Trudy Reid
Acting Head of Trauma & Orthopaedics and Ophthalmology Southern Health and Social Care Trust
Telephone [redacted]
Mobile [redacted]

From: Burns, Deborah
Sent: 13 February 2014 16:43
To: Reid, Trudy; Trouton, Heather
Subject: RE: Triage

This must be immediately escalated to Belfast asap -today and followed with a phone call D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Reid, Trudy
Sent: 12 February 2014 15:07
To: Trouton, Heather
Cc: Burns, Deborah
Subject: Triage
Importance: High

Heather Sharon has run a quick report on triage– but Katherine is doing a more in-depth report for tomorrow On Sharons report there are 238 patients currently not triaged of which 153 are over 2 weeks and 85 are waiting less than 2weeks for triage- longest waiter for triage is 20 weeks

Regards,

Trudy

Trudy Reid
Acting Head of Trauma & Orthopaedics and Ophthalmology Southern Health and Social Care Trust
Telephone Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Carroll, Anita [redacted]
Sent: 17 February 2014 16:10
To: Carroll, Anita; Boyce, Tracey; Conway, Barry; Gibson, Simon; McVey, Anne; Carroll, Ronan; Trouton, Heather
Cc: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis; Robinson, Katherine; Burns, Deborah; Stinson, Emma M; Lappin, Aideen; Hewitt, Irenee; Lawson, Pamela; Cunningham, Lucia; Cunningham, Andrea; McCaul, Helen; McGinn, Noreen; Rafferty, Lauri; OHanlon, Carmel; Watters, Kate; Cunningham, Lucia; Loughran, MarieT
Subject: Triage of referrals
Attachments: Triage Process.docx

Dear all

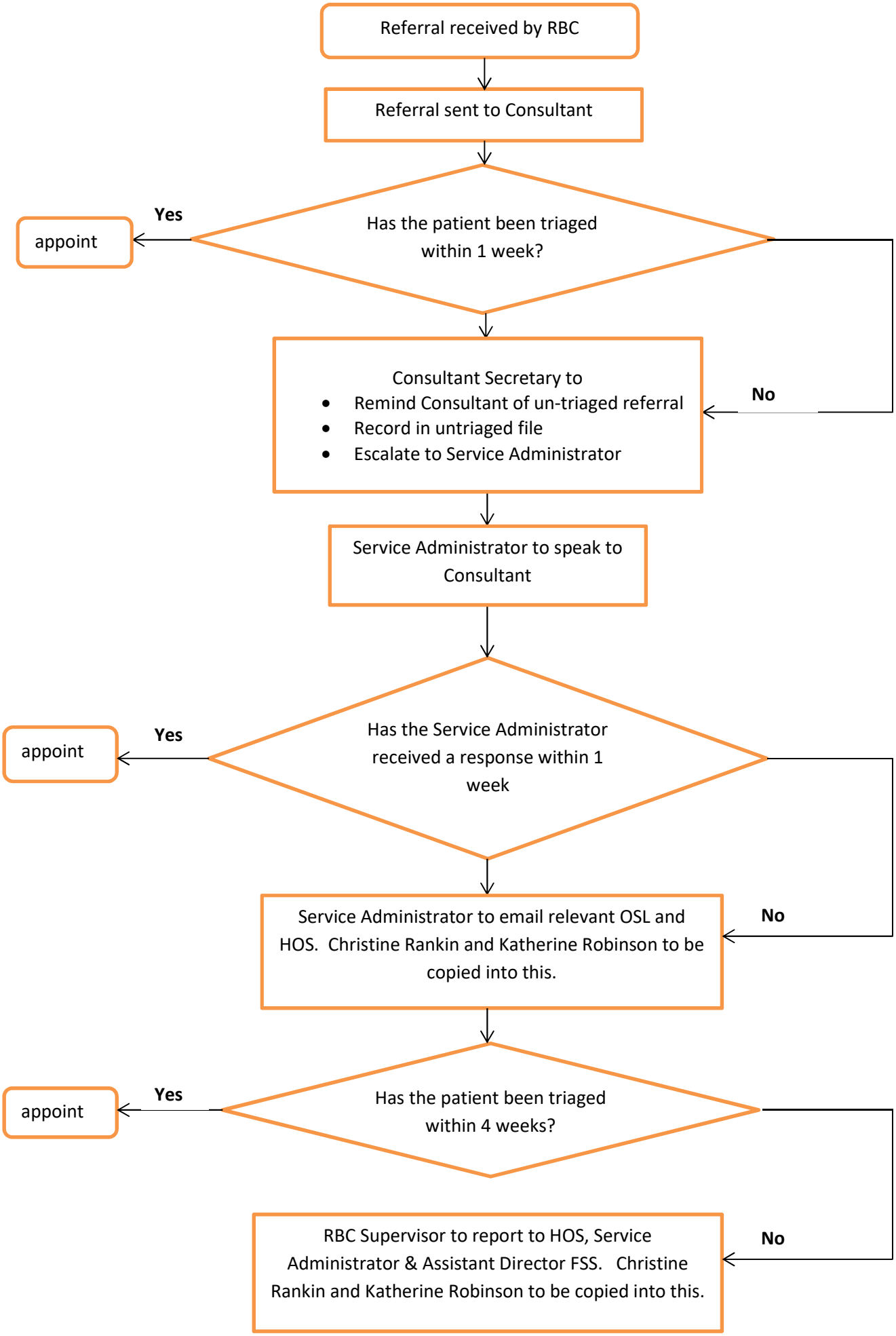
I attach the draft process that we will follow as an interim. I suggested to Heather that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week then we move to appoint, but I appreciate you would have to discuss with Clinicians. However any comments on process as outlined to be returned to me by Wednesday 19th February otherwise we will ensure this is adhered to by all secretaries and Service Administrators, OSLs and RBC Supervisors and Managers.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: [redacted]
Fax: [redacted]

TRIAGE PROCESS



Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Stinson, Emma M

From: Trouton, Heather <Personal Information redacted by the USI>
Sent: 19 February 2014 11:14
To: Carroll, Anita; Boyce, Tracey; Conway, Barry; Gibson, Simon; McVey, Anne; Carroll, Ronan
Cc: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis; Robinson, Katherine; Burns, Deborah; Stinson, Emma M; Lappin, Aideen; Hewitt, Irenee; Lawson, Pamela; Cunningham, Lucia; Cunningham, Andrea; McCaul, Helen; McGinn, Noreen; Rafferty, Lauri; OHanlon, Carmel; Watters, Kate; Cunningham, Lucia; Loughran, MarieT
Subject: RE: Triage of referrals

Anita

I am supportive of the attached process .

Heather

From: Carroll, Anita
Sent: 17 February 2014 16:10
To: Carroll, Anita; Boyce, Tracey; Conway, Barry; Gibson, Simon; McVey, Anne; Carroll, Ronan; Trouton, Heather
Cc: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis; Robinson, Katherine; Burns, Deborah; Stinson, Emma M; Lappin, Aideen; Hewitt, Irenee; Lawson, Pamela; Cunningham, Lucia; Cunningham, Andrea; McCaul, Helen; McGinn, Noreen; Rafferty, Lauri; OHanlon, Carmel; Watters, Kate; Cunningham, Lucia; Loughran, MarieT
Subject: Triage of referrals

Dear all

I attach the draft process that we will follow as an interim. I suggested to Heather that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week then we move to appoint, but I appreciate you would have to discuss with Clinicians. However any comments on process as outlined to be returned to me by Wednesday 19th February otherwise we will ensure this is adhered to by all secretaries and Service Administrators, OSLs and RBC Supervisors and Managers.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 03 September 2013 15:11
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 03 September 2013 10:11
To: Burns, Deborah
Cc: Corrigan, Martina; Forde, Helen
Subject: FW: CHARTS TO CONSULTANT'S HOME

Debbie how do you think its best to deal with this , should the HOS discuss with mr o brien can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out Happy to discuss Anita

From: Forde, Helen
Sent: 27 August 2013 18:15
To: Trouton, Heather; Corrigan, Martina
Cc: Carroll, Anita
Subject: FW: CHARTS TO CONSULTANT'S HOME

Please see below – Mr O'Brien continues to have charts at home. This is causing problems for records as per Pamela's e-mail. What can be done to resolve this?

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : [redacted]
Mobile : [redacted]

From: Lawson, Pamela
Sent: 27 August 2013 11:06
To: Forde, Helen
Subject: CHARTS TO CONSULTANT'S HOME

Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

We are wasting a lot of valuable time searching for charts that are not tracked properly and we are falling behind. Last week was particularly bad and we are short-staffed which doesn't help matters.

Please see list of IR1 forms to date

27/08/13	AOB	3 charts
23/08/13	AOB	2 charts
22/08/13	AOB	3 charts
14/06/13	AOB	1 chart
31/05/13	AOB	2 charts
20/05/13	AOB	1 chart
16/05/13	AOB	1 chart
08/05/13	AOB	1 chart

Many thanks
Pamela

Pamela Lawson
Health Records Manager (HRM)
CAH, BBPC and STH
Tel Personal Information redacted by the USI
Mob Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 05 September 2013 07:24
To: Burns, Deborah; Mackle, Eamon
Subject: RE: CHARTS TO CONSULTANT'S HOME

Debbie

I will speak with him again today and then let Robin follow up on this?

One of the things that was said to me before is that he is not the only consultant who brings a chart home, but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for, I will let you both know how I get on

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Burns, Deborah
Sent: 05 September 2013 06:38
To: Mackle, Eamon; Corrigan, Martina
Subject: FW: CHARTS TO CONSULTANT'S HOME

? We need this addressed
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Brown, Robin
Sent: 04 September 2013 21:17
To: Burns, Deborah
Subject: RE: CHARTS TO CONSULTANT'S HOME

I will try to get to meet Aidan week after next. I am Sow next week.

Robin

From: Burns, Deborah
Sent: 03 September 2013 15:11
To: Corrigan, Martina; Mackle, Eamon; Brown, Robin
Subject: FW: CHARTS TO CONSULTANT'S HOME

I know you have tried before – this is a governance issue – Robin can you discuss again with Mr O'Brien - or do we need to escalate?
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 03 September 2013 10:11
To: Burns, Deborah
Cc: Corrigan, Martina; Forde, Helen
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Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

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Sent: 27 August 2013 11:06
To: Forde, Helen
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Helen – can you please raise this issue with the appropriate person? I have been submitting IR1 forms regarding this but the problem is getting worse instead of better.

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31/05/13	AOB	2 charts
20/05/13	AOB	1 chart
16/05/13	AOB	1 chart

08/05/13 AOB 1 chart

Many thanks
Pamela

Pamela Lawson
Health Records Manager (HRM)
CAH, BBPC and STH
Tel Personal Information redacted by the USI
Mob Personal Information redacted by the USI

Corrigan, Martina

From: Burns, Deborah < Personal Information redacted by the USI >
Sent: 10 May 2013 19:17
To: Corrigan, Martina
Subject: FW: Charts being removed from the Trust by consultants

Can you give me background on work to date

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Carroll, Anita
Sent: 09 May 2013 16:28
To: Burns, Deborah
Cc: Lappin, Aideen
Subject: Fw: Charts being removed from the Trust by consultants

Debbie

See below can we discuss at 1 - 1
This chart was tracked to his pp drawer but actually wasn't there Anita

From: Forde, Helen
To: Carroll, Anita
Sent: Thu May 09 10:22:03 2013
Subject: FW: Charts being removed from the Trust by consultants
Anita – I've spoken to Martina before about Mr O'Brien taking patient charts home, and yesterday a patient was admitted to MAU and the chart was in Mr O'Brien's house. Pamela has completed an IR1 regarding this.

Could we have a chat at 1 : 1 to see from a Records point of view what else we need to be doing.

I went to speak to Martina today about this but she's not in her office.

Thanks.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Forde, Helen
Sent: 09 May 2013 10:16
To: Corrigan, Martina (Personal Information redacted by the USI)
Subject: Charts being removed from the Trust by consultants

Martina – we have spoken before about charts not being available for clinics or admissions as some of the consultants have taken them home. Yesterday a patient was admitted to MAU and after searching Mr O'Brien's

office and checking with his secretary it was found that the chart was in Mr O'Brien's house. This has led to a delay in the chart being available for the ward.

We have filled in an IR1 about this incident but I want to raise this issue with you again as this is a problem for the Trust.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

Corrigan, Martina

From: Burns, Deborah [redacted]
Sent: 10 May 2013 19:59
To: Corrigan, Martina
Subject: FW: Consultants taking charts home

Can you speak to me

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Carroll, Anita
Sent: 10 May 2013 14:01
To: Burns, Deborah
Subject: Fw: Consultants taking charts home

Just fyi

From: Forde, Helen
To: Carroll, Anita
Sent: Fri May 10 13:54:04 2013
Subject: Consultants taking charts home Anita just to let you know that another IR1 has been put in today for 2 charts that Mr O'Brien has at home and that are needed for Monday.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : [redacted]
Mobile : [redacted]

Corrigan, Martina

From: Burns, Deborah <Personal Information redacted by the USI>
Sent: 13 May 2013 15:09
To: Corrigan, Martina
Subject: RE: Charts being removed from the Trust by consultants

IF YOU ENED ANY HELP PLEASE LET ME KNOW

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 12 May 2013 16:28
To: Burns, Deborah
Subject: RE: Charts being removed from the Trust by consultants

Debbie,

This has been an ongoing problem for years. The last time that Helen spoke to me about this I spoke to Aidan and advised him of the issues which he did say he would stop it and it did stop for a while but I had asked Helen if it happened again to raise it with me and also to raise an IR1. Unfortunately there are three charts now in Aidan's house and I am unsure if anyone has spoken to him about it direct (I will check with Helen tomorrow).

I am happy to talk to Aidan again but think we may need to involve Robin as CD as well?

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Burns, Deborah
Sent: 10 May 2013 19:17
To: Corrigan, Martina
Subject: FW: Charts being removed from the Trust by consultants

Can you give me background on work to date

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

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Sent: 09 May 2013 16:28
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Cc: Lappin, Aideen
Subject: Fw: Charts being removed from the Trust by consultants

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I went to speak to Martina today about this but she's not in her office.

Thanks.

Helen Forde
Head of Health Records
Operations Office, Admin Floor, CAH
Direct Line : Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

From: Forde, Helen
Sent: 09 May 2013 10:16
To: Corrigan, Martina (Personal Information redacted by the USI)
Subject: Charts being removed from the Trust by consultants

Martina – we have spoken before about charts not being available for clinics or admissions as some of the consultants have taken them home. Yesterday a patient was admitted to MAU and after searching Mr O'Brien's office and checking with his secretary it was found that the chart was in Mr O'Brien's house. This has led to a delay in the chart being available for the ward.

We have filled in an IR1 about this incident but I want to raise this issue with you again as this is a problem for the Trust.

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Head of Health Records
Operations Office, Admin Floor, CAH
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Corrigan, Martina

From: Carroll, Anita [redacted]
Sent: 12 November 2013 11:58
To: Burns, Deborah; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

I think to escalate to Dr Simpson might be worth a try

From: Burns, Deborah
Sent: 12 November 2013 08:40
To: Trouton, Heather; Carroll, Anita; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

SEE MY EMAIL - VIEW?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Trouton, Heather
Sent: 12 November 2013 08:37
To: Carroll, Anita; Corrigan, Martina
Cc: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Anita

I have spoken both to Mr O'Brien himself and Mr Young as clinical lead for Urology

Mr O,Brien advised that he would cease this practice.

We could ask Mr Brown to discuss with him but I don't think it would have any effect.

hetaher

From: Carroll, Anita
Sent: 11 November 2013 13:28
To: Trouton, Heather; Corrigan, Martina
Cc: Burns, Deborah
Subject: FW: Mr O'Brien and charts

Dear all I know we have discussed before and heather I know you met him Really don't know what we now do A

From: Forde, Helen
Sent: 11 November 2013 13:07
To: Carroll, Anita
Subject: Mr O'Brien and charts

Just to keep you in the loop as this may be going to Debbie, and I've said to Martina.

A patient was attending Dr Convery's clinic this morning but the chart was tracked to Mr O'Brien in the Thorndale Unit. When records looked for it his secretary said she thought Mr O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9 am this morning. The chart didn't arrive in records and Dr Convery refused to see the patient without the chart. Pamela went to speak to Dr Convery and ask if he would see the patient as she had got as much information as she could for the appointment.

Mr O'Brien's secretary is off today so eventually Pamela got Mr O'Brien's number and phoned him to enquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning and got the chart and then brought it round to Dr Convery, and he informed Pamela that he was going to write to Debbie about this.

Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI
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Corrigan, Martina

From: Carroll, Anita < Personal Information redacted by the USI >
Sent: 12 November 2013 11:58
To: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Yes patient was seen

From: Burns, Deborah
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

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Helen Forde
Head of Health Records
Admin Floor, CAH

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Corrigan, Martina

From: Trouton, Heather [redacted]
Sent: 12 November 2013 08:43
To: Burns, Deborah
Subject: RE: Mr O'Brien and charts

Ok

I'll check with Robin today

Heather

From: Burns, Deborah
Sent: 12 November 2013 05:56
To: Carroll, Anita; Trouton, Heather; Corrigan, Martina
Subject: RE: Mr O'Brien and charts

Did the patient get seen? I think if we cant agree with him – John Simpson needs involved. Heather was robin addressing this with him – follow up with robin to check that happened - if it did John is next step D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

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Helen Forde
Head of Health Records
Admin Floor, CAH
Personal Information redacted by the USI
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Willis, Lisa

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Heather
I wonder if could you call me on the phone to discuss this I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient [redacted], so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Despite the fact that patients sitting not triaged from August mean that we have breached the access standard before we even start to look for appointments I am more concerned about the clinical implications for patients who need seen urgently and possibly even needing upgraded to a red flag status.

We really need you to speak with Mr O'Brien both in the capacity of a colleague but also in your capacity of Clinical lead and Clinical Director for Urology as well of course as patient advocates.

I also really need a response within 1 week on how this is being addressed for now and the future or I will be forced to escalate to Debbie and Mr Mackle as Director and AMD for this service. It has already been suggested that Dr Simpson be involved which I have not progressed to date but it may have to come to that unless a sustainable solution can be found.

Thank you for your assistance

Heather

From: Corrigan, Martina
Sent: 26 November 2013 08:02
To: Robinson, Katherine; Glenny, Sharon
Cc: Trouton, Heather
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear both

Please see below – Katherine can you advise if you receive these?

Thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: O'Brien, Aidan
Sent: 26 November 2013 02:08
To: Corrigan, Martina
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Martina,
I really am so sorry that I have fallen so behind in triaging.
However, whilst on leave, I have arranged all outstanding letters of referral in chronological order, so that I can passed them to CAO via Monica in that order, beginning tomorrow.
I know that I have fallen behind particularly badly (except for red flag referrals which are up to date) and I do appreciate that this causes many staff inconvenience and frustration, and that all have been patient with me!
I can assure you that I will catch up, but am determined to do so in a chronologically ordered fashion,

Aidan

From: Corrigan, Martina
Sent: 24 November 2013 17:28

To: O'Brien, Aidan
Cc: McCorry, Monica; Robinson, Katherine; Glenny, Sharon
Subject: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Importance: High

Dear Aidan,

Please advise, this is holding up picking patients for all clinics as these letters have not been triaged and I know that this will need to be escalated early this week if not resolved.

I would be grateful for your action/update

Thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Robinson, Katherine
Sent: 21 November 2013 14:31
To: Corrigan, Martina
Subject: FW: MISSING TRIAGE

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre Ramone Building Craigavon Area Hospital

t: Personal Information redacted by the USI
e: Personal Information redacted by the USI

From: Browne, Leanne
Sent: 21 November 2013 14:12
To: McCorry, Monica
Cc: Cunningham, Andrea; Robinson, Katherine
Subject: MISSING TRIAGE

Monica

Here is list of missing triage as requested.

CAH

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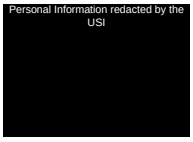


URO

AOB

ROUTINE

03/09/2013

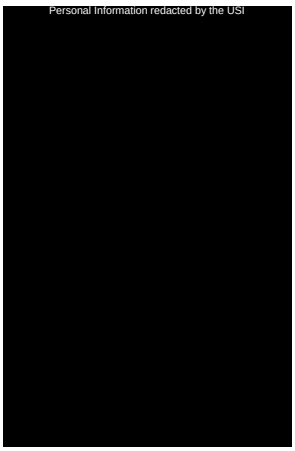
65

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

email to sharon 11.11.13

CAH



URO

GURO

ROUTINE

23/08/2013

76

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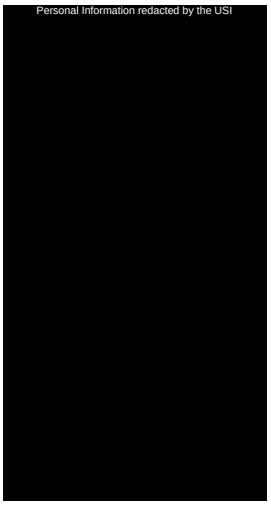
EMAIL TO SHARON GLENNY 1.11.13

CAH



URO

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ROUTINE

27/08/2013

72

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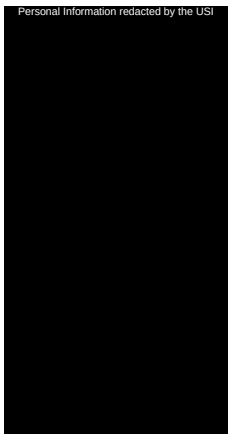

URO

GURO

ROUTINE

28/08/2013

71

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH

URO

GURO

ROUTINE

28/08/2013

71

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

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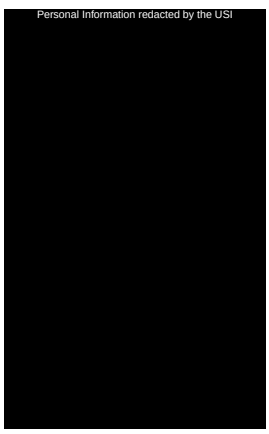

URO

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ROUTINE

29/08/2013

70

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

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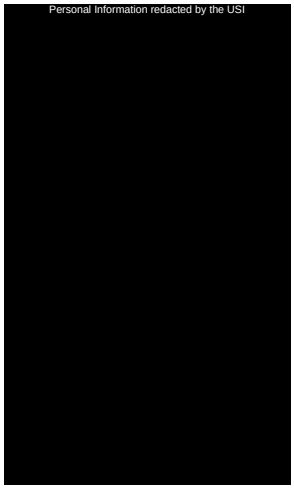

URO

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ROUTINE

29/08/2013

70

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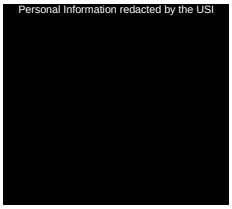

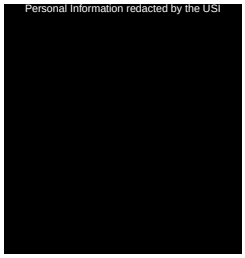

URO

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ROUTINE

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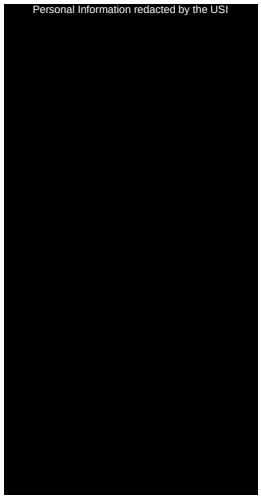

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29/08/2013

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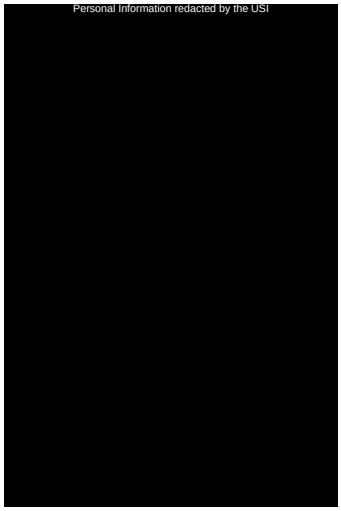

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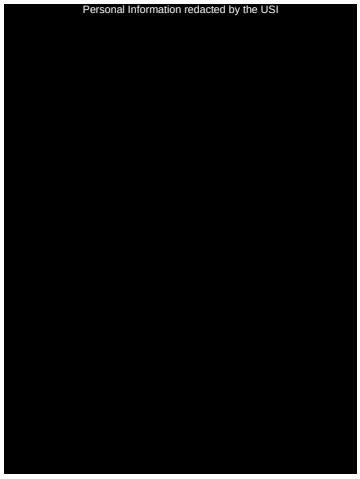

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29/08/2013

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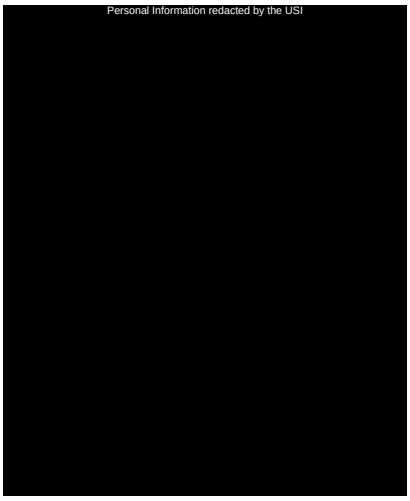

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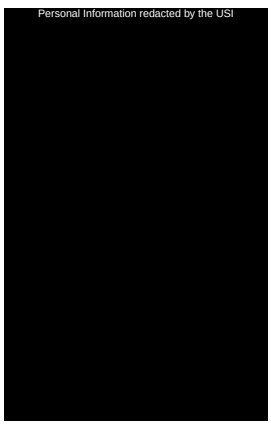

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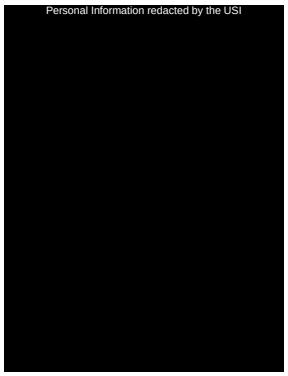

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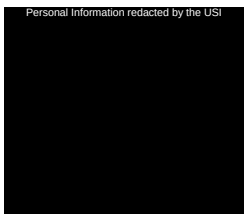

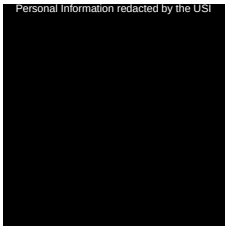

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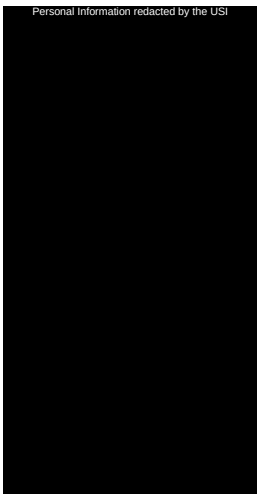

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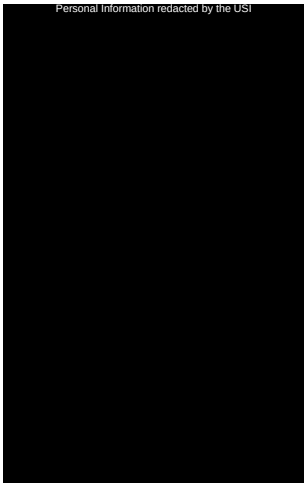

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AOB

ROUTINE

03/09/2013

65

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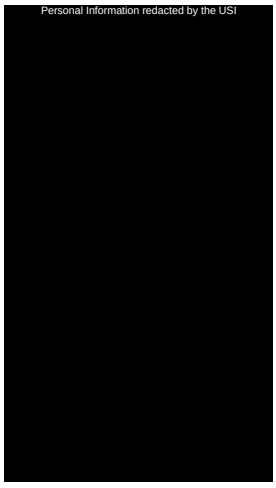

URO

GURO

ROUTINE

04/09/2013

64

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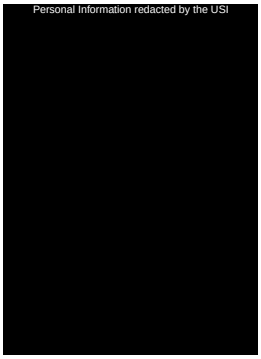

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ROUTINE

09/09/2013

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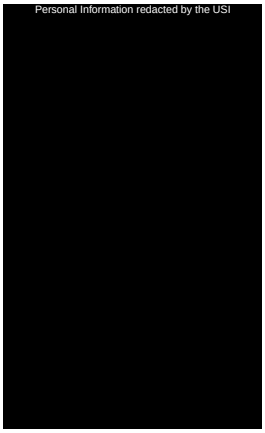

Personal Information redacted by the USI

URO

AOB

URGENT

10/09/2013

58

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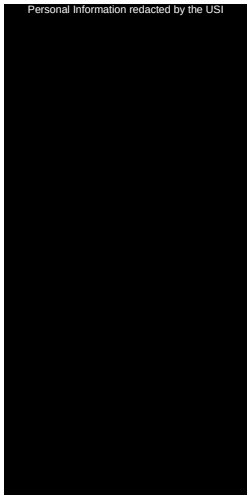
EMAIL TO SHARON GLENNY 1.11.13

CAH

Personal Information redacted by the USI



URO

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ROUTINE

10/09/2013

58

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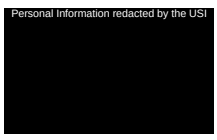


URO

AOB

ROUTINE

10/09/2013

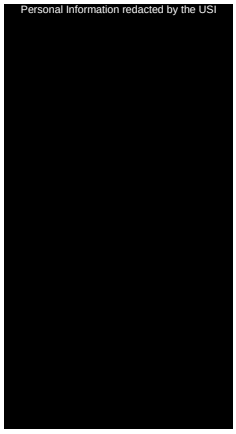
58

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

CAH



URO

AOB

ROUTINE

11/09/2013

57

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

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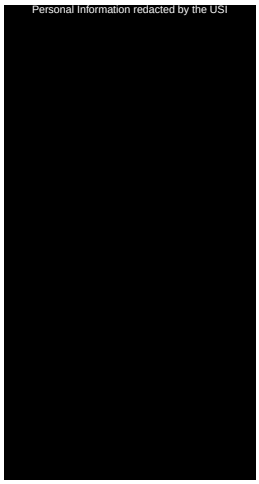


URO

GURO

ROUTINE

27/08/2013

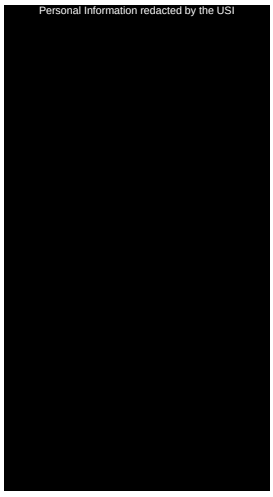
72

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMIAL TO SHARON GLENNY 1.11.13

CAH



URO

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ROUTINE

28/08/2013

71

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMIAL TO SHARON GLENNY 1.11.13

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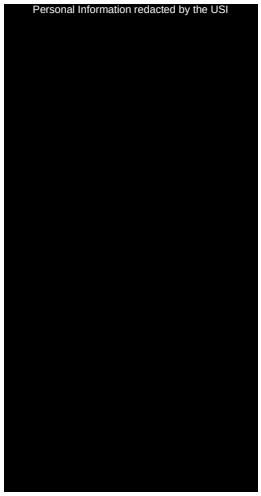

URO

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ROUTINE

29/08/2013

70

EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMIAL TO SHARON GLENNY 1.11.13

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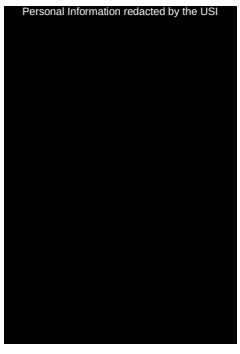

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ROUTINE

03/09/2013

65

MY TO AOB - EMAIL TO MONICA/NOLEEN 091013 - AC

EMAILED ANDREA 161013 AC

EMAIL TO SHARON GLENNY 1.11.13

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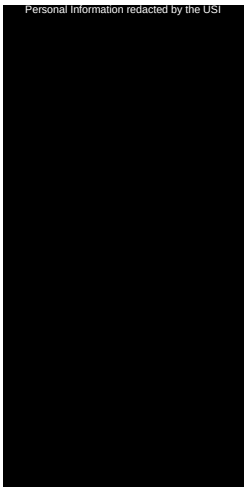

URO

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ROUTINE

19/09/2013

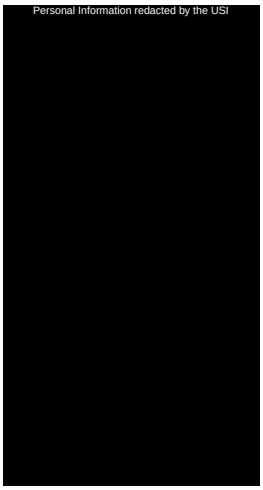
49

EMAIL SENT TO MONICA 161013

email to andrea 1.11.13

email to sharon 11.11.13

CAH



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URGENT

19/09/2013

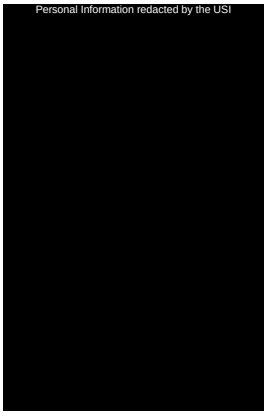
49

EMAIL SENT TO MONICA 161013

email to andrea 1.11.13

email to sharon 11.11.13

CAH



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AOB

ROUTINE

20/09/2013

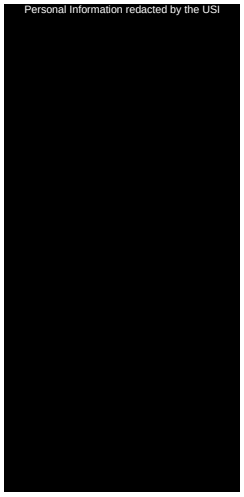
48

EMAIL SENT TO MONICA 161013

email to andrea 1.11.13

email to sharon 11.11.13

CAH



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ROUTINE

26/09/2013

42

email to monica 11.11.13

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AOB

ROUTINE

27/09/2013

41

email to monica 11.11.13

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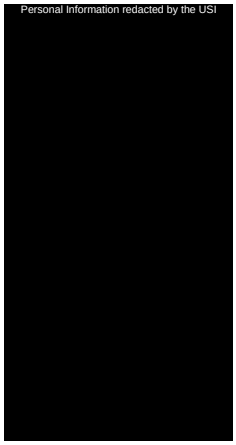

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AOB

URGENT

30/09/2013

38

email to monica 11.11.13

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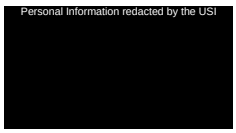

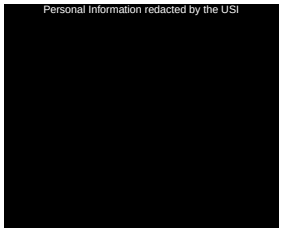

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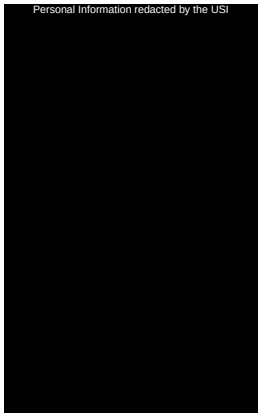
ROUTINE

02/10/2013

36

email to monica 11.11.13

CAH



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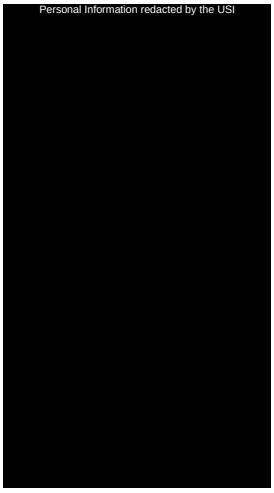
ROUTINE

02/10/2013

36

email to monica 11.11.13

CAH



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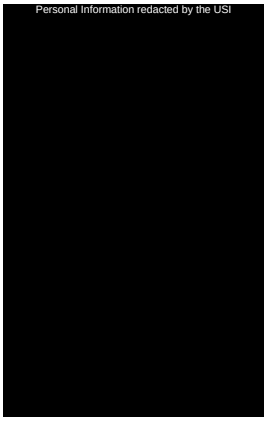
URGENT

09/10/2013

29

email to monica 11.11.13

CAH



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ROUTINE

11/10/2013

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email to monica 11.11.13

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email to monica 11.11.13

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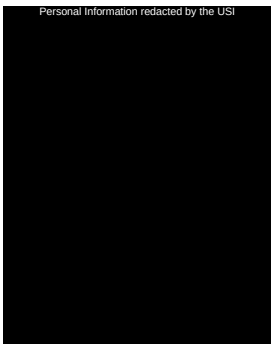

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ROUTINE

11/10/2013

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email to monica 11.11.13

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email to monica 11.11.13

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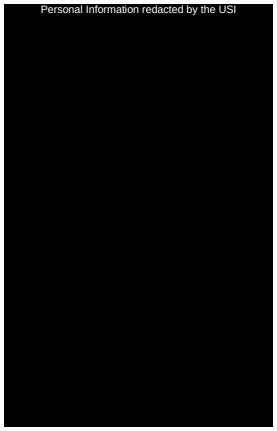

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ROUTINE

11/10/2013

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email to monica 11.11.13

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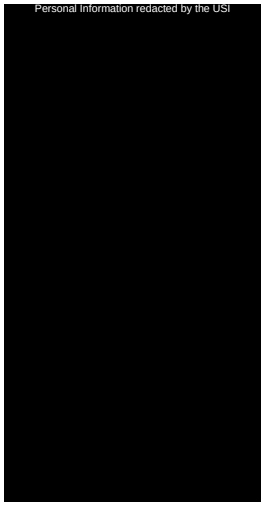

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ROUTINE

11/10/2013

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email to monica 11.11.13

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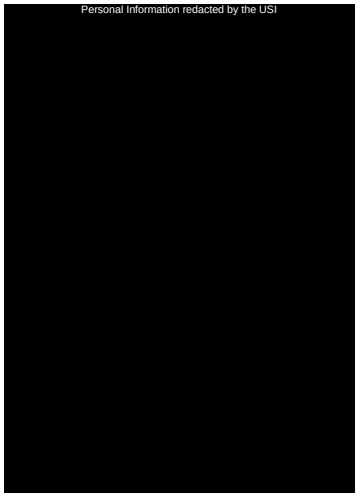

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ROUTINE

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email to monica 11.11.13

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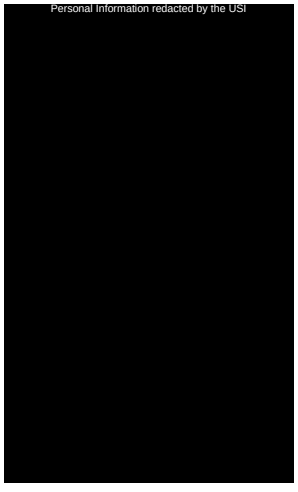

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ROUTINE

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email to monica 11.11.13

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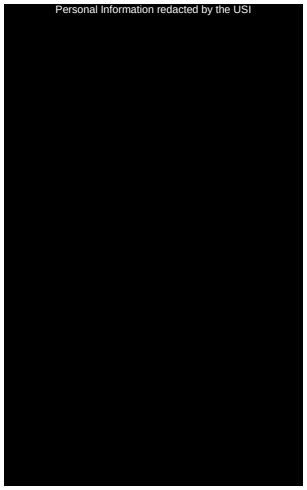

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email to monica 11.11.13

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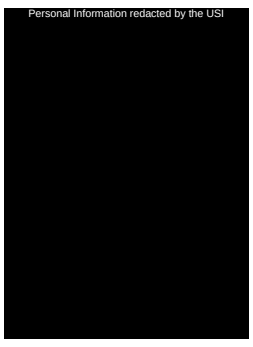

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email to monica 11.11.13

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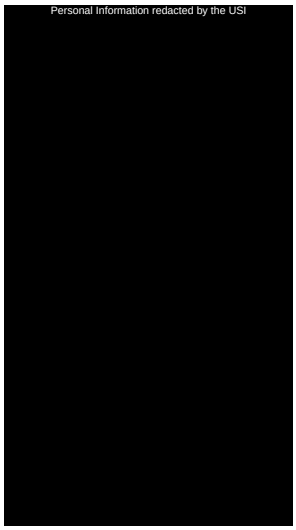

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email to monica 11.11.13

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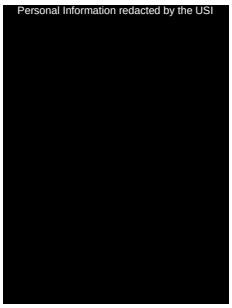

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email to monica 11.11.13

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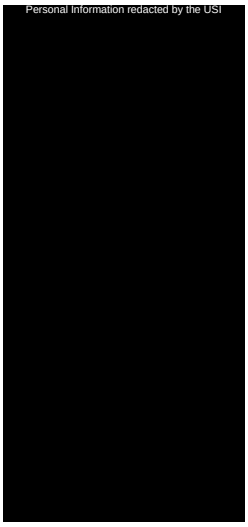

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ROUTINE

11/10/2013

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email to monica 11.11.13

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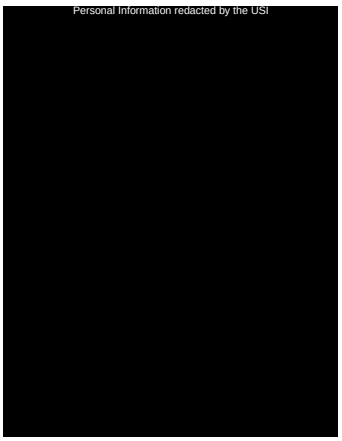

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ROUTINE

11/10/2013

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email to monica 11.11.13

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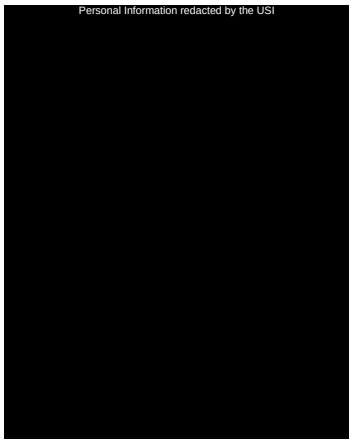

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ROUTINE

11/10/2013

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email to monica 11.11.13

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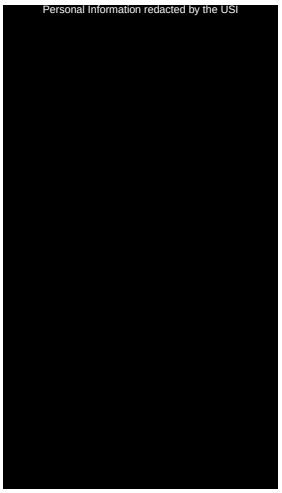

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GURO

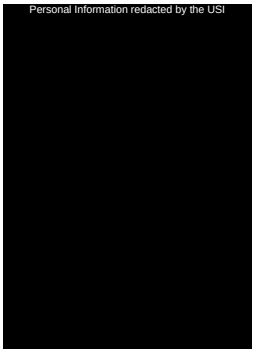
URGENT

14/10/2013

24

email to monica 11.11.13

CAH



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14/10/2013

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email to monica 11.11.13

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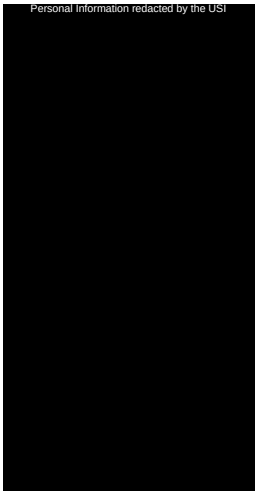

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ROUTINE

14/10/2013

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email to monica 11.11.13

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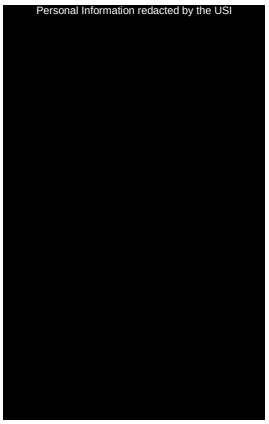

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14/10/2013

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email to monica 11.11.13

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14/10/2013

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email to monica 11.11.13

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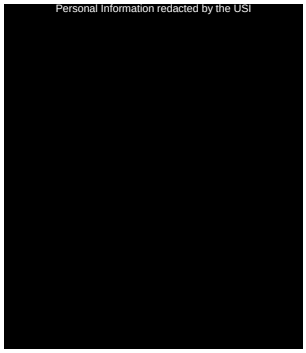

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ROUTINE

14/10/2013

24

email to monica 11.11.13

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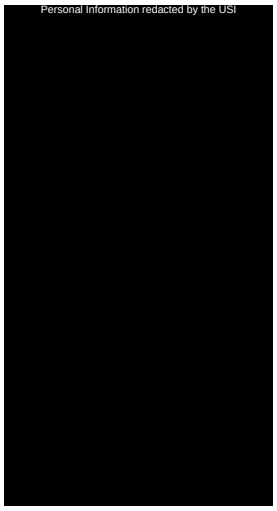

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ROUTINE

14/10/2013

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email to monica 11.11.13

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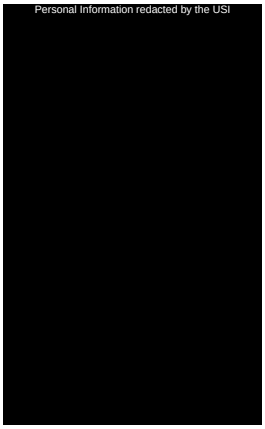

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ROUTINE

14/10/2013

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email to monica 11.11.13

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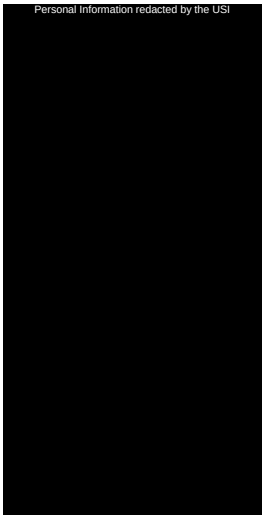

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ROUTINE

14/10/2013

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email to monica 11.11.13

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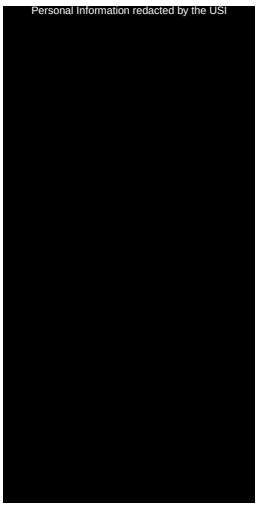

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ROUTINE

14/10/2013

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email to monica 11.11.13

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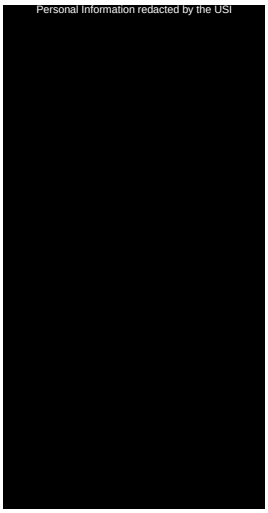

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ROUTINE

14/10/2013

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email to monica 11.11.13

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ROUTINE

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email to monica 11.11.13

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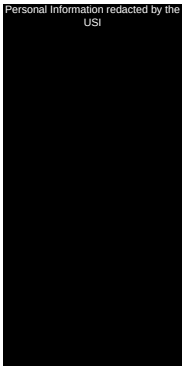

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ROUTINE

15/10/2013

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email to monica 11.11.13

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15/10/2013

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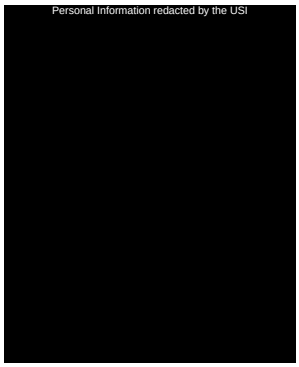

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ROUTINE

15/10/2013

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email to monica 11.11.13

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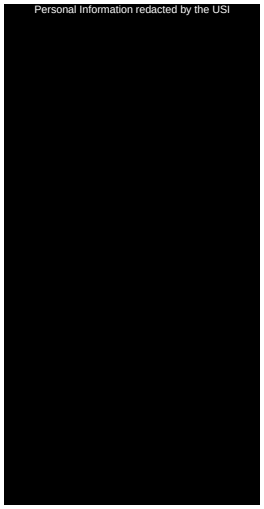

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15/10/2013

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email to monica 11.11.13

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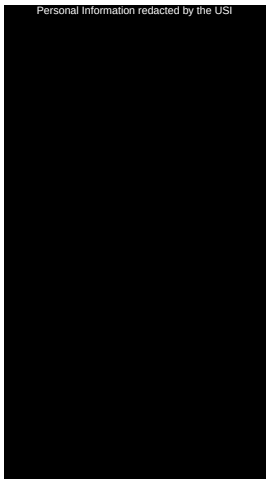

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ROUTINE

16/10/2013

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email to monica 11.11.13

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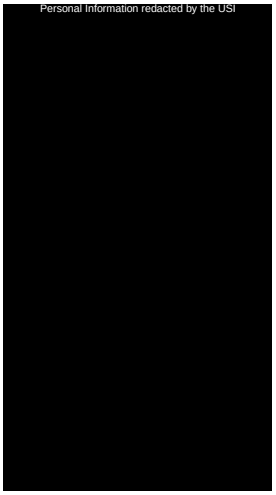

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ROUTINE

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email to monica 11.11.13

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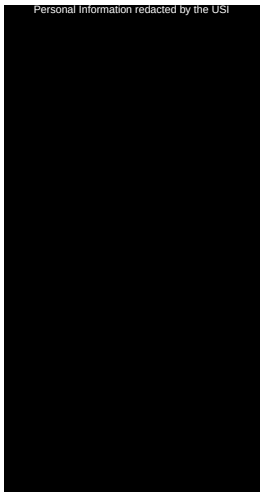

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ROUTINE

16/10/2013

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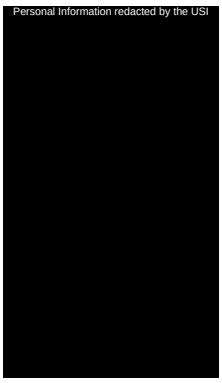

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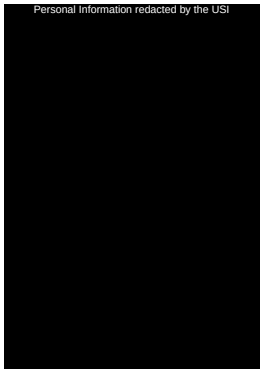

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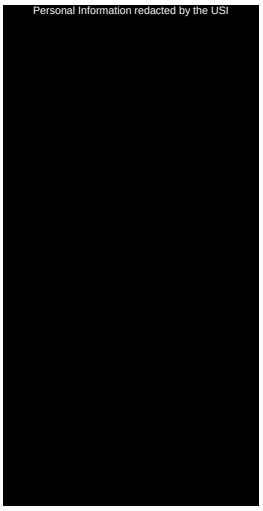

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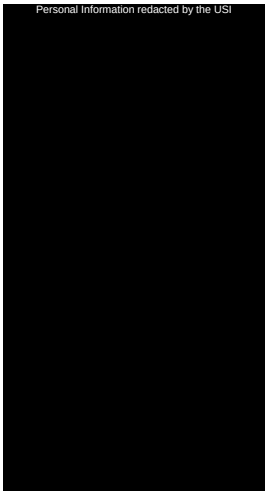

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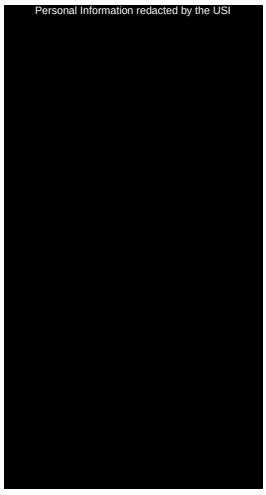

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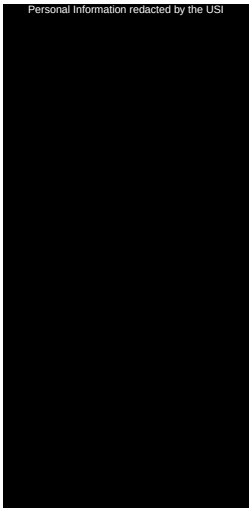

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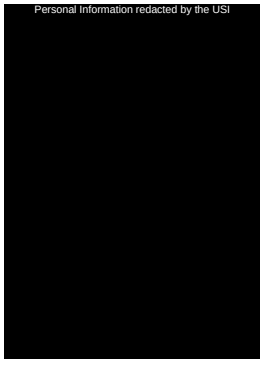

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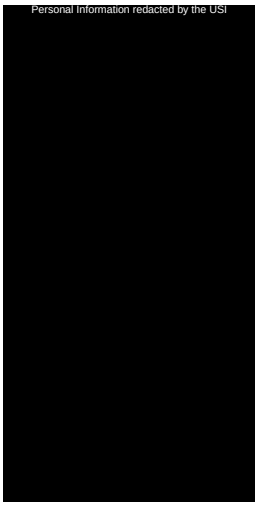

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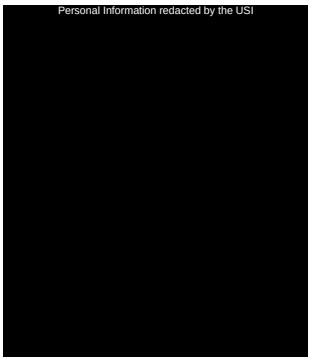

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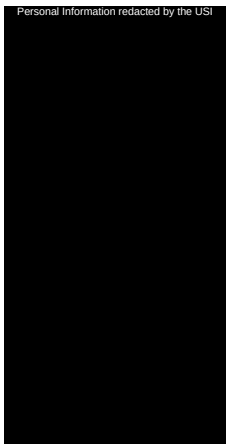

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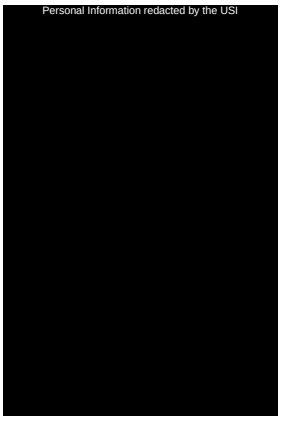

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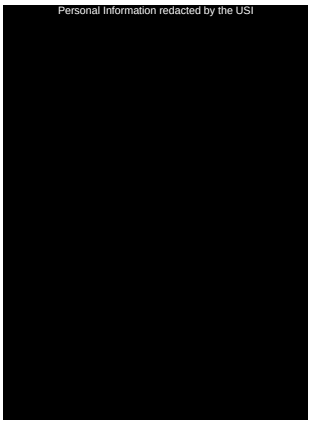

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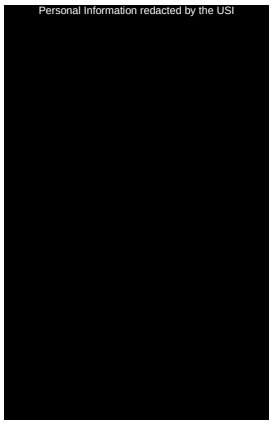

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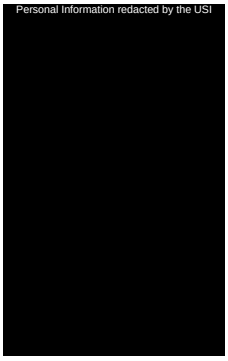

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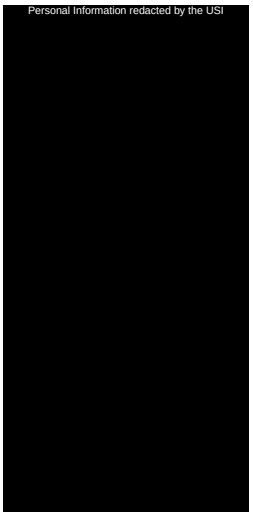

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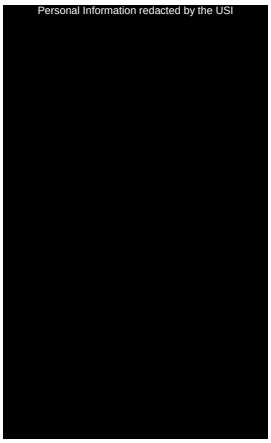

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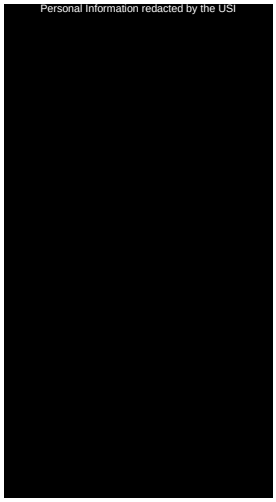

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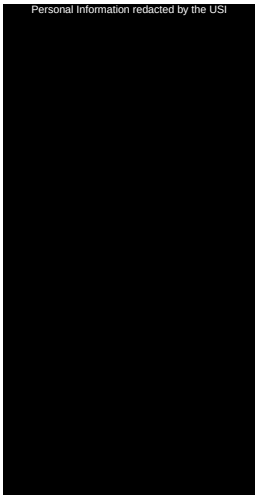

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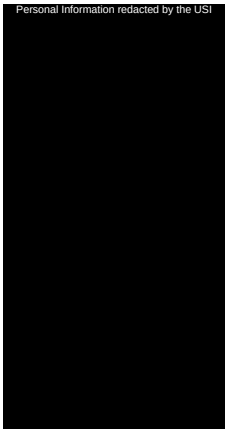

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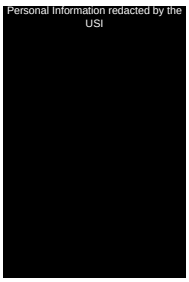

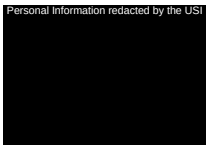

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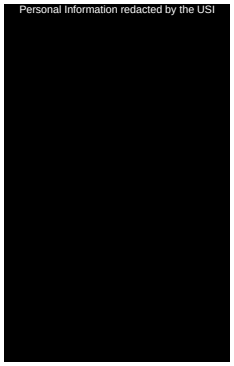

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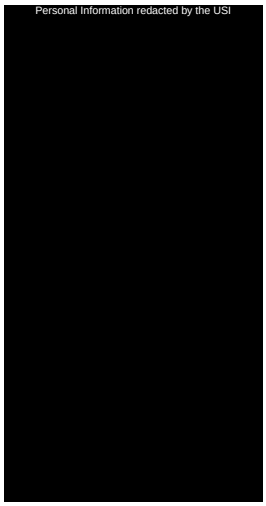

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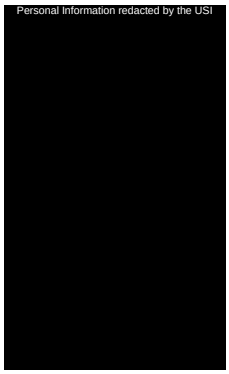

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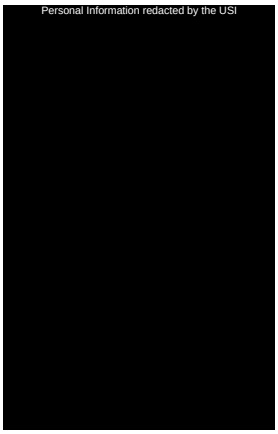

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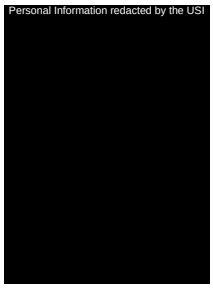

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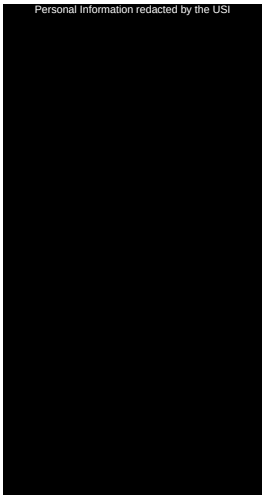

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ROUTINE

17/10/2013

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email to monica 11.11.13

Leanne

Leanne Browne
Acting Supervisor
Referral & Booking Centre
Ramone Building
Craigavon Area Hospital
T: Personal Information redacted by the USI
E: Personal Information redacted by the USI

Corrigan, Martina

From: Mackle, Eamon [redacted]
Sent: 20 February 2014 11:30
To: Burns, Deborah
Subject: Fw: CHARTS AND aob

From: Carroll, Anita
Sent: Wednesday, February 12, 2014 04:47 PM GMT Standard Time
To: Trouton, Heather; Mackle, Eamon
Cc: Corrigan, Martina
Subject: FW: CHARTS AND aob

Sharing as requested
A

From: Lawson, Pamela
Sent: 12 February 2014 16:46
To: Carroll, Anita
Subject: RE: can i have an update on mr o brien ?

Anita – please see below – these are details of the IR1 forms submitted re charts Mr O'Brien has had to bring in from his home for clinics and admissions.

08/05/13 – 1 chart
20/05/13 – 1 chart
16/05/13 – 1 chart
31/05/13 – 2 charts
14/06/13 – 1 chart
22/08/13 – 3 charts
23/08/13 – 2 charts
27/08/13 – 3 charts
30/08/13 – 2 charts
16/09/13 – 1 chart
18/09/13 – 1 chart
20/09/13 – 1 chart
03/10/13 – 6 charts
14/10/13 – 1 chart
15/10/13 – 1 chart – AOB forgot to bring chart in – pages and labels had to be made up for CDSU procedure
15/10/13 – 1 chart
04/11/13 – 1 chart – chart did not arrive in time for clinic
25/11/13 – 6 charts
11/12/13 – 6 charts
08/01/14 – 2 charts
09/01/14 – 2 charts
21/01/14 – 3 charts – not able to get these charts as AOB was out of the country and his secretary was on leave
24/01/14 – 3 charts
12/02/14 – 3 charts

From: Carroll, Anita
Sent: 12 February 2014 16:38

To: Lawson, Pamela
Subject: can i have an update on mr o brien ?

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
Daisy Hill Hospital
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina <[redacted]>
Sent: 06 March 2014 18:04
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

Debbie and I met with Mr O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is oncall he will be no longer triaging general urology letters.

Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

Any issues can you please highlight to me in the first instance.

Many thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

Willis, Lisa

From: Corrigan, Martina
Sent: 04 April 2014 14:55
To: Robinson, Katherine; Carroll, Anita
Cc: Trouton, Heather
Subject: Re: Mr O'Brien triage

Follow Up Flag: Follow up
Flag Status: Flagged

Katherine

It is definitely Mr Young supposed to be triaging as this was agreed with Debbie. As you know I am off today but I will email Mr Young and Paulette. The problem will be that Mr Young is off on leave next week so I will get a plan in place on Monday to get this sorted.

Will let you know as soon as possible.

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile Personal Information redacted by the USI

From: Robinson, Katherine
Sent: Friday, April 04, 2014 02:20 PM
To: Corrigan, Martina; Carroll, Anita
Subject: Fw: Mr O'Brien triage

What's going on. Do u know

From: Coleman, Alana
Sent: Friday, April 04, 2014 02:00 PM
To: Robinson, Katherine; Corrigan, Martina; Browne, Leanne
Subject: FW: Mr O'Brien triage

Hi Katherine/Martina,

Per email below we were advised to send Mr O'Brien triage to Mr young excluding named referrals. I have sent these to Mr Young's secretary and I have just received a batch of referrals date stamped 01/04/14 and 02/04/14 not triaged (more triage was also returned yesterday un-triaged but we have sent these back to Paulette). On the pro-forma which is sent with referrals Paulette has written *Mr Young not on call – Mr O'Brien* this was also written on the returned referrals yesterday.
I have attached emails between myself and Paulette regarding the triage, can you advise if these is a change from the email below and that the referrals do actually need to go to Mr O'Brien.

Thanks
Alana

From: Browne, Leanne
Sent: 06 March 2014 19:55
To: Coleman, Alana

Subject: FW: Mr O'Brien triage

From: Robinson, Katherine
Sent: Thursday, March 06, 2014 7:54:55 PM
To: Browne, Leanne
Subject: Fw: Mr O'Brien triage
Auto forwarded by a Rule

From: Corrigan, Martina
Sent: Thursday, March 06, 2014 06:03 PM
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Willis, Lisa

From: Carroll, Anita
Sent: 04 April 2014 15:23
To: Trouton, Heather
Subject: FW: Mr O'Brien triage
Attachments: RE: Mr O'Brien triage.eml; REFERRALS.eml

Follow Up Flag: Follow up
Flag Status: Flagged

From: Robinson, Katherine
Sent: 04 April 2014 14:21
To: Corrigan, Martina; Carroll, Anita
Subject: Fw: Mr O'Brien triage

What's going on. Do u know

From: Coleman, Alana
Sent: Friday, April 04, 2014 02:00 PM
To: Robinson, Katherine; Corrigan, Martina; Browne, Leanne
Subject: FW: Mr O'Brien triage

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Many thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Willis, Lisa

From: Dignam, Paulette [redacted]
Sent: 03 April 2014 09:24
To: Coleman, Alana
Subject: REFERRALS

Hi Alana

Have been trying to phone you back but your line is constantly engaged. Mr Young is not triaging Mr O'Brien's referrals. He did some of his backlog to help clear this a while back but Mr O'Brien is doing his own triage.

Many thanks
Paulette

Willis, Lisa

From: Dignam, Paulette [redacted]
Sent: 03 April 2014 11:19
To: Coleman, Alana
Subject: RE: Mr O'Brien triage

Hi Alana

I haven't been told this and on checking with Monica this morning she has informed me Mr O'Brien is triaging himself.

Many thanks
Paulette

From: Coleman, Alana
Sent: 03 April 2014 09:29
To: Dignam, Paulette
Subject: FW: Mr O'Brien triage

Hey,

Sorry was speaking with Leanne to try and figure out what's going on, email below indicates Mr Young has agreed to triage all Mr O'Brien triage apart from his named referrals.

Thanks
Alana

From: Browne, Leanne
Sent: 06 March 2014 19:55
To: Coleman, Alana
Subject: FW: Mr O'Brien triage

From: Robinson, Katherine
Sent: Thursday, March 06, 2014 7:54:55 PM
To: Browne, Leanne
Subject: Fw: Mr O'Brien triage
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To: Robinson, Katherine
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Subject: Mr O'Brien triage

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Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

Any issues can you please highlight to me in the first instance.

Many thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Willis, Lisa

From: Corrigan, Martina
Sent: 13 April 2014 16:27
To: Trouton, Heather
Subject: RE: Mr O'Brien triage

Follow Up Flag: Follow up
Flag Status: Flagged

No Heather

Paulette had decided that Mr Young was too busy and returned these I have since spoken to her and Mr Young and I have all sorted!

Martina

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

Telephone: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Trouton, Heather
Sent: 07 April 2014 19:21
To: Corrigan, Martina
Subject: FW: Mr O'Brien triage

Martina

Has Mr Young refused to do this ?
Heather

From: Carroll, Anita
Sent: 04 April 2014 15:23
To: Trouton, Heather
Subject: FW: Mr O'Brien triage

From: Robinson, Katherine
Sent: 04 April 2014 14:21
To: Corrigan, Martina; Carroll, Anita
Subject: Fw: Mr O'Brien triage

What's going on. Do u know

From: Coleman, Alana
Sent: Friday, April 04, 2014 02:00 PM

To: Robinson, Katherine; Corrigan, Martina; Browne, Leanne
Subject: FW: Mr O'Brien triage

Hi Katherine/Martina,

Per email below we were advised to send Mr O'Brien triage to Mr young excluding named referrals. I have sent these to Mr Young's secretary and I have just received a batch of referrals date stamped 01/04/14 and 02/04/14 not triaged (more triage was also returned yesterday un-triaged but we have sent these back to Paulette). On the pro-forma which is sent with referrals Paulette has written *Mr Young not on call – Mr O'Brien* this was also written on the returned referrals yesterday.
I have attached emails between myself and Paulette regarding the triage, can you advise if these is a change from the email below and that the referrals do actually need to go to Mr O'Brien.

Thanks
Alana

From: Browne, Leanne
Sent: 06 March 2014 19:55
To: Coleman, Alana
Subject: FW: Mr O'Brien triage

From: Robinson, Katherine
Sent: Thursday, March 06, 2014 7:54:55 PM
To: Browne, Leanne
Subject: Fw: Mr O'Brien triage
Auto forwarded by a Rule

From: Corrigan, Martina
Sent: Thursday, March 06, 2014 06:03 PM
To: Robinson, Katherine
Cc: Carroll, Anita; Trouton, Heather; Burns, Deborah
Subject: Mr O'Brien triage

Katherine

Debbie and I met with Mr O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is oncall he will be no longer triaging general urology letters.

Mr Young has asked that during the week of Mr O'Brien's oncall, can the general urology letters that Mr O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr O'Brien is oncall for March is actually 31 March, so this will not happen until then.

Any issues can you please highlight to me in the first instance.

Many thanks

Martina

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

Telephone: Personal Information redacted by the USI (Direct Dial)
Mobile: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Stinson, Emma M

From: Carroll, Ronan <[redacted]>
Sent: 05 March 2014 16:23
To: Trouton, Heather; Corrigan, Martina; Burns, Deborah
Cc: Reddick, Fiona; Clayton, Wendy
Subject: Urology Cancer Summary Feb 14 D2
Attachments: Urology Cancer Summary Feb 14 D2.doc

Importance: High

Please see attached paper drafted by Cancer team which outlines urology cancer performance against D62 day target. Solutions are proffered as this requires round table discussion and agreement, but we all know we have commenced on the reengineering process – Fiona, Wendy and myself are happy to talk though Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICS
Mobile [redacted]

Urology Cancer Analysis

Introduction

The following document describes the urology cancer performance against the required 62 day pathway for patients who are referred in as a RF by their GP or the GP referral is upgraded to RF by consultant following triage

Background

Since October 2006 the Cancer Services Team have been tracking pathway and time lines for suspect cancer referrals and newly diagnosed cancer patients in the Trust.

- By March 2009 95% of GP suspected cancer referrals to be diagnosed and commence treatment within 62 days –
- By March 2008 98% of patients diagnosed with cancer should begin treatment within 31 days of the decision to treat date.

It is accepted 62day cancer pathways are challenging as there are many steps in the pathway, each with distinct time limits.

Through the NICaN urology tumour group pathways have been agreed for prostate, renal, testicular and bladder cancers. A pathway can be split into the following sections:

1. Triage of referral – 0-2 days
2. 1st outpatient appointment – D0-D10
3. Diagnostic tests – D10- D20
4. Multi-disciplinary meeting – D20-D31
5. 1st Definitive treatment within D62

The following information describes the Urology performance against each step 1-5 (as described above). RF GP or GP referrals upgraded to RF by consultant following triage can be subdivided into two main tumour groups i.e. prostate and haematuria. For the cancer team working with the Urology HoS the challenge centres almost exclusively on haematuria RF patients.

The data and summaries presented herein do not separate out RF prostate and haematuria patients, therefore this is the entire urology RF performance. The information is extracted from Business Objects XI (BOXI) on 'closed' cases only for 62 day urology patients over Oct-Dec 2013

1. TRIAGE

The triage target for all RF referrals is 48 hours from receipt of referral. A manual audit was undertaken between 1st Dec 2013 to the 31st January 2014 on the triage turnaround of urology referrals from receipt of referral to triage complete.
Table 1 details findings:

TABLE 1	
Triage Turnaround (days)	**No. of referrals**
0	15
1	24
2	19
3	16
4	26
5	12
6	7
7	10
8	2
9	0
10	1
11	1
	133
Outstanding refs	13
Total referrals	146
% turnaround within 48 hours	**39.7%**

As demonstrated above only 39.7% of referrals were triaged within 48 hours.

2. 1st outpatient appointment

The target for 1st red flag (RF) outpatient appointment is by Day 10 of the 62 day pathway. Table 2 below demonstrates length of time patients have waited for 1st appointment from date RF urology referral was received
Table 2

Month RF ref received	D0-10	D11-14	D15-20	D20+	Total refs
Oct 13	17 (16%)	22 (21%)	35 (33%)	31 (30%)	105
Nov 13	18 (15%)	8 (7%)	24 (21%)	75 (57%)	117
Dec 13	4 (5%)	6 (7%)	8 (9%)	68 (79%)	86

In summary:

- Oct 16% of urology patients received their 1st appointment within 10 days
- Nov 15% of urology patients received their 1st appointment within 10 days
- Dec 5% of urology patients received their 1st appointment within 10 days

3. Diagnostic tests

There are a number of tests as part of the urology cancer pathway these include CT, MRI, cystoscopy and TRUS biopsy. In order to progress the patient along the urology pathway within target, it is recommended that all diagnostic tests are completed by D20.. The Table 3 below demonstrates the average length of time patients have had their diagnostic tests performed on the pathway.

Table 3

Month diagnostic performed	By D20	D21-30	D31-40	D41-50	D51-60	D60+
CT	2 (10%)	3	2	3	4	6
Cystoscopy	3 (19%)	2	5	2	1	3
MRI	1 (20%)	0	0	0	0	4
TRUS B	1 (20%)	1	1	1	1	0

4. Multi-disciplinary Meeting (MDM)

Each RF urology patient is to be discussed at a Urology MDM in order for the mutli-disciplinary team to collective agree the best first definitive treatment plan for the patient. Discussion at MDM is to be by D21 in order to enable to complete their pathway by D62. Table 4 below shows average length of days a RF patient waits for discussion at their 1st MDM

Table 4

Month	By D21	D22-30	D31-40	D41-50	D51-60	D60+
1st MDM day	4 (14%)	4	3	5	4	9

5. 1st Definitive Treatment

The patient's pathway is complete when the 1st definitive treatment is commenced, whether it is hormone treatment, palliative, radiotherapy, chemotherapy or surgery. Table 5 outlines average (per month) day patient received their 1st definitive treatment.

Table 5

Month	By D62	D63-75	D76-85	D86-100	D100+
1st def tx	6 (40%)	2	2	1	4

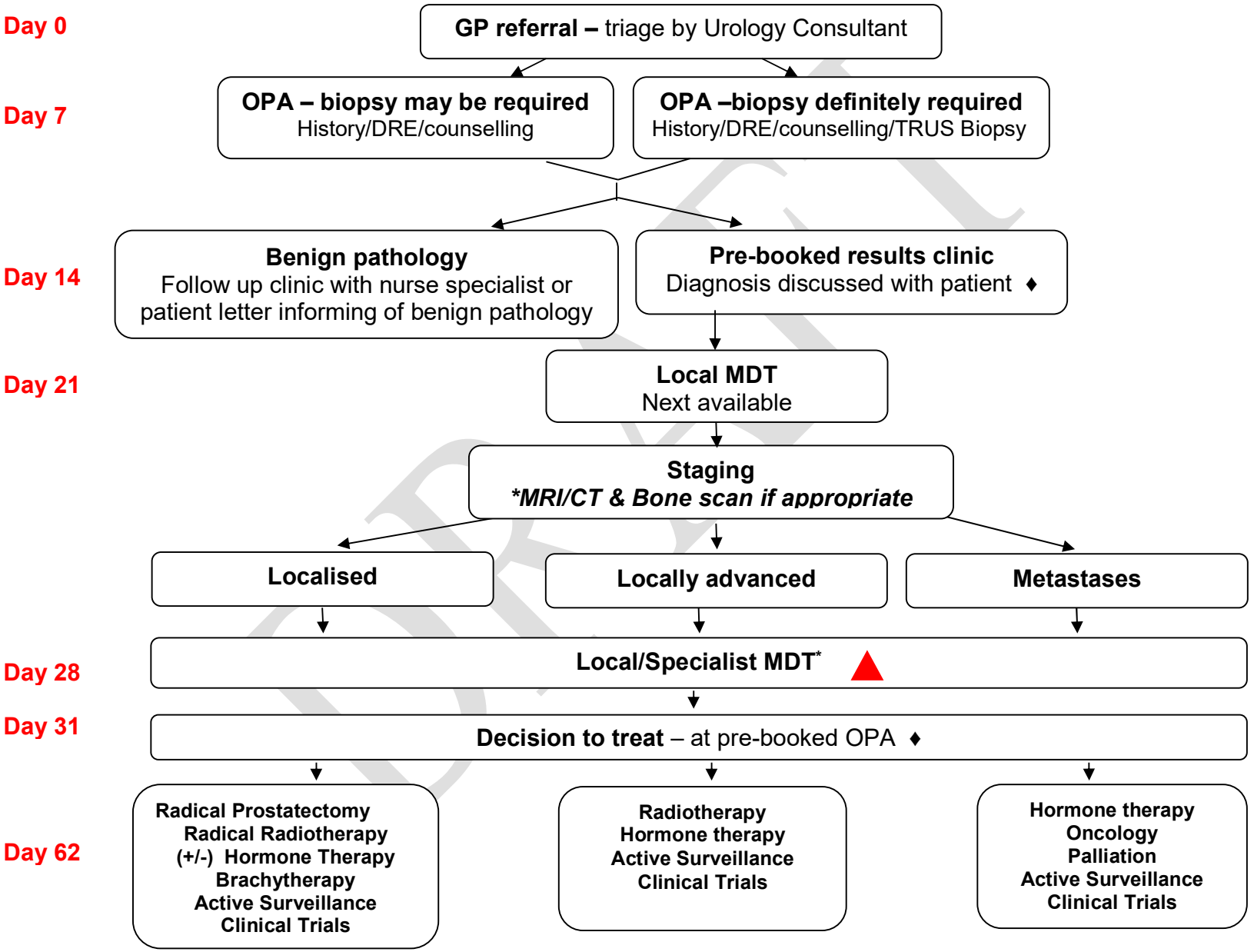
SUMMARY

The urology patient journey is a complex one with a number of time limiting milestones before 1st treatment. Below is a summary of achievement of each milestone (average per month)

1. Triage – 39.7% turnaround of triage within 48 hours
2. 1st RF outpatient appointment – 12% of appointments within D10
3. Diagnostic tests by D20 CT 10% - Cystoscopy 19% - MRI 20% Trus B 20%
4. MDM discussion – 14% of RF patients were discussed by D21
5. 1st Definitive Treatment – 40% of patients received their 1st treatment by D62

Solutions

Prostate Pathway



Renal Tumour

Maximum Wait	Pathway	Good Practice & Quality Parameters
1/62	GP referral	See NICaN referral guidelines, 2007
7/62	One Stop Haematuria Clinic Flexible cystoscopy + Upper Tract Imaging/ History Physical	
	Renal Tumour	
	Stage tumour	
28/62	**Patient discussed at MDT** Δ	
31/62	Other point of entry (A&E, Incidental Findings) → Outpatient's appointment Treatment options discussed Decision to treat ♦	
62/62		

- Letter from MDT to GP
- Proactive pathway management
- PACS
- Regionally agreed dataset and d'base (NICR)

*** *Manual of Cancer Service Standards*
Oncology Protocols (to include Clinical Trials)

PT1a B	PT2	PT3a	PT3b	PT4 M1
Laparoscopic Treatment of choice ? Partial ? Open Surgery ? Laparoscopic	Laparoscopic ? Open	Open ? Laparoscopic	Open ? Laparoscopic Vascular Surgeon Cardiac Bypass	? Debulk + Immunotherapy Embolisation Radiotherapy Palliative Care New drugs

Renal Preservation

Partial Nephrectomy
Open/ Laparoscopy
Auto transplant
Radio Frequency Ablation
Cryotherapy

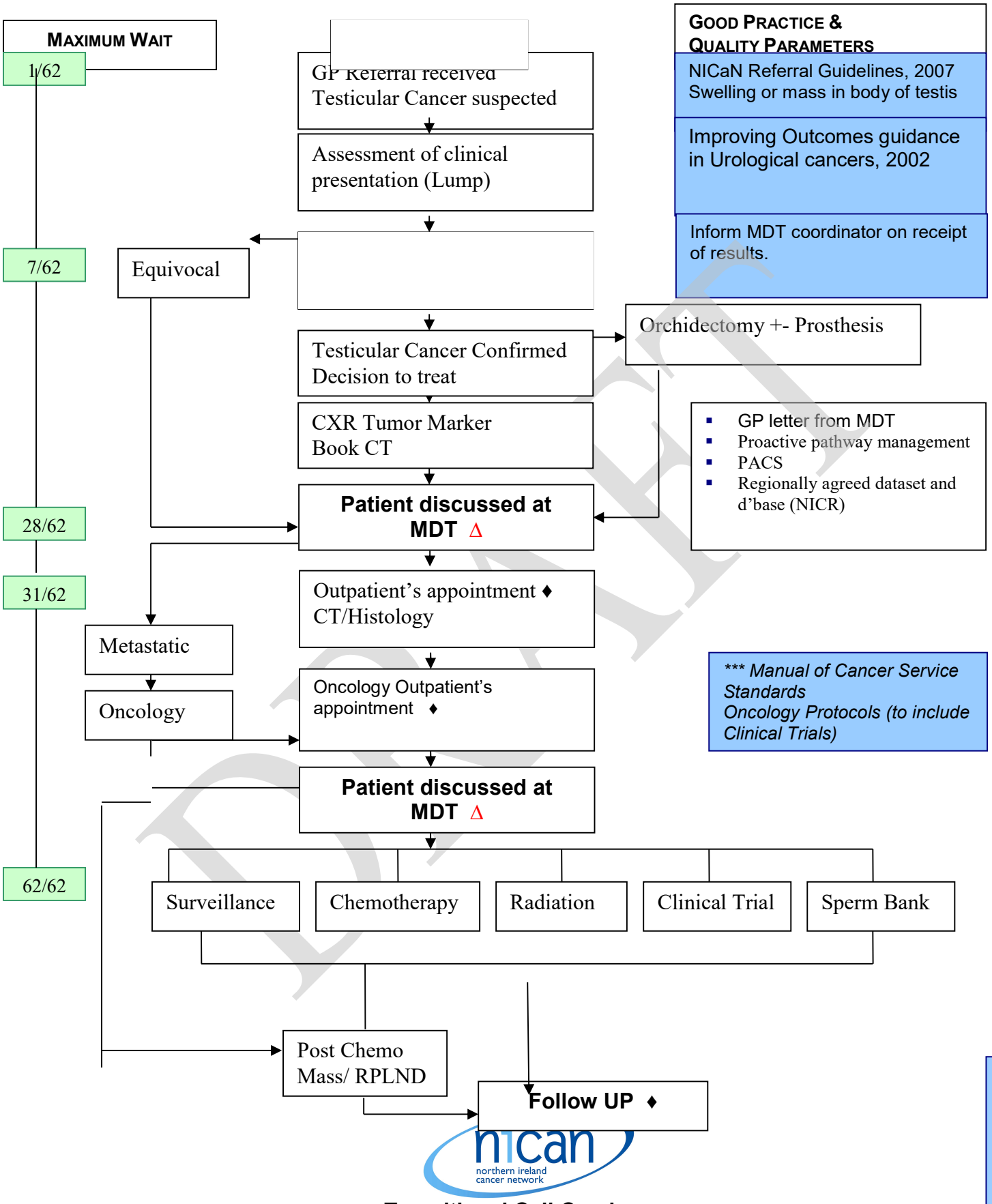
Follow UP ♦

*Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE*

Patient support & informa

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

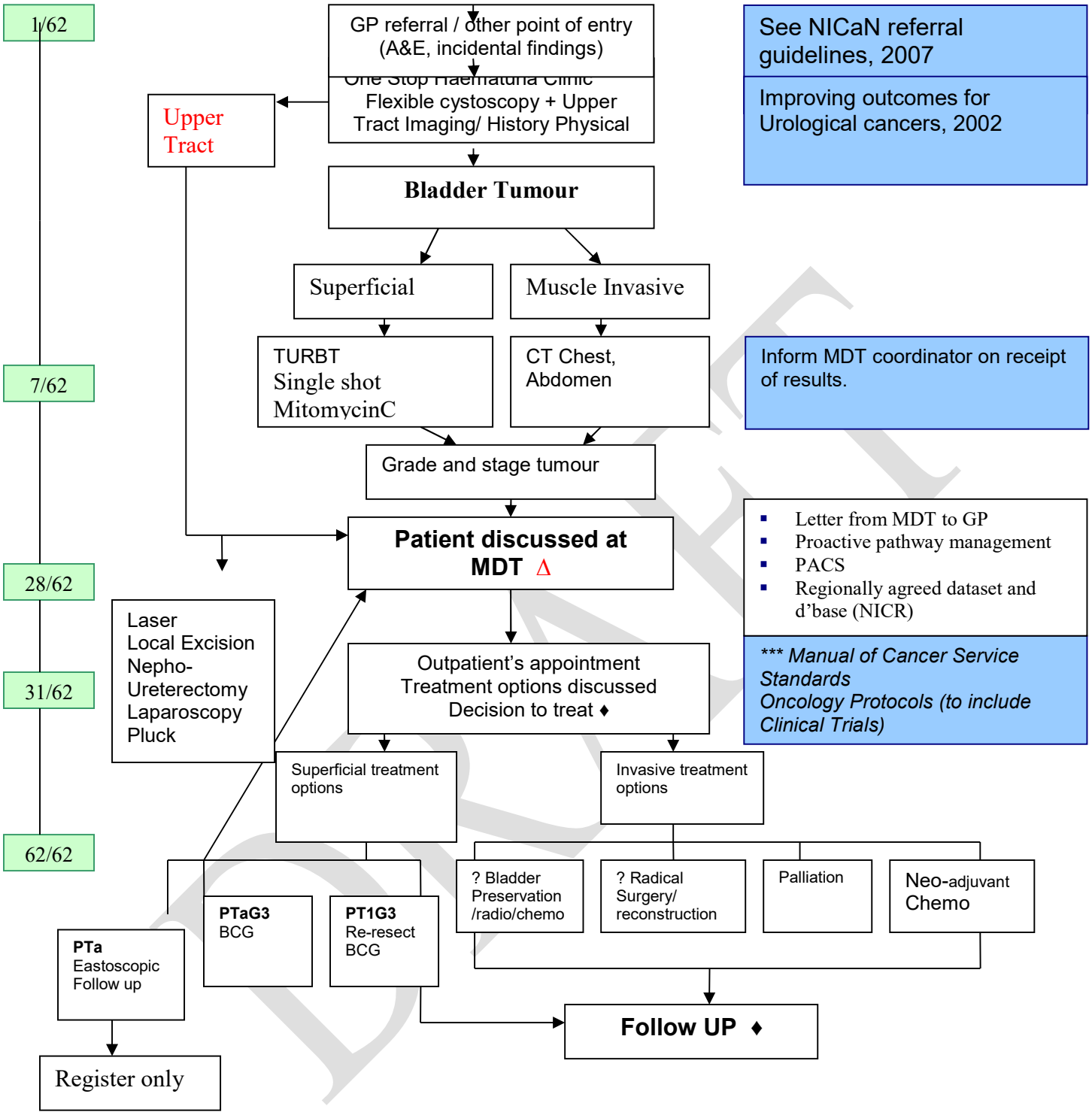
Testicular Cancer Pathway



Transitional Cell Carcinoma

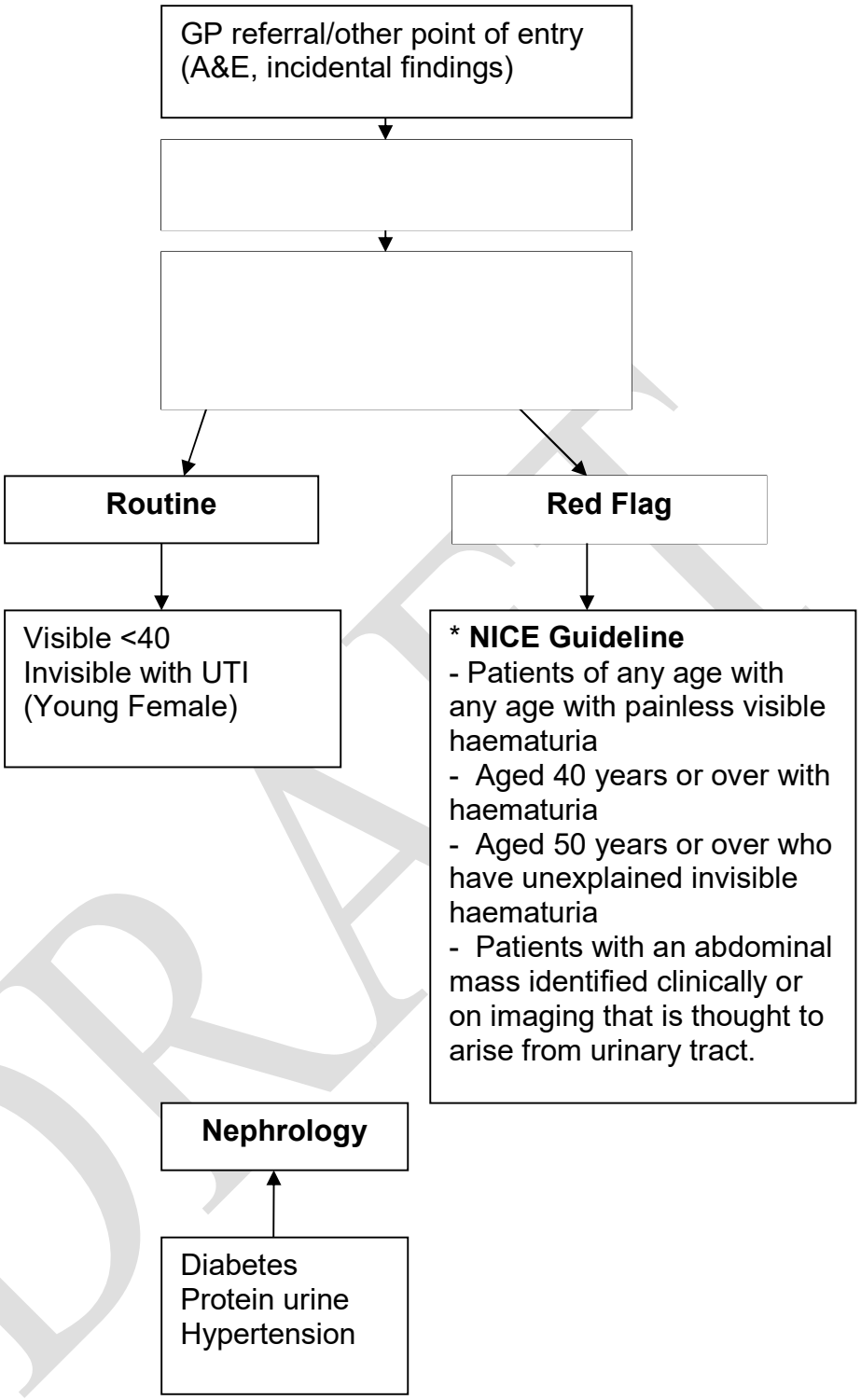
MAXIMUM WAIT	PATHWAY	GOOD PRACTICE & QUALITY PARAMETERS

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.



nican
northern ireland cancer network

Haematuria Referral Guideline



Corrigan, Martina

From: Reddick, Fiona [redacted]
Sent: 02 July 2015 10:54
To: Burns, Deborah
Cc: Carroll, Ronan
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Importance: High

Debbie,

Just wanted to give you the heads up – I rang Aidan to get an update as to where the below R/F referrals are as some of them are now sitting at D8 and we have no account of what is happening. This is the escalation process within cancer services as the staff are dealing with so many at one point in time and are responsible for keeping all tracked.

Aidan is aware of this from previous conversations. He is dealing with them and processing investigations as he triages but he just needs to let us know and keep informed so that we can track accordingly. He is bringing them in shortly but is very cross at this process and he tells me that he is coming to speak to you. The escalation process works well across all other areas.

Happy to discuss further.

Regards

Fiona

Fiona Reddick
Head of Cancer Services
Southern Health and Social Care Trust
Macmillan Building
Tel: [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 02 July 2015 10:18
To: Reddick, Fiona
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Fiona
Martina off can u speak with Aidan pls

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
[redacted]

From: Muldrew, Angela
Sent: 02 July 2015 10:11

To: Carroll, Ronan
Subject: RE: UROLOGY LATE TRIAGE ESCALATION

Mr O'Brien is the triager. Martina had emailed him on 30/06/15

Angela Muldrew
RISOH Implementation Officer
Tel. No. (028) Personal Information redacted by the USI (Mon, Thurs & Fri)
(028) Personal Information redacted by the USI (Tue & Wed)

From: Carroll, Ronan
Sent: 02 July 2015 09:45
To: Muldrew, Angela
Subject: RE: UROLOGY LATE TRIAGE ESCALATION

Who is the triager

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by the USI

From: Muldrew, Angela
Sent: 02 July 2015 09:24
To: Nelson, Amie
Cc: Corrigan, Martina; Davies, Caroline L; Carroll, Ronan; Reddick, Fiona
Subject: FW: UROLOGY LATE TRIAGE ESCALATION
Importance: High

Hi Amie

In Martina's absence are you able to help us as we have still not received the below referrals back from triage

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. (028) Personal Information redacted by the USI (Mon, Thurs & Fri)
(028) Personal Information redacted by the USI (Tue & Wed)
From: Corrigan, Martina
Sent: 30 June 2015 10:54
To: O'Brien, Aidan
Cc: Davies, Caroline L; Carroll, Ronan; Reddick, Fiona; Muldrew, Angela
Subject: Re: UROLOGY LATE TRIAGE ESCALATION

Aidan

Can you please advise?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology & Outpatients
Mobile Personal Information redacted by the USI

From: Muldrew, Angela
Sent: Tuesday, June 30, 2015 10:30 AM
To: Corrigan, Martina
Cc: Davies, Caroline L; Carroll, Ronan; Reddick, Fiona
Subject: FW: UROLOGY LATE TRIAGE ESCALATION

Martina

See below referrals that we are waiting coming back from triage. Would you be able to chase these up with Mr O'Brien?

Thanks

Angela Muldrew
RISOH Implementation Officer
Tel. No. (028) Personal Information redacted by the USI (Mon, Thurs & Fri)
(028) Personal Information redacted by the USI (Tue & Wed)

From: Davies, Caroline L
Sent: 30 June 2015 09:35
To: Muldrew, Angela
Subject: UROLOGY LATE TRIAGE ESCALATION

Hi Angela, the following referrals have still not come back from triage, I have just come back from the Thorndale Unit and there is nothing in my tray:

Surname

Name

Hosp. NO /HCN

Specialty

specific clinic if appropriate

Date Referral Received in Trust

MONTH

Date Referral Received in Cancer Services

Referral received via RF Fax, CCG, RBC, 1 south, Gynae, Secretary

Referrer (GP or OC - if OC put name of referrer)

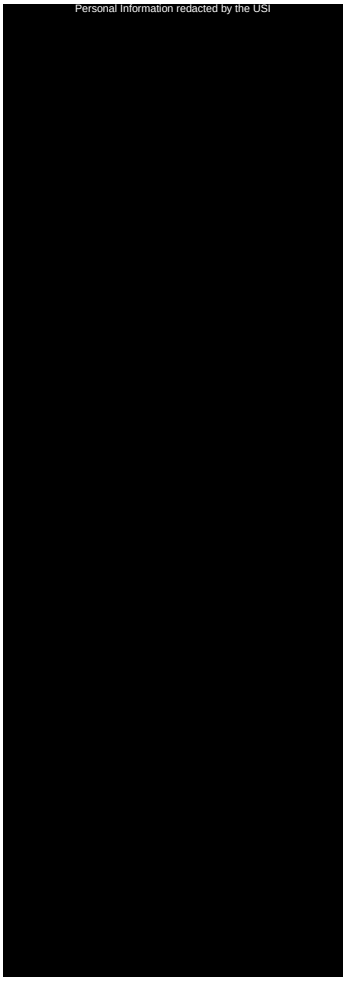
Date ORE'd

Initial of staff member who Ore'd referral

Date sent to triage

Date received back from triage

Comment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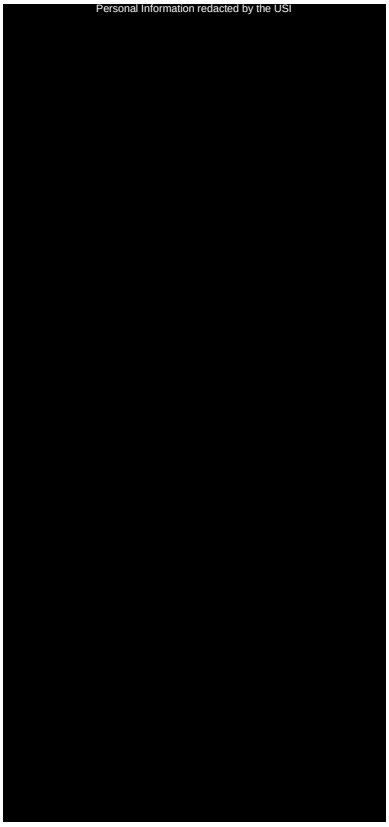
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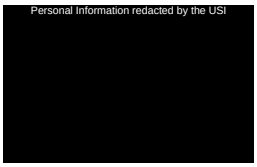
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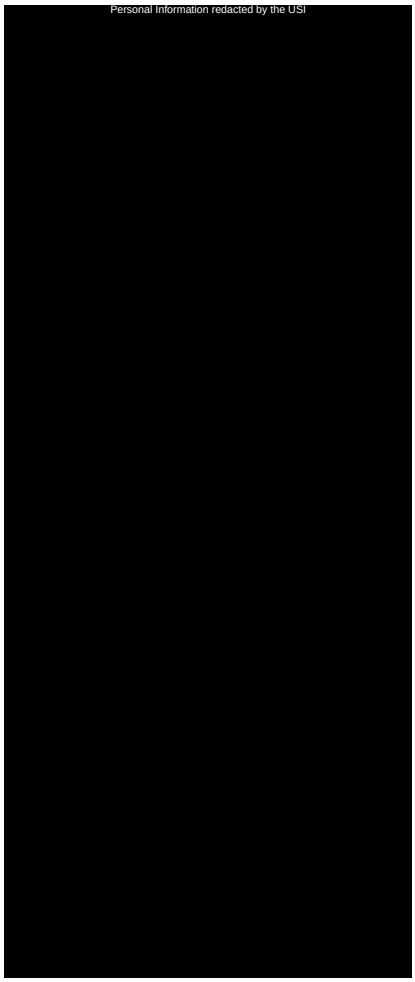
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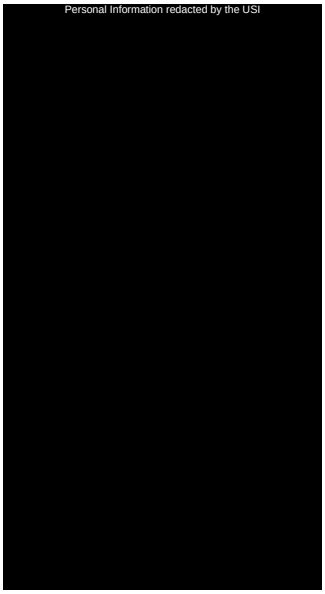
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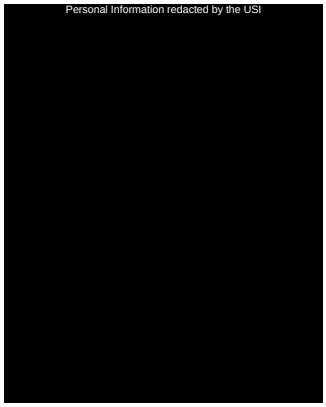

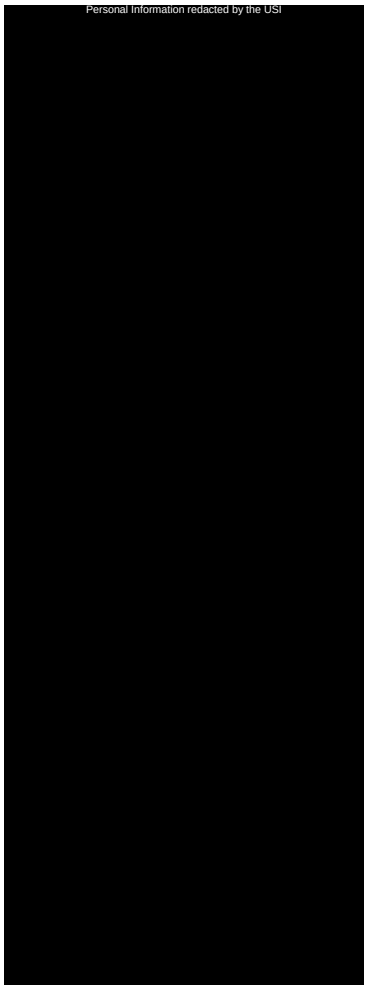

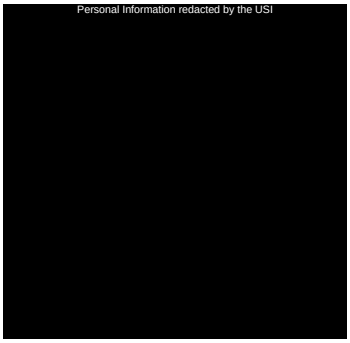

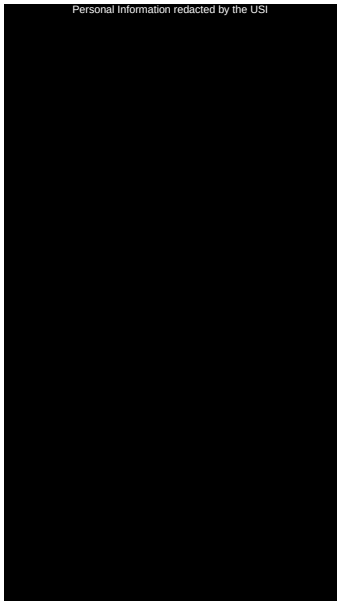
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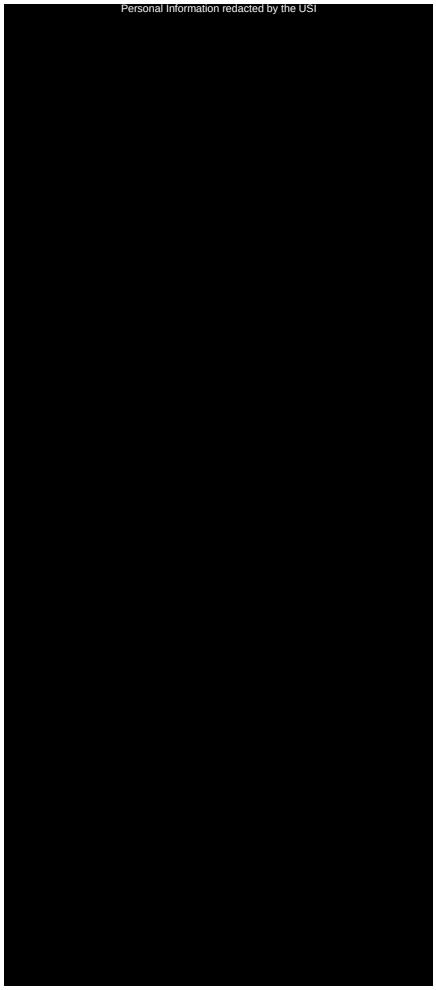
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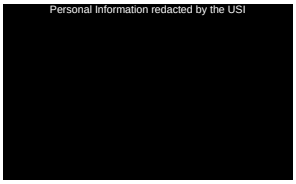
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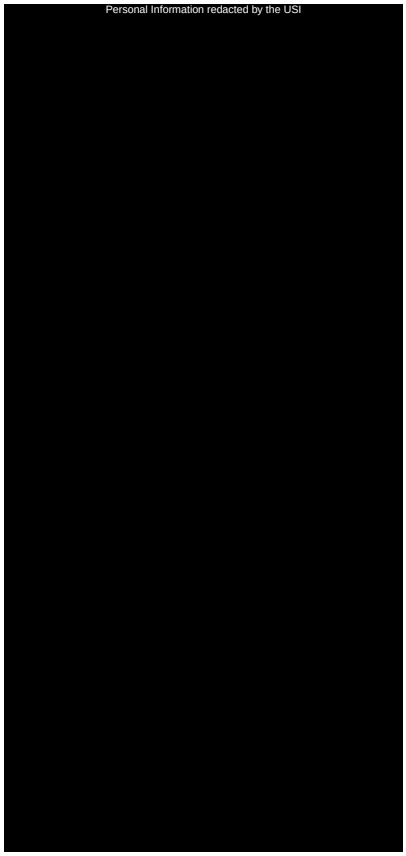

Regards Caroline

Southern Health and Social Care Trust

Interview with Martina Corrigan (MC)

PRESENT: Dr J Johnston
Mrs Trudy Reid

Introductions
Dr Johnston explained his clinical history, he retired as an Anaesthetist in 2013, then becoming the Assistant Medical Director in the Belfast Health and Social Care Trust. More recently he is working for the Department of Health developing the Regional Morbidity and Mortality electronic system.

The review of this Serious Adverse Incident (SAI) is not part of his role working for Department of Health, Dr Wright (Medical Director for Southern Health and Social Care Trust (SHSCT)) requested Dr Johnston to lead SAI.

Dr Johnston stated the interview was in relation to the triage aspect within the Trust and more particularly Mr O'Brien. He was aware may be other issues, however was not aware of the specifics, his remit was only to review triage.

Mark Haynes was advising regarding clinical issues and Dr Rankin and Mrs Gishkori had been interviewed.

Mrs Corrigan (MC) stated she was the Head of Service (HoS) for ENT/Urology/Ophthalmology and outpatients. She had been in post approximately nine years; she was in the post from 2009. MC stated from talking with others she was aware this was a long running issue, perhaps ongoing for twenty five years.

Martina Corrigan stated she inherited the problem and highlighted this was an ongoing issue with Mr O'Brien. He was the worst offender for not triaging and took longest to triage.

There were issues with other consultants and specialists but nowhere as problematic as Mr O'Brien.

When waiting times were nine weeks, it was more of an issue if letters were not triaged in 72 hours as per the Integrated Elective Access Protocol (IEAP).

If there were issues, she contacted a consultant and there would be an improvement. Mr O'Brien could have been contacted and letters did not appear.

- Waiting times increased e.g. – urology 92 weeks routine – if letter came in today, the 72-hour triage rule is not as crucial as it was when waiting times were 9 weeks.
- If allocated to Red flag route, the triage is still 24 hours regardless of waiting times 14 days. (this is not problem with other consultants)
- All Red Flag referrals go to the Red Flag cancer team, who bring them to the on-call consultant or via e-triage. The Surgeon of the Week (SOW) has to triage to see if they need to remain Red Flagged. The SOW may order scans etc.

Governance Office, Ground Floor, The Maples
Craigavon Area Hospital
Tel: Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

All on the triage list need completed.
If he doesn't triage – the administration team in the past would have escalated to the HoS.

- Escalated letters to the HoS were put on list/appointed to continue the process.
- The Normal & Urgent sat on a list.
- 500 letters were found – (including Red Flag letters; but all the R/F had been appointed)

This is where the problem arose; the letters that sat on the waiting list and were not upgraded.

Dr Johnston stated this had been happening over 25 years,
Mr O'Brien was not only one who, on occasion, did not triage but was the only one, that when asked, didn't do it.
This came to head in 2014.

The informal default process, why was it informal?
Why was Mr O'Brien not told just to do it?
MC stated she raised it; she wrote to Mr O'Brien and then escalated to the Assistant Director and Associate Medical Director.
This was addressed finally with Dr Rankin who with AD, AMD at time of the British Association of Urology Specialists (BAUS conference), and MC remembered that despite triaging the letters at that time, Mr O'Brien did not get the conference due to a volcanic ash cloud.

During Mrs D Burn's time as Interim Director of Acute services, the un-triaged letters built up again. Mrs Burns met with Mr O'Brien and MC and very firmly told him to triage. Note: according to DB interview, she told AO'B to stop triaging.

Mrs A Carroll, Mrs K Robinson and & MC met. Mrs Carroll considered what are we going to do; if Mr O'Brien was not triaging patients then they were not going onto any waiting list (urgent/routine), they were the only people in room.
While the process of putting people on the waiting list without triage meant that people did not get missed which was good to be on a list, it meant that there was no way of picking up who was triaged or what was the extent of non-triage.

Dr Johnston highlighted, if letters were not triaged, patients were not upgraded.
MC stated yes this is a problem. GP's should have same responsibility, but the extent had been known. In the referral default process, there was not a safety net; this took away her safety net of checking triage compliance, as she could not see what was triaged.

Dr Johnston – meetings were held, they were difficult. Processes were put on place. Why it was not escalated earlier?
MC stated process was to put patients on waiting list; this was better than nothing. She didn't know why escalation didn't go higher. Consultants saw some triaged letters – then worked out why it happened and identified the gap. The problem was only found out by looking at on call weeks.

Dr Johnston stated that [redacted] *was the index case. In December 2016 during the SAI Mr T Glackin wrote a letter exposing the problem.*

Mrs Corrigan stated in December 2016 she found the letters in a filing cabinet.

Mr O'Brien Personal information redacted by USI in November 2016 and was off work; due to come back middle to end December. Mr O'Brien was brought in to tell him there was an issue. Mr O'Brien met with MC off site to give info regarding other issues. Mr O'Brien told MC to go to middle drawer of filing cabinet. There she found almost 700 letters. Some patients had already been seen; this instigated the look back exercise.

Dr Johnston asked, now what happens?
MC stated most referrals are via the CCG gateway, by the majority of GP's. There was an attempt to get GP's to refer by symptom but currently it is just by Red Flag, Urgent and Routine.

Mr Haynes, Mr Glackin and MC are working to get symptoms for referral on CCG. MC highlighted it is a longer process; consultants have the ability to review clinical history on NIECR. Some Consultants now do advanced triage but it takes longer.
MC stated every Speciality triages, but that Neurology & Urology do advanced triaged. Urology was the first specialty to go electronic.

Dr Johnston asked if Mr O'Brien did electronic triage?
MC stated, "Yes AO'B does it", but that she cannot look into NIECR / CCG to review if triage is done.

Part of Mr O'Brien's return to work agreement was that he would complete,
- Red Flag referral triage with 24 hrs.
- By 5pm Friday pm all triage must be complete, SOW stops – on call 5pm Thursday.

MC has monitored Mr O'Brien since his return to work. On an occasion when MC was on leave Mr O'Brien did not triage R/F referrals. When she found R/F referrals were not triaged she met with him on Thursday.

Most consultants do not triage within 72 hours, Mr O'Brien was also given some flexibility. MC checks all urology triage on an adhoc basis, but Mr O'Brien on a daily basis during SOW week. There were no R/F issues until last week.

The Escalation process is MC to Mr R Carrol (AD) to Mr Haynes (AMD).
Prior to the Thursday meeting Mr O'Brien did not ask for help. MC has written to him regarding this meeting. Currently Mr O'Brien is scrutinised, this has added to MC's work load and it is not just triage. There are extra slots weekly for upgrades from triage. There is a Red Flag demand capacity issue.

Dr Johnston highlighted GP vacant posts, GP performance on triage decreased if short staffed. Consults will have to be there for safety net.
MC highlighted they could be a safety net but should be triage by clinical symptoms.

Dr Johnston stated more sophisticated electronic CCG method is required but Urology not difficult in relation to guidelines. Guidelines including 2005 NICE Guidelines & NICAN Guidelines are currently in use.

The Urology Cancer 2016 guidance was signed by Mr O'Brien.

The 2015 NICE NG 12 has been held up by GP's who are reluctant to sign off.

Stinson, Emma M

From: Simpson, John <[redacted]>
Sent: 03 April 2014 15:33
To: Burns, Deborah; Morgan, Paul
Cc: Donaghy, Kieran; Crilly, Miceal; Rice, Francis; McAlinden, Mairead
Subject: RE: JOB PLANNING STEERING GROUP MEETING
Attachments: image001.jpg

Kieran, what is your advice on how to proceed?
John

From: Burns, Deborah
Sent: 03 April 2014 15:04
To: Morgan, Paul; Simpson, John
Cc: Donaghy, Kieran; Crilly, Miceal; Rice, Francis; McAlinden, Mairead
Subject: RE: JOB PLANNING STEERING GROUP MEETING

Agree would be happy to meet and do this – John?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Morgan, Paul
Sent: 03 April 2014 08:50
To: Burns, Deborah; Simpson, John
Cc: Donaghy, Kieran; Crilly, Miceal; Rice, Francis; McAlinden, Mairead
Subject: RE: JOB PLANNING STEERING GROUP MEETING
Importance: High

Yes I think following our recent meeting with Francis,that it was critical in moving forward within acute,how we fully utilise the AMD and CD in their management roles,augmented by greater input,operationally,from the nursing governance leads.Maybe the way forward is for us to meet and scope/shape what that arrangement would look like vis a vis accountability;governance;standards etc,Paul

From: Burns, Deborah
Sent: 02 April 2014 18:06
To: Simpson, John; Morgan, Paul
Cc: Donaghy, Kieran; Crilly, Miceal; Rice, Francis; McAlinden, Mairead
Subject: RE: JOB PLANNING STEERING GROUP MEETING

I think Paul means in terms of the management review John -I know that I am I think Paul too is considering Kieran's suggestion of increased medical management. So in acute as the senior medics expressed a view decision making is too slow and we cant split the directorate one of the only solutions left is increased management of smaller areas – and possibility for this is medical management – so we look to possibily expand AMD and CD roles?

Paul is that correct?

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Simpson, John
Sent: 02 April 2014 13:30
To: Morgan, Paul
Cc: Burns, Deborah; Donaghy, Kieran; Crilly, Miceal; Rice, Francis
Subject: RE: JOB PLANNING STEERING GROUP MEETING

Probably not. I need to sit down with HR first to scope this out (re interviewing CD's trustwide for example) John

From: Alexander, Ruth On Behalf Of Morgan, Paul
Sent: 02 April 2014 12:22
To: Simpson, John
Cc: Burns, Deborah; Donaghy, Kieran; Crilly, Miceal; Rice, Francis
Subject: FW: JOB PLANNING STEERING GROUP MEETING
Importance: High

John

Would this be an opportunity to table/discuss the management roles or our AMDs and CDs?
Paul

From: Parks, Zoe
Sent: 26 March 2014 14:38
To: Hall, Stephen; Mackle, Eamon; Murphy, Philip; Hogan, Martina; McAllister, Charlie; OReilly, Seamus; Chada, Neta; Khan, Ahmed; Burns, Deborah; Morgan, Paul; Crilly, Miceal; Simpson, John; Donaghy, Kieran
Cc: Brown, Robin; Hall, Sam; Scullion, Damian; Fawzy, Mohamed; McCusker, Grainne; McCaffrey, Patricia; Sim, David; Hughes, James; McMahon, Dr; McGuinness, Dr Joan; Trouton, Heather; Conway, Barry; Maguire, Geraldine; Gibson, Simon; Carroll, Ronan; Mallagh-Cassells, Heather; Clegg, Malcolm; McVey, Anne
Subject: JOB PLANNING STEERING GROUP MEETING
Importance: High

Dear all,

Job Planning Steering Group

It has been some time since the last Job Planning Steering Group Meeting (notes attached). Following my email to AMD's at the end of last year, the consensus was most find these Job planning Steering Meetings useful to discuss on-going challenges and ensure consistency across the Trust. It was therefore agreed that we would arrange a further less formal meeting at the beginning of the next job planning round.

I would therefore be grateful if you could hold Wednesday 7 May 2014 at 5pm, Boardroom Trust HQ in your diary for the next meeting.
I would be grateful if you have any agenda items that you would like to discuss, if you could advise me of these as soon as possible.

Many thanks

Mrs Zoe Parks
Medical Staffing Manager
* Southern Health & Social Care Trust
Trust Headquarters
68 Lurgan Road, Portadown. BT63 5QQ
(Personal Information redacted by the USI
Personal Information redacted by the USI
Personal Information redacted by the USI
Fax:
8 Personal Information redacted by the USI

From: Parks, Zoe
Sent: 23 September 2013 11:44
To: Hall, Stephen; Murphy, Philip; Hogan, Martina; Mackle, Eamon; McAllister, Charlie; Chada, Neta; O'Reilly, Seamus; Khan, Ahmed
Cc: Brennan, Anne; Clegg, Malcolm; Mallagh-Cassells, Heather
Subject: JOB PLANNING STEERING GROUP MEETINGS
Importance: High

Associate Medical Directors,

JOB PLANNING STEERING GROUP MEETING

You will recall the last Job planning Steering Group Meeting was held on 27 March 2013. I have attached the last notes for your information.

I am writing to seek your feedback on the usefulness of these Job Planning meetings.

Do you think they are helpful? Are you happy with the current format or would they be better less formal – i.e. workshops to work through some of the outstanding issues? I would welcome your comments on areas you would like to discuss and whether you would be interested in a further meeting scheduled sometime in January/February 2014.

I look forward to hearing from you.

Zoe

Mrs Zoe Parks
Medical Staffing Manager
Southern Health & Social Care Trust
Craigavon Area Hospital
68 Lurgan Road, Portadown

Phone: Personal Information redacted by the USI
Blackberry: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

Stinson, Emma M

From:	Stinson, Emma M <[redacted]>
Sent:	03 October 2014 16:07
To:	Boyce, Tracey; Walker, Helen; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather; Burke, Mary; Carroll, Kay; Corrigan, Martina; Devlin, Louise; Donaldson, Ruth; Forde, Helen; Magee, Brian; McGeough, Mary; McGoldrick, Kathleen; McIlroy, Cathie; McLoughlin, Sandra; McStay, Patricia; Murray, Eileen; Nelson, Amie; Reddick, Fiona; Reid, Trudy; Robinson, Jeanette; Hall, Stephen; Hogan, Martina; Mackle, Eamon; McAllister, Charlie; Murphy, Philip; OReilly, Seamus
Cc:	Livingston, Laura; Marshall, Margaret; Conlon, Noeleen; Graham, Michelle; Lappin, Aideen; Murphy, Jane S; Beattie, Pauline; Lindsay, Gail; McVeigh, Elizabeth; Renney, Cathy; Slaine, Delma
Subject:	*For Information* Governance Team Realignments
Attachments:	image001.png; image002.png; image005.jpg

Dear all

From 1st October 2014 the following changes in line management arrangements within the Governance Team will be implemented:

The Acute Directorate Governance Team will be co-ordinated by Dr Tracey Boyce and Mrs Connie Connolly and Mr Paul Smith will join this team. The teams key areas of responsibility will continue to support the Directorate in the management, investigation and learning from complaints and incidents. This Team will also continue to support the Directorate with respect to directorate risk registers.

Anne Quinn and Paula Fearon will join the Patient Safety and Quality Team from the 1st October 2014. The team will provide outreach support to the Directorate in the following key areas: implementation of standards and guidelines, equipment management, level 2 and 3 SAI investigations and support required for RQIA reviews. This team will report to the Interim Assistant Director of Clinical and Social Care Governance.

In the coming weeks the teams will be engaging with Assistant Directors, AMDs and Heads of Services to seek feedback in order to ensure that their teams are effectively supporting the Directorate with regard to their areas of responsibility.

Margaret Marshall will conclude her secondment as Clinical and Social Care Governance Coordinator in the Acute Directorate from the 1st October 2014.

Please disseminate through your teams as appropriate.

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services

Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: Personal Information redacted by the USI Direct Fax: Personal Information redacted by the USI
Personal Information redacted by the USI

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Stinson, Emma M

From: Burns, Deborah <Personal Information redacted by the USI>
Sent: 09 December 2011 17:58
To: Rankin, Gillian; Simpson, John; Trouton, Heather; Marshall, Margaret
Cc: Magennis, Joscelyn
Subject: Fw: SAI Personal information redacted by USI Response
Attachments: Dr D Corrigan response re Personal information redacted by USI nov 11.doc

Hi all please see final draft that went today to diane. I know that margaret and heather are working together to help all the divisions get a baseline assessment re result reviewing and then the next step will b to agree a fairly uniform way forward that both works for consultant staff and accomodates the move to online reporting especially for labsm I know that gillian intends to keep this on her gov agenda also

Hope this is useful update
D

From: Magennis, Joscelyn
To: diane.corrigan Personal Information redacted by the USI <Personal Information redacted by the USI>
Cc: Burns, Deborah
Sent: Fri Dec 09 15:13:37 2011
Subject: SAI Personal information redacted by USI Response

Dr Corrigan

Please find attached response from Debbie Burns A/Director of Corporate Clinical & Social Care Governance SHSCT re SAI Personal information redacted by USI

Kindest Regards

Joscelyn Magennis

Governance Admin Assistant
Corporate Clinical & Social Care Governance Dept Trust HQ
Personal Information redacted by the USI

Dr D Corrigan,

Consultant in Public Health Medicine

Public Health Agency

Tower Hill

Armagh

BT61 9DR

24 November 2011

Dear Dr Corrigan,

Thank you for your letter dated 14 November 2011 in relation to Serious Adverse Incident Personal Information redacted by the, and your constructive comments on the subsequent review report. The Trust agrees that you raise a very pertinent issue which should have been listed as a recommendation and subsequent action, namely the requirement for assurance that Consultant medical staff review all diagnostic results as they become available and do not wait until the patient is reviewed at an outpatient appointment, specifically in light of the improving but on-going backlog in outpatient review appointments.

Although this issue was not included as a recommendation or action the Trust has recognised the need for the above assurance and ~~or~~ a Trust protocol and has taken the following actions:

- The current practice of Consultant surgical staff in relation to review of diagnostic results has been scoped and this baseline of practice is being widened to all four acute divisions where appropriate.
- Initial scoping indicates that in the main Consultant surgeons are reviewing diagnostics in a timely manner, although variances in how this is being done have been highlighted.

As a result of the above findings and with the added impact of on line results being available for diagnostics, for example via PACS and order comms, it is timely that the Trust

undertakes a thorough review of practices which may lead to a Trust protocol being devised. Action on this issue, while not outlined in the review report, is therefore on going, and the Trust would be happy to share the conclusions of this work with you.

Yours sincerely

D Burns

Stinson, Emma M

From: Stinson, Emma M <Personal Information redacted by the USI>
Sent: 08 June 2015 15:23
To: 'Esther Gishkori'
Subject: RE: orientation visits.
Attachments: image001.png; image002.png; image003.jpg

That would be great – 1.30 pm it is. I am sure you will be fine but I will do whatever I can to help you settle in. I'm not sure if you know where our office is but when you come in through the main hospital entrance there are stairs to your left, at the top of those stairs turn right (through a set of double doors) and we are in the corner office.

I'm looking forward to meeting you.

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

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From: Esther Gishkori [mailto:Personal Information redacted by the USI]
Sent: 08 June 2015 15:17
To: Stinson, Emma M
Subject: Re: orientation visits.

Hello Emma,
Thank you for the welcome. I have worked for SET in its various forms for the past 25 years so I will be depending on you to keep me right for quite a while!
I can't make the Trust Board meeting on 11th June but am happy to drop in on Monday 15th to see Debbie. We can take future meetings from there.

Should we say around 1.30pm so Debbie can have a bite of lunch before I turn up?

Many thanks
Esther.

On 8 Jun 2015, at 14:16, Stinson, Emma M <[redacted] > wrote:

Dear Esther

Welcome to the Southern Trust. I'm not sure if you are attending the Trust Board meeting on 11th June but if not then next Monday 15th June anytime from 1pm would be a good day to call in if that would suit you?

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

<image001.png> Direct Line: [redacted] Direct Fax: [redacted]
<image002.png>[redacted]
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<image005.jpg>

'You can follow us on Facebook and Twitter'

From: Burns, Deborah
Sent: 08 June 2015 12:12
To: Esther Gishkori; Stinson, Emma M
Subject: RE: orientation visits.

Hi Esther,
Firstly congratulations. I am very happy that you come in at any time and as often as you wish and sit in on as many meetings as you wish and meet whoever. SO probably as a first step do you want to have a think through what time you want to give it and also contact emma and come in to chat through your ideas and requirements with me as a first go?

Emma can you give Esther any free slots this week or next to do initial meeting

Thanks
D

Debbie Burns

Acting Director of Acute Services
SHSCT
Personal Information redacted by the USI
Tel: Personal Information redacted by the USI

From: Esther Gishkori [mailto:Personal Information redacted by the USI]
Sent: 08 June 2015 12:00
To: Burns, Deborah
Subject: orientation visits.

Hi Debbie,
I told Kieran and Paula that I would contact you directly on my return from holiday.

I was wondering if it would be possible to arrange to come in to see you some time?

I know there are some meetings I need to attend and people I need to meet. I also know you are on leave in July.

I'm fairly free throughout the summer but since its likely I will have to pay another visit to Bahrain, I would be grateful if you could offer me some dates that suit so that I can make other plans.

Looking forward to meeting you,
Best regards
Esther.

Southern Health & Social Care Trust IT Department Personal Information redacted by the USI

Stinson, Emma M

From: Stinson, Emma M <[redacted]>
Sent: 26 June 2015 11:10
To: 'Esther Gishkori ([redacted])'
Subject: Dates for Diary
Attachments: image001.png; image002.png; July 2015 Calender - Mrs E Gishkori.xlsx; image005.jpg

Hi Esther

I hope you are well. I have been busy arranging as many of these meetings as possible and have attached in a spreadsheet. Have a good weekend.

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]

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JULY 2015 CALENDAR - Mrs E Gishkori

	Mon 29 June	Tues 30 June	Wed 1	Thurs 2	Fri 3	Mon 6	Tues 7	Wed 8	Thurs 9	Fri 10
08:00						NOT IN OFFICE		IN DHH WITH ANNE MCVEY		Acute Clinical Governance with ADs and AMDs in Board Room, Ground Floor, CAH
08:30										
09:00			Infection Control Weekly Meeting	Simon Gibson & Barry Conway re: Business Meeting, Barry's office	Anne McVey for Part 1 of CAH Tour of IMWH, Anne McVey's office					
09:30		BCBV, Board Room, Trust HQ	Acute Divisional Performance Meetings							
10:00							Dr Tracey Boyce - Pharmacy Office			hold for extra-ordinary JOF
10:30										
11:00				Simon Gibson, Barry's office					Surgical Sisters Meeting, Meeting Room, Admin Floor	
11:30							Meet with Chair in Trust HQ			
12:00			Meeting with Lesley Leeman (Lesley's office, Trust HQ)							
12:30										
13:00										
13:30					Meet ED Staff with Mary Burke, Meeting Room, Admin Floor CAH				Acute Divisional Finance Meetings, Debbie's office, CAH	
14:00			Sandra Waddell & Claire Kelly Senior Planners, The Brackens	Pre LNC Meeting with SMT						
14:30				LNC, Board Room, CAH	Diabetes Update Meeting with Trust and PHA, Board Room, Trust HQ		Acute Directorate Governance Meeting, Meeting Room, Admin Floor			
15:00										
15:30										
16:00									Meeting with AMD Philip Murphy & Barry Conway, Barry's office	
16:30										
17:00										
17:30										
18:00										

Meetings in CAH
Meetings Requiring Travel
Meetings useful for you to attend as part of orientation

Mon 13	Tues 14	Wed 15	Thur 16	Fri 17	Mon 20	Tues 21	Wed 22	Thurs 23
Bank Holiday								CCS Governance Meeting, Medical Executive's office, Admin Floor
						Debbie Annual Leave		Meet with Ronan Carroll for tour of CCS departments
				hold for extra-ordinary JOF				
			Meet in Lurgan Hospital with Helen O'Neill (AD Finance) Carol Cassells & Gary Donaghy (Senior Acute Accountants)		Meet with Anita Carroll in CAH to see FSS and attend team meeting, Board Room, CAH			
			Anne McVey for Part 2 of CAH Tour of IMWH, Anne McVey's office				Meet with Heather Trouton and Eamon Mackle (AMD) Heather's office	

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

Fri 24	Mon 27	Tues 28	Wed 29	Thurs 30	Fri 31
Travel	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave
Francis Rice in Bannvale House, Gilford	Meet with Ronan Carroll in DHH for tour of CCS departments				
Travel					
			SMT, Board Room, CAH		

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

JULY 2015 CALENDAR - Mrs E Gishkori

	Mon 29 June	Tues 30 June	Wed 1	Thurs 2	Fri 3	Mon 6	Tues 7	Wed 8	Thurs 9	Fri 10	Mon 13	Tues 14	Wed 15	Thur 16	Fri 17	Mon 20	Tues 21	Wed 22	Thurs 23	Fri 24	Mon 27	Tues 28	Wed 29	Thurs 30	Fri 31
08:00						NOT IN OFFICE		IN DHH WITH ANNE MCVEY		Acute Clinical Governance with ADs and AMDs in Board Room, Ground Floor, CAH	Bank Holiday								CCS Governance Meeting, Medical Executive's office, Admin Floor						
08:30																									
09:00			Infection Control Weekly Meeting	Simon Gibson & Barry Conway re: Business Meeting, Barry's office	Anne McVey for Part 1 of CAH Tour of IMWH, Anne McVey's office												Debbie Annual Leave			Travel	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave	Debbie Annual Leave
09:30		BCBV, Board Room, Trust HQ	Acute Divisional Performance Meetings																	Francis Rice in Bannvale House, Gilford	Meet with Ronan Carroll in DHH for tour of CCS departments				
10:00							Dr Tracey Boyce - Pharmacy Office			hold for extra-ordinary JOF					hold for extra-ordinary JOF				Meet with Ronan Carroll for tour of CCS departments						
10:30																									
11:00				Simon Gibson, Barry's office					Surgical Sisters Meeting, Meeting Room, Admin Floor					Meet in Lurgan Hospital with Helen O'Neill (AD Finance) Carol Cassells & Gary Donaghy (Senior Acute Accountants)		Meet with Anita Carroll in CAH to see FSS and attend team meeting Board Room, CAH				Travel					
11:30																									
12:00			Meeting with Lesley Leeman (Lesley's office, Trust HQ)				Meet with Chair in Trust HQ																		
12:30																									
13:00																									
13:30					Meet ED Staff with Mary Burke, Meeting Room, Admin Floor CAH				Acute Divisional Finance Meetings, Debbie's office, CAH					Anne McVey for Part 2 of CAH Tour of IMWH, Anne McVey's office				Meet with Heather Trouton and Eamon Mackle (AMD) Heather's office						
14:00			Sandra Waddell & Claire Kelly Senior Planners, The Brackens	Pre LNC Meeting with SMT			Acute Directorate Governance Meeting, Meeting Room, Admin Floor																SMT, Board Room, CAH		
14:30				LNC, Board Room, CAH	Diabetes Update Meeting with Trust and PHA, Board Room, Trust HQ																				
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17:00																									
17:30																									
18:00																									

Meetings in CAH

Meetings Requiring Travel

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.